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	IL6004758	A. BUILDING: _____ B. WING _____	C 03/31/2025

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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S 000	Initial Comments Complaint Investigation 2572303/IL188257 Investigation of Facility Reported Incident of 2/25/25; IL188894	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.615f) 300.625c)2) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. These REQUIREMENTS were not met as evidenced by: Based on interview and record review the facility failed to check the Illinois Department of Corrections (IDOC) website and check the Illinois State Police (ISP) website within 24 hours of a resident's admission for 5 of 6 residents (R4, R10-R13) reviewed for criminal history background checks in the sample of 14. The findings include: R4's Admission Record showed R4 was admitted to the facility on 2/19/25. R4's electronic medical	S9999		

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records dated 2/19/25-3/31/25 showed no IDOC, Illinois Sex Offender Registry, or National Sex Offender Registry website checks had been completed on R4.

R10's Admission Record showed R10 was admitted to the facility on 3/20/25. R10's National Sex Offender Registry check was not completed until 3/31/25.

R11's Admission Record showed R11 was admitted to the facility on 3/17/25. R11's electronic medical records dated 3/17/25-3/31/25 showed no IDOC, Illinois Sex Offender Registry, or National Sex Offender Registry website checks had been completed on R11.

R12's Admission Record showed R12 was admitted to the facility on 1/27/25. R12's electronic medical records dated 1/27/25-3/31/25 showed no IDOC, Illinois Sex Offender Registry, or National Sex Offender Registry website checks had been completed on R12.

R13's Admission Record showed R13 was admitted to the facility on 1/8/25. R13's National Sex Offender Registry check was not completed until 3/31/25.

On 3/31/25 at 11:00 AM, V1 Administrator stated all criminal history background checks, for newly admitted residents, are to be completed within 24 hours of a resident's admission.

On 3/31/25 at 11:05 AM, V7 Social Services stated the ISP, IDOC, and National Sex Offender Registry website checks had never been completed on R4, R11, or R12. V7 she had just completed the National Sex Offender Registry website checks on R10 and R13 today (3/31/25).

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S9999	Continued From page 2 The facility's Resident Background Checks policy dated October 2024 showed, "When a resident is admitted to the facility, an electronic name-based background check must be ordered within 24 hours..." (C) Section 300.625 Identified Offenders 2 of 3 300.625c)2 c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to initiate fingerprint-based criminal history	S9999		

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background checks on identified offender residents within 72 hours of being notified of a resident's identified offender status. These failures apply to 2 of 6 (R12, R13) residents reviewed for criminal history background checks/identified offenders in the sample of 14.

The findings include:

R12's Admission Record showed R12 was admitted to the facility on 1/27/25. R12's Criminal History Information Response Process (CHIRP) report dated 1/27/25 showed R12 was an identified offender due to his convictions of aggravated battery resulting in great bodily harm, theft, possession of drug paraphernalia, criminal damage to state property, and resisting a peace officer. R12's fingerprint-based criminal history background check was not completed until 2/4/25.

R13's Admission Record showed R13 was admitted to the facility on 1/8/25. R13's CHIRP report dated 1/8/25 showed R13 was an identified offender due to his convictions of obstructing justice, theft, deceptive practice, resisting a peace officer, and endangering life/health of a child. R13's fingerprint-based criminal history background check was not completed until 2/4/25.

On 3/31/25 at 11:00 AM, V1 Administrator stated, "A CHIRP should be run on a resident within 24 hours of their admission. If the CHIRP shows the resident is an identified offender, fingerprints should be ordered and done on that resident immediately."

The facility's Resident Background Checks policy dated October 2024 showed, "If the background

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S9999	Continued From page 4 check response contains convictions that match the Identified Offender offenses, the resident is an identified offender... Once the facility determines the resident is an Identified Offender, the facility must arrange for the resident to undergo a live scan State and FBI (national) fingerprint-based Fee Applicant criminal history check within 72 hours... (C) 300.610a) 3 of 3 Violations 300.1210b) 300.1210d)6 300.3210t) 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	S9999		

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plan. Adequate and properly supervised nursing 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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review the facility failed to ensure residents were free from mental abuse for 3 of 8 residents (R2, R3, R6) reviewed for abuse in the sample of 14. This failure resulted in R2 feeling fearful of R1 and socially isolating due to R1's threats against him. This failure resulted in R6 suffering mental anguish related to R1's threats to physically harm and kill R6. This failure resulted in R3 being fearful of physical and mental retaliation from R1.

The findings include:

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An initial facility abuse investigation report dated 3/17/25 showed R2 reported to V1 Administrator that R1 had threatened to "kill and strangle him" if R2 told facility staff that R1 had sold R2 marijuana. The final facility abuse investigation report dated 3/24/25 showed, on 3/18/25, R6 reported to V1 Administrator that R1 had offered R6 drugs in the facility. When R6 refused the drugs from R1, R1 became angry and told R6 that he would "knock out his teeth" if R6 reported to anyone that R1 had offered him drugs. R6 stated R1 threatened to break R6's neck and "throw you out the window to make it look like a suicide." Per the report, R6 stated, on another occasion, R1 came into R6's room and told R6, "I will kill you if you snitch on me. I have no one to lose. I will kill you and make it look like you are having a seizure." The final facility abuse investigation report showed, on 3/18/25, R3 reported to V1 Administrator that he too was afraid of R1. R3 stated R1 hid alcohol bottles in R3's room. R3 stated R1 "is very threatening and intimidating. I don't want to be here if he is here. Once he threatened to beat me... I am terrified and want to be left alone... He (R1) knows a lot of people on the street, if he finds out I can get killed easily." The report showed R3 was visibly shaking, when speaking about R1, to V1 Administrator on 3/18/25. The facility's final abuse investigation report dated 3/24/25 showed abuse was substantiated related to the actions of R1. A police report was filed.

R1's Admission Record showed R1 was admitted to the facility on 9/13/24 for rehabilitation therapy services due to his diagnosis of low back pain.

R1's current care plan showed R1 was cognitively intact, ambulatory, and needed no staff assistance to complete his activities of daily living.

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The plan showed R1 had a history of verbally aggressive behaviors towards others. The plan showed R1 was an "identified offender" due to his criminal history of attempted armed violence.

R1's progress and nursing notes dated November 2024-March 2025 were reviewed. These notes showed multiple documented episodes of R1 having alcohol, drugs, and drug paraphernalia in the facility. The notes showed incidents of R1 being verbally aggressive and threatening towards residents and staff. The notes showed incidents of R1 repeatedly disobeying facility rules and leaving the facility despite his community pass privileges being revoked due to his behaviors. They showed multiple incidents of the local police being called to the facility due to R1's behaviors. A note dated 2/6/25 showed the facility served R1 a 30-day discharge notice due to his behaviors and R1 no longer needing skilled nursing services. R1 appealed his discharge. A note dated 3/3/25 showed a coat, belonging to R1, was found in the facility containing 9 bags of marijuana, a scale and a pipe. A note dated 3/11/25 showed R1 was sent to a local behavioral health hospital due to R1 threatening to shoot V1 Administrator and V2 Assistant Administrator. R1 was allowed to return to the facility on 3/19/25 pending the appeal related to his discharge. Upon return from the hospital, R1's notes dated 3/20/25-3/31/25 showed R1's behaviors continued. On 3/21/25, R1 walked out of the facility and did not return until noon on 3/22/25. On 3/23/25, R1 was verbally aggressive with staff. On 3/23/25, it was reported to facility staff that R1 "had been smoking crack with another resident." On 3/25/25, R1 was found in another resident's room. R1 took food from the resident's room, and left.

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S9999	Continued From page 8 On 3/27/25 at 8:45 AM, R1 was in his room, lying in bed. R1 denied selling drugs to any residents in the facility. When this surveyor asked R1 about his interactions with R2 and if he had ever threatened R2, R1 began to get upset and his voice became louder. He immediately stood up from his bed, took a step towards this surveyor and stated, "I have already told this story before. I already talked to the police." R1's voice continued to raise his voice as he spoke. R1 began walking towards the door of his room. R1 very loudly asked this surveyor to leave his room. This surveyor exited R1's room. 1. R2's Admission Record dated 12/5/24 showed R2 was admitted to the facility with diagnoses of autism, developmental delays and a heart transplant. R2's admission nurse practitioner note dated 12/30/24 showed R2 was cognitively intact. On 3/27/25 at 8:30 AM, R2 was in his room, lying in bed, with the lights off. R2 stated R1 threatened to kill R2 "sometime in late February if I snitched and told anyone where I got my pot (marijuana) from." R2 stated he had bought marijuana from R1 in February. R1 stated, "After I bought pot from him, there were a couple of times when (R1) would just come into my room (unannounced). I was definitely scared of him then. He never asked to come in my room... after that, I finally told on him because I was angry from what he said to me and I was also a little scared of him... Now that (R1) is back from the hospital, I just stay away from him. I stay in my room to avoid him. I know he has other people (residents) watching me so he knows who I talk to. I am still a little scared of him..."	S9999		

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On 3/27/25, V5 Social Services stated R2 had reported to V5 in the past that R2 did not feel safe around R1 because R1 had threatened to "choke him (R2) out" if R2 told anyone he bought marijuana from R1. V5 stated when R1 returned from the hospital, R2 "reported feeling afraid because of (R1). (R2) has been spending more time in his room to avoid conflicts..." V5 stated, "(R1) is very intimidating. He becomes verbally aggressive. Staff are afraid he will hit them if they try to enforce the rules. I worry that (R1) will attack me or other staff... I don't feel comfortable with (R1) and he intimidates me. The dilemma is that we don't know what to do with him when he acts out other than call the police..."

A social service noted for R2, dated 3/25/25, showed R2 reported to social services "that a co-resident came into his room when he wasn't present and the he doesn't want this co-resident to come into his room anymore..."

On 3/27/25 at 12:27 PM, V4 Social Services was asked about the resident referenced in R2's social service note dated 3/25/25. V4 stated, "The resident in (R2's) room was (R1). (R2) came to me and told me that the day before (3/24/25), (R2) walked into his room and found (R1) standing in his room, talking to (R2's) roommate. (R2) reported to me that he immediately felt uncomfortable and walked back out of his room. I think he was a little fearful when he saw (R1) in his room. Since his return from the hospital, we try to monitor where (R1) is at when he is in the building but he goes where he wants. We have tried to revoke (R1's) community pass privileges due to his behaviors but he doesn't care. He feels like he's above the rules and leaves anyway."

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On 3/27/25 at 9:13 AM, V1 Administrator stated on 3/17/25, R2 reported to V1 that R1 had threatened to kill R2 if he told anyone R1 had sold him marijuana. V1 stated all staff and many residents are afraid of R1 due to his behaviors. V1 stated, "We were finally able to send (R1) out to the hospital after he threatened to kill me, (V2 Assistant Administrator), and our families but he was allowed to return. When he came back, we tried to put him (R1) in a private room, but he refused. We tried to move him to a room on the first floor, but he refused. We revoked his community pass privileges but he doesn't care, he still leaves the facility. We try to monitor where he is every hour that he is in the facility..." V1 stated facility staff are afraid to enforce the facility's rules with R1 because they are afraid he will try to hurt and physically assault them.

2. On 3/27/25 at 10:45 AM, R6 was asked about his interactions with R1. R6 was initially hesitant to speak with this surveyor, stating, "I don't want to get involved. If I say something, there is nothing you can do. I already made my statement (during the abuse investigation)..." R6 continued to talk and then stated he had been threatened by R1 in the past. R6 stated, "One night, when he (R1) wasn't sober, he came into my room and threatened to break my neck and throw me out a window. He said he could break my neck and tell staff it was a seizure since there is no cameras in my room. I started yelling and a CNA (certified nursing assistant) came and got him out of my room... Many residents are afraid of him. He has power and no one can stop him. He is big and intimidates people... It would be better if he left and never came back. The police just bring him back and he does whatever he wants... (R1) has said before he can leave people crippled in a wheelchair or a vegetable, what are

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they waiting for? Someone to die or get hurt?"

On 3/27/25 at 9:13 AM, V1 Administrator stated on 3/18/25, R6 reported to V1 that he was scared of R1 because R1 had threatened to break R6's neck.

3. On 3/27/25 at 11:10 AM, R3 refused to speak to this surveyor about R1.

On 3/27/25 at 11:10 AM, R4 stated R3 "won't come down and talk to you guys because he's fearful of his safety. (R1) is big and has threatened (R3) before. I have seen (R1) drinking (alcohol) in (R3's) room before. (R3) is timid and shy...He doesn't want to get beat up by (R1)..." R4 stated she was the resident that reported R1 had threatened to kill V1 Administrator and V2 Assistant Administrator. R4 stated, "(R1) was pissed off because he thought (V2) was trying to get him kicked out of the facility. He told me that he could be sitting in a bar and have someone shoot (V1) and (V2) and their families so I reported that to (V2)." R4 stated she has seen R1 "smoke weed" and drink alcohol in the facility.

A social service note dated 3/19/25 for R3 showed, "Resident is upset and scared that a co-resident (R1) got admitted back to the facility..." On 3/31/25 at 10:24 AM, V7 Social Services was asked about the note she documented on 3/19/25 for R3. V7 stated R3 said he was scared because R1 had been readmitted to the facility.

On 3/27/25 at 9:13 AM, V1 Administrator stated on 3/18/25, "(R3) told me he felt terrible. He said he was afraid of (R1). He said (R1) was very threatening. He said (R1) hides alcohol and

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drugs in (R3's) room. (R3) can't tell on him because (R3) is scared of him."

On 3/27/25 at 10:20 AM, V2 Assistant Administrator stated, "I spoke with (R3). He told me he is afraid of (R1). (R3) said his room is where (R1) hides his drugs and alcohol. (R3) is afraid that if he snitches and tells on (R1), (R1) will have people come and get (R3) and kill him... (R4) came to me and told me (R1) threatened to kill me and my family... Since then, I don't stay home alone..." V2 became tearful during the interview. V2 stated, "We are all afraid that (R1) is back. We are sitting ducks right now..."

On 3/27/25 at 1:00 PM, V6 Psychiatric Nurse Practitioner stated he has been treating R1 for a mood disorder but recently also for substance abuse and his threatening behaviors. V6 stated, "(R1) doesn't follow the rules. When staff try to enforce the rules, he gets upset and starts threatening staff and residents. It's a big deal. That is why we sent him to the hospital and then he was allowed to come back. He's threatened to hurt staff and residents. I am very concerned about his behaviors. His behaviors are worsening. I am not sure if that's related to his substance abuse or there is something else going on. Staff and residents are fearful of him. He is a risk. His homicidal threats are a big deal."

The facility's Abuse Prevention-Program Policy revised 2/26/25 showed, "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment... Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical

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 03/31/2025

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 13 harm, pain, or mental anguish to a resident... Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation... Mental abuse is also the use of verbal or nonverbal contact which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation..." The facility presented an abatement plan to remove the immediacy on 3/31/25. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a second revised abatement plan on 3/31/25. The abatement plan was returned to the facility for revisions. The facility presented a third revised abatement plan on 3/31/25 and the survey team accepted the abatement plan on 3/31/25. (A)	S9999		