STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments FRI of 1/7/2024/IL168808	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1 300.1210d)2 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by V3 (Agency LPN-Licensed Practical Nurse).

This failure resulted in R1 experiencing physical abuse by a staff member (V3).

This applies to 1 of 3 residents (R1) reviewed for staff-to-resident abuse in the sample of 3.

The findings include:

On January 22, 2024 at 10:00 AM, R1 was sitting in a chair in her room. R1 said she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 2	S9999		

physically abused by V3 (Agency LPN) on January 7, 2024. R1 said, "It started over medications that I normally get at 8:00 AM. It was 1:00 in the afternoon, and I had not received my medications for the day. [V10] (CNA-Certified Nursing Assistant) said we had a temporary nurse, and she was sitting in the lobby area at the nurse's station, and if you wanted your medications, you had to line up for the medications, and those who could not line up were disregarded. It is my preference to take my medications in my room. I walk with a cane, and it is hard for me to walk to the nurse's station. Also, I am a high risk for falls, so I usually stay in my room all day. When I stand up I get dizzy and I fall easily, so I did not walk to the nurse's station to get my medications. At 2:00 PM, [V3] (Agency LPN) finally came to my room with my morning medications. She came to the doorway and said, "Come and get your medications." She said it very rudely. I did not get up, so she then said, "Did you hear me say come get your medications? Come and get them!" I told her she needed to bring the medications to me. She handed me the medications and turned to leave the room. I was yelling to her that some of my medications were missing. She continued walking out of the room and slammed the door. I got up after she did not come back and stood in the doorway of my room. When she came out of the room across the hall, she looked at me and made another smart remark. I threw my pills down and she ran up in my face, pointing at my face and yelling at me. She was shaking her hand at me with a pointed finger and hitting the tip of my nose with her finger. I said stop hitting my nose and I put my hand up to block her from hitting my nose. When I made that motion, she grabbed my hair and my hands and threw me down to the floor and hit me. She said, "Are you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

going to stop? Are your going to stop?" She was screaming it loudly and trying to make people think I was attacking her. I have never seen [V3] working at this facility before. She left me there in the room and walked out. I went over to my telephone and called 911. I explained to the operator that I had been attacked and where I was at. She assured me the police were on their way. [V10] (CNA) could back up the problems we were having with getting our medications that day, but she did not witness the altercation. [V11] (CNA) came and saw me crying when it was all over. I told the police I wanted to press charges because [V3] threw me to the floor by the hair. The police kept asking me if I wanted to go the hospital, and I said no. I had just been in the hospital recently, and the last place I wanted to go was the hospital. Later in the evening I had chest pain, and I went to the hospital. The paramedics said my blood pressure was over 200. I went to the hospital and came back the same night. It happened two weeks ago, and I still have some neck pain, back pain, and a headache."

On January 23, 2024 at 2:45 PM, V3 (Agency LPN) said, "The first time I worked at the facility was around December 31, 2023. The second time was on January 7, 2024. I did not receive any abuse training from the facility. I did not receive any training from the facility regarding dealing with resident behaviors. They never pointed out an agency binder or did any education with me. When you come into a facility, they give you an assignment, and they put you to work. I know when you are working at a facility with residents with mental illness, you are at risk as a caregiver. I learned some techniques to restrain residents, not to hurt the person. As you restrain them, you are putting them in a compromising

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 4	S9999		

position. [R1] was aggressive and combative. She struck me and she grabbed me by the hair. I said she should let go and she did not. This was all because she was not happy with her medications. My main thought was to get her loose. I know I cannot hit her, but I don't want to be hurt either. Earlier she was verbally aggressive towards me. I walked away, closed the door, and went about my business. I did not call the doctor. I did not ask another nurse to help me or to give [R1] her pills. [R1] came out of the room and threw her pills. I asked her, "Why did you throw your pills? That's your health." She struck me in the face and pulled me in. She got my hair, and I asked her to let go. I grabbed both of her hands over my head, while lowering her down to the ground. Once I got her down to the floor I put her hands on her chest and held them there and I said I am going to let go of your hands if you promise to let go. I asked her if she wanted me to help her get up, and she said no. I left the room and went and gave medications to two other residents. Then I went to the bathroom to fix my hair. I went over to the nurse's station and said what do I do, [R1] just attacked me, and the nurse said she didn't know. Before I could ask what to do, the resident had called 911 and the police were there. This is normal for these type of residents to curse at you and call you names. This is a psych facility. I did not see [R1's] diagnoses so I don't know if she has any psychiatric issues. No one gave me a heads up about the resident and if she had behaviors. All of this was because of her medications."

On January 22, 2024 at 10:45 AM, V8 (RN-Registered Nurse) said, "[R1] has never tried to hit me. She cannot chase anyone down. There are times she will refuse her medications but will take them later. She will say I prefer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 5	S9999		

later."

On January 22, 2024 at 10:49 AM, R2 said, "[V3] did not give me my medications. She said they weren't important. She only gave me one pill. When I asked for my other medications, she had a lousy attitude and said I would be last."

On January 22, 2024 at 10:55 AM, R3 said, "[V3] had an attitude. Usually, the nurses go room to room to give medications. She came to work around 9:00 AM. She said, "You have to line up at the medication cart,, do you see these other people, they are all in line, you have to wait. I asked for medication, and she gave me attitude."

On January 22, 2024 at 12:48 PM, V9 (CNA-Certified Nursing Assistant) said, "I saw [V3] (Agency LPN) was rude to the residents and wasn't very respectful. She was that way to everybody, all of the residents. She was irritated. She kept giving a reason why she was busy. I have never seen [R1] get physical and grab someone's hair. She really does not come out of her room. She cannot run after anyone. She uses a cane."

On January 22, 2024 at 1:06 PM, V10 (CNA) said, "I worked here that day. It was a busy day. We were short a CNA, and that nurse (V3) came late. I never met [V3] before. It would be out of character for [R1] to hit someone. She can be angry but be respectful. She can use her words sometimes, and say she's upset. She has a limp and walks with a cane. [V3] (Agency LPN) was expecting the residents to come to the desk to get their medications. I was actually on my break when the incident happened. When I got back, a police officer was here. I saw [R1] right after the incident. She was bawling and said, "I don't know

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

why she would do this to me." She told me that [V3] pulled her hair and pushed her on the ground. [R2] was asking for anti-nausea medication and [V3] was rude and said you have to hold on, you have to give me a second."

On January 22, 2024 at 1:26 PM, V11 (CNA) said, "I was here that day (January 7, 2024). That was my assigned hallway. I was on my lunch break. I did not hear about it until I came back. When I came back, there was an ambulance, and the police were here. [R1] called me over and told me what happened. She said the nurse tried to give her medicine and [R1] told [V3] (Agency LPN) she had waited quite some time and the nurse got upset, and [R1] threw her medication. I was surprised because [R1] has never been rude or aggressive towards me. I have never seen her hit or scratch someone. She was crying."

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on August 27, 2022. R1 has multiple diagnoses including, acute respiratory failure with hypoxia, COPD (Chronic Obstructive Pulmonary Disease), cerebral infarction, heart disease, traumatic subarachnoid hemorrhage, muscle weakness, cognitive communication deficit, abnormal gait and mobility, lack of coordination, abnormal posture, need for assistance with personal care, falls, hypertension, anxiety disorder, and major depressive disorder.

R1's MDS (Minimum Data Set) dated January 4, 2024 shows R1 is cognitively intact, has a lower extremity functional limitation in range of motion on one side and uses a cane for mobility. R1 is able to eat and dress her upper body independently, requires supervision with transfers between surfaces and walking, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 7	S9999		

partial/moderate assistance with oral hygiene, toilet hygiene, showering, lower body dressing, and personal hygiene. R1 is occasionally incontinent of bowel and bladder.

R1's care plan, initiated July 24, 2023, shows R1 is high risk to be susceptible to abuse and/or neglect. "This is determined by the resident's comprehensive assessment revealing a history of abuse, resident's physical and mental condition and/or compromised medical health." Interventions initiated on July 24, 2023 include: "Assure resident that she is in a safe and secure environment with caring professionals to help, assure resident that staff members are here to help, explain that psychological adjustment is often facilitated by developing a trusting relationship with another person (i.e., social worker, nurse and/or CNA) and by verbalizing thoughts, needs, and feelings. Observe resident for signs of fear and insecurity during delivery of care. Take steps to calm resident to make her feel safe."

The facility's undated Final Incident Investigation Report Form, received by the State Agency on January 12, 2024 shows: "Upon further investigations, the incident was substantiated as the nurse [V3] (Agency LPN) was acting unprofessional to a point that it escalated this incident where the resident (R1) needs to be physically controlled and lowered down to floor for her safety. The police, NP/MD (Nurse Practitioner/Medical Doctor) and family members were informed, and the Resident was assessed by the nurses for injuries and was sent to the local hospital for evaluation. No injury was noted." The Final Incident Investigation Report Form continues to show the facility substantiated R1 was abused by V3 (Agency LPN).

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	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

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RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 8	S9999		

The local police department Field Case Report dated January 7, 2024 shows, "On arrival, I went to [R1's room]. [R1] was crying, incredibly emotional, and unable to speak clearly. [R1] had a red mark on her left cheek, which appeared to be bleeding ..."

On January 22, 2024 at 3:37 PM, V12 (Police Officer) said, "We arrested [V3] (Agency LPN). I was present for the arrest part. [V3] was charged with aggravated battery. It was because she hit the resident. Aggravated means because the victim was over 65 or disabled. [V14] (Police Officer) must have had probable cause to arrest [V3]. There had to be video surveillance or marks on the victim (R1). I am reading the notes of the police report. [R1] had a red mark on her left cheek which appeared to be bleeding. In the report it is noted [V3] had called a supervisor and told the supervisor she had engaged physically with [R1] because of some aggression. It says [V3] had also stated she had to go hands-on after a scuffle with the patient. The probable cause would have been the admission of the physicality of the incident, the marks on the victim, and advised to pursue charges."

On January 22, 2024 at 9:24 AM, and on January 22, 2024 at 3:54 PM, V1 (Administrator) said, R1 does not have a history of violent outbursts or attacking staff or residents. V1 continued to say the facility does not have behavior tracking for R1. V1 said, "I substantiated the allegation as physical abuse based on the interview, and that [V3] physically held [R1] and put her down on the ground."

On January 25, 2024 at 10:29 AM, V17 (NP-Nurse Practitioner) said she examined R1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004758	A. BUILDING: _____ B. WING _____	C 01/30/2024

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RIVER VIEW REHAB CENTER	50 NORTH JANE ELGIN, IL 60123

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S9999	Continued From page 9 January 8, 2024. V17 said, "I am familiar with [R1]. I have never known her to be physically aggressive with anyone. When I saw her she complained of scalp and neck soreness. I documented the resident had a neck sprain based on what [R1] was saying. No resident should be abused while residing in a facility." The facility's policy entitled; "Abuse Prevention Program - Policy" adopted "1/20" shows: "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms." (A)	S9999		