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 01/26/2023

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 Complaint investigation 2370621/IL155655	S 000		
S 690	Section 300.690 Incidents and Accidents This Regulation is not met as evidenced by: Statement of Licensure Violations 300.690 a) 300.690b) 300.690c) Section 300.690 Resident Care Policies a) The facility shall maintain a file of all written reports of each resident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process.... b) The facility shall notify the Department of any serious incident or accident.... c) The facility shall, by fax or phone , notify the Regional Office within 24 hours after each reportable incident or accident... These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to report to state department regarding a resident that had eloped from the facility. This applies to 1 of 5 residents (R1) reviewed for supervision in the sample of 5. The findings include: The EMR (Electronic Medical Record) shows R1, a 56-year-old was admitted to the facility on	S 690	Attachment A Statement of Licensure Violations	

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S 690	Continued From page 1 12/11/2020. R1 had multiple diagnoses including alcohol dependence with alcohol-induced persisting dementia, mood disorder due to known physiological condition with manic features, Wernicke's encephalopathy, psychotic disorder with delusions due to known physiological condition, pseudobulbar affect, anemia, convulsions and BPH (benign prostatic hyperplasia). The MDS (Minimum Data Set) dated 1/18/2023 and 9/24/2022 shows R1's BIMS (Brief Interview Mental Status) score was 4/15 (severely impaired in cognition). R1 also was assessed with delusion and behavior of inattention that continues and does not fluctuate. The Community Survival Skills Assessment dated 10/24/2022 provided by V4 (Director of Social Work) shows that R1 was assessed as not capable of unsupervised outside privileges. It also shows that R1 does not have community access due to impaired cognition. R1 was also assed as not sufficiently alert, oriented, coherent, and knowledgeable allowing him to be considered for independent outside privileges. The facility's undated "Investigation Report" documented by V4 shows that on 1/21/2023 (Saturday) at 6:20 P.M., the facility exit alarm by the 400 hallway/exit door on the first floor was triggered. Upon a staff (V5, RN) checking the exit door where alarm was triggered, there was no resident found, no cause was determined what triggered the alar, Other staff went to the front of the facility looking for a resident. Other staff in the facility did a head count and determined that R1 was missing and not found in the facility. (V3, Assistant Administrator) and V4 (PRSD/Psychosocial Rehabilitation Services	S 690		-

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S 690	Continued From page 2 Director/SWD/Social Worker Director) drove around the facility and V4 finally found R1 at 7:30 P.M., few blocks away from the facility. (0.24 miles). R1 was taken to the facility at 8:00-8:10 P.M. then taken to hospital for further evaluation at 9:30 P.M. R1 returned to the facility after hospital evaluation and his condition was stable. The report also shows that local police department was notified. On 1/24/2023 at 3:20 P.M., V1 (Administrator) and V2 (Director of Nursing) said "this Incident Report that occurred on 1/21/2023 regarding (R1's) elopement will be reported to the Department of Health today (1/24/2023). On 1/24/2023 at 2:15 P.M., V4 said she drove around and facility's nearby areas and found R1, at 0.24 miles away from the facility. V4 said that R1 was sitting on the steps of a door entrance of an office building. V4 said that R1 was scared and confused. V4 said that R1 was wearing only a T-shirt, sweatpants and gym shoes. V4 said she offered her coat to R1 because it was cold. The temperature was 30 degrees Fahrenheit. V4 said that R1 was unaware of surrounding, no safety awareness and only knows his name. V4 also said that R1 had history of elopement prior to his admission to the facility. V4 added that R1 goes out from his room and seems to wander around going to another resident's room or just stay in his room and isolate himself. V4 said that there was no care plan that address R1's history of elopement risk. The undated facility's policy for "Missing Resident" shows "B.)9) The decision to notify the Illinois Department of Public Health is made by the Administrator."	S 690		

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S 690	Continued From page 3 (B)	S 690		