

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2026
NAME OF PROVIDER OR SUPPLIER Rivaya Care of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and policy review, the facility failed to follow its written abuse prevention policy when administration did not enforce policy rules after confirming a Certified Nursing Assistant (V3) crossed professional boundaries with a resident (R1) and deleted social media evidence during an internal investigation. This failure by management to enforce its abuse policy puts all 133 residents in the facility at risk for unchecked staff misconduct. Findings include: The facility's policy titled Abuse Prevention Policy states in part: Photographing and Recording Residents. Staff photographing or recording residents or their private space . for other than medical or facility purposes . is strictly prohibited. Staff posting or sending a photo or recording on social media or otherwise keeping or sending a photo or record through multimedia messaging . is strictly prohibited. Staff taking or using a photograph or recording of a resident in a manner that demeans or humiliates a resident . will be handled as an allegation of abuse in accordance with the procedures set forth below. On 7/24/26 at 1:50 PM, an interview with V3 (CNA) confirmed an ongoing failure to adhere to professional boundary expectations. V3 acknowledged initiating and maintaining an unapproved social media relationship via Instagram with R1 over a three-month period while assigned as R1's direct caregiver multiple times per week. V3 stated she was aware R1 had a diagnosis of clinical depression having been informed by a facility nurse and acknowledged personally observing R1 crying on multiple occasions. V3 additionally acknowledged awareness of R1's diagnosis of generalized anxiety disorder; however, V3 admitted that because she is not a clinician, she did not recognize the clinical difference between depression and generalized anxiety disorder. Despite knowing R1 suffered from these psychiatric conditions, V3 maintained private communications and admitted R1 obtained personal photos of her from her Instagram account. V3 stated that after her husband discovered the interaction, she abruptly severed contact, causing R1 to become emotionally distraught. V3 admitted to deleting her Instagram account, posts, and message history prior to and during the facility's internal investigation, thereby removing digital evidence of the boundary breach. On 7/24/26 at 2:30 PM, an interview with V1 (Administrator) revealed a failure of facility leadership to enforce written policy mandates upon confirming staff misconduct. V1 acknowledged V3 CNA crossed professional boundary policies with R1 and was placed on suspension. However, V1 confirmed administration elected not to enforce full policy sanctions or terminate V3, offering an unverified assertion that R1 was manipulative and citing R1's personal background as rationale for V3's involvement. V1 acknowledged that administration never inspected the digital messages or photographic evidence exchanged between V3 and R1 because V3 deleted the account prior to administrative review, yet leadership took no administrative or disciplinary action regarding the destruction of evidence during an active abuse investigation. On 7/25/26 at 10:20 AM, an interview with R1 corroborated the administrative breakdown in protecting residents from boundary breaches. R1 stated V3 initiated a private social media relationship while providing direct care, causing him significant emotional (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	distress, depression, and a request to be discharged when V3 abruptly stopped communicating. R1 confirmed facility administration was aware of the incident and suspended V3, but noted he expressed a desire for V3 not to be fired due to feelings generated by the boundary violation, demonstrating the heightened vulnerability created when administrative controls fail to mitigate staff boundary crosses. On 7/26/26 at 12:30 PM, an interview with V5 (Human Resources Director) revealed that she served as manager on duty when V4 (Director of Nursing) instructed that V3 be removed from the floor and suspended pending investigation. V5 stated she conducts inservice training on abuse prevention, during which she emphasized the facility's policy prohibiting social media interactions with residents, and affirmed that all staff social media communication with residents is prohibited. On 7/26/26 at 1:00 PM, an interview with V4 (Director of Nursing - DON) confirmed she received a call and text message from R1 regarding his Instagram relationship with V3. V4 then directed V5 to suspend V3 pending an internal investigation. V4 stated V3 committed a clear boundary violation by allowing R1 access to her personal phone to connect on Instagram. V4 acknowledged that she could not verify the full nature of the communications because V3 deleted her account during the investigation, and acknowledged concerns regarding compromised transparency.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate personal property inventory and failed to safeguard personal belongings for 1 of 3 resident (R2) reviewed for missing personal property. Specifically, the facility failed to complete or provide an itemized personal inventory list upon admission or during care, and failed to investigate or provide objective evidence to substantiate the whereabouts of R2's missing wedding ring and fur coat. Findings include: R2 is an [AGE] year-old female with medical diagnoses including atrial fibrillation, bradycardia, chronic gout, and stage 4 chronic kidney disease, and is wheelchair-dependent. A review of R2's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. On 7/24/26 at 11:15 AM, an interview was conducted with Assistant Administrator V2 regarding the facility's tracking of missing resident property. When requested to provide a missing items log, V2 stated that the facility did not maintain a dedicated missing items log and only maintained a general concern/complaint log. A subsequent review of the facility's concern/complaint log revealed no entry or record documenting R2's reported missing wedding ring or fur coat. On 7/24/26 at 11:50 AM, Administrator V1 was asked to provide R2's completed personal property inventory sheet and any investigative documentation regarding the missing items. V1 was unable to furnish an inventory list for R2 or any record of a missing property investigation. V1 stated he believed R2 may have lost the items during a prior hospitalization; however, when asked to provide documentation, transfer logs, hospital transport checklists, or any corroborating evidence showing the items left the facility with R2 during her hospital transfer, V1 stated that no proof or documentation was available. On 7/25/26 at 2:35 PM, an interview with R2 revealed that her wedding ring and a fur coat went missing while residing at the facility. R2 reported that facility staff did not provide her or her representative with a personal property inventory list upon admission, nor was an established facility protocol, inventory log, or tracking method provided to identify or locate lost or missing personal items. On 7/26/26 at 11:15 AM, V1 was requested again to provide an inventory sheet as evidence of R2's personal property. No evidence was provided to demonstrate that the facility maintained an inventory sheet to account for the resident's personal belongings, nor was evidence provided showing that R2's property was located or replaced. On 7/26/26 at 12:30 PM, an interview with V5 (Human Resources Director) revealed she was unaware of any complaints regarding staff involvement in missing items. V5 stated it was the responsibility of the nursing staff to inventory resident belongings upon admission. V5 noted she had previously observed nurses writing resident items on loose paper, but stated she was unaware of what happened to those records afterward. On 7/26/26 at 1:00 PM, an interview with V4 (Director of Nursing - DON) confirmed that R2 admitted from another facility with numerous personal items, including a refrigerator. V4 acknowledged that nursing staff failed to document or itemize any of R2's belongings on an inventory sheet or official record upon admission. A subsequent review of R2's clinical and administrative records revealed no documented personal property inventory form completed upon admission or updated during her stay. Furthermore, the facility record contained no documented investigative report, missing item log, or follow-up entries regarding the reported disappearance of R2's wedding ring or fur coat.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 3 residents (R1) reviewed for abuse was protected from staff boundary violations and potential emotional exploitation when Certified Nursing Assistant (V3) established an unauthorized personal social media relationship with R1, causing R1 emotional distress, and deleted her account history during the facility's investigation. Findings Include: R1 is a [AGE] year-old alert and oriented resident with diagnoses including diabetes, heart failure, protein-calorie malnutrition, and radiculopathy of the lumbar region. A review of R1's Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15, confirming intact cognition (alert and oriented x 3), with no documented diagnoses of mental illness or behavioral symptoms. On 7/24/26 at 1:50 PM, an interview with V3 (CNA) confirmed an improper personal relationship and awareness of the resident's psychological vulnerability. V3 admitted to initiating and maintaining an unapproved social media connection via Instagram with R1 while providing direct care over a three-month period. V3 stated she was aware that R1 had a diagnosis of clinical depression, noting that a facility nurse had informed her of the diagnosis, and V3 acknowledged personally witnessing R1 crying on multiple occasions. Despite knowing R1 suffered from depression, V3 engaged in private social media communications and admitted that R1 obtained personal photos of her from her Instagram account. V3 stated that after her husband discovered the interaction, she abruptly severed communication, leading R1 to become distraught. V3 acknowledged knowing that maintaining a private social media relationship crossed professional boundaries and placed a resident with known emotional vulnerabilities at risk of distress and potential exploitation. V3 further admitted to deleting her Instagram account, posts, and message history prior to and during the facility's internal investigation. On 7/24/26 at 2:30 PM, an interview with V1 (Administrator) revealed that V1 acknowledged V3 crossed professional boundaries and was suspended. However, V1 stated he believed the conduct did not warrant termination, offering an unverified assertion that R1 was manipulative and citing R1's prior personal history as rationale for R1's involvement with V3. When asked by the surveyor if he reviewed any of the posts or messages sent between V3 and R1, V1 stated he did not view any because V3 had deleted the Instagram account prior to administrative review. On 7/25/26 at 10:20 AM, an interview with R1 revealed that V3 (CNA) established an improper personal friendship outside of professional duties via Instagram messaging and posts while R1 resided in the facility. R1 reported feeling distraught, emotionally manipulated, and led on by the ongoing digital interactions and subsequent circumstances. R1 stated he became depressed and emotionally distressed when V3 abruptly ended communication without explanation. R1 expressed that this emotional distress was severe enough that he requested to be discharged from the facility. R1 confirmed that facility administration was aware, noting he learned V3 was suspended, but stated he did not want V3 fired because he still held feelings for V3 as a result of the unmitigated boundary violation. On 7/26/26 at 12:30 PM, an interview with V5 (Human Resources Director) revealed that she was the manager on duty when V4 (Director of Nursing) requested that V3 (CNA) be removed from the floor and placed on suspension pending the investigation into her personal relationship with R1. V5 stated that she conducts inservice training on abuse prevention for all staff, during which she recently emphasized the facility's policy prohibiting social media interactions with residents. V5 affirmed that staff are prohibited from engaging in any social media communication with residents, as doing so violates professional standards. On 7/26/26 at 1:00 PM, an interview with V4 (Director of (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Nursing - DON) revealed that she received a call and text message from R1 regarding his Instagram relationship with V3 (CNA). V4 then contacted the facility and instructed V5 (HR Director), who was serving as manager on duty, to remove V3 from the floor pending an internal investigation. V4 stated that V3 made a clear boundary violation by allowing R1 access to her personal phone to set up or connect via Instagram. V4 acknowledged that while she did not believe the relationship was sexual, she could not verify the full nature of the communication because V3 deleted her Instagram account during the investigation. When asked by the surveyor whether deleting the account compromised transparency during the investigation, V4 acknowledged the concern but did not provide a direct answer. A review of the facility's policy titled Abuse Prevention Policy revealed that it reads in part: Photographing and Recording Residents. Staff photographing or recording residents or their private space (even if the resident is not present) for other than medical or facility purposes, as described in a signed Audio, Video and Photographic Release Form, is strictly prohibited. Staff posting or sending a photo or recording on social media or otherwise keeping or sending a photo or record through multimedia messaging other than for facility purposes as described in a signed Audio, Video and Photographic Release Form is also strictly prohibited. Staff taking or using a photograph or recording of a resident in a manner that demeans or humiliates a resident, regardless of the resident's cognitive status or whether the resident consented, is strictly prohibited and will be handled as an allegation of abuse in accordance with the procedures set forth below.		