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 06/29/2023

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 FRI of 6/7/2023/IL160937	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)3 300.3240a) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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 06/29/2023

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 1 progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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 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	S9999		

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	IL6004758	A. BUILDING: _____ B. WING _____	C 06/29/2023

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S9999	Continued From page 2 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 implement their policy to thoroughly investigate an allegation of employee to resident sexual abuse. The facility also failed to investigate an allegation of resident-to-resident abuse. This failure resulted in R1 reporting V3 (Maintenance Director) sexually abused R1 and the facility not conducting a thorough investigation including assessing R1 for injuries and immediately contacting emergency services. This has the ability to affect all 139 residents residing in the facility. The findings include: The Facility Data Sheet dated June 20, 2023	S9999		

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	IL6004758	A. BUILDING: _____ B. WING _____	C 06/29/2023

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 3	S9999		

shows the facility's census of 139 residents.

1. R1's EMR (Electronic Medical Record) shows R1 was admitted to the facility on February 23, 2023, with multiple diagnoses including diabetes, anxiety, and hypertension.

R1's MDS (Minimum Data Set) dated May 10, 2023, shows R1 is cognitively intact.

The facility's "Final Incident Investigation Report Form" submitted to IDPH (Illinois Department of Public Health) on June 12, 2023, shows "Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Abuse is unsubstantiated, as follows: [R1] states that maintenance man, [V3 (Maintenance Director)] dropped off a bed and wheelchair to her room. After the bed and wheelchair, [R1] stated [V3] walked over to the bed where she was laying and touched her breast and kissed her on the lips. [R1] pushed [V3] away and told him to stop but says [V3] tried kissing her another time but was unsuccessful. [V3] then walked out of the room. PRSD (Psychiatric Rehabilitation Services Director) conducted an internal investigation and found no other residents or staff that accuse [V3] of being sexually inappropriate with them. There were no reported injuries and no witnesses to the occurrence. [V3] denies all claims that he was inappropriate with [R1]."

The report continues to show a full head to toe assessment was not completed, R1's physician was not notified of the allegation, and R1 was not offered or received counseling/social services.

On June 20, 2023, at 3:50 PM, R1 said, " On June 7, 2023, I was laying on my bed. Someone

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 06/29/2023

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
S9999	Continued From page 4	S9999		

knocked at the door and I said come in. I thought it would be the nurse. [V3] came in and asked if he could put a bed and wheelchair in my room, and I said sure because that part of the room is not my space. He brought them in the room, and I was laying on my bed listening to music. I looked over and he was standing by the curtain and was just staring at me. I asked him what he wanted. He then came over and touched my breasts and kissed me. I told him to stop and was pushing him away. I told him if he didn't stop, I would scream, then he left the room. I was so scared and nervous. I eventually got up and looked out my door and saw [V8 (NP/Nurse Practitioner)] so I asked her to come in my room. I told her what happened. I felt bad and started crying because I was sexually abused when I was little. [V8] asked if she could tell [V6 (Social Services Director)] and I said that was fine. [V6] talked to me and the police came. The police asked me if I wanted to press charges and I said yes. They let me know I will have to see him in court. I don't want to see him in court, but I want to press charges. Nobody from social services has been meeting with me. I am hoping [V3] does not come back because I am scared. I haven't seen him since it happened, but I don't know if he is coming back so I am always looking around for him. The bed and the chair in the room are a constant reminder of [V3] and I wish they could be out of my room. I told [V6] I was scared. I leave the facility on pass more often now because I am scared to be here. I told them it felt like he was in here for 15 minutes, but I wasn't paying attention to the time because I was pushing him away. There is not a clock in my room, and I couldn't look at my phone to see what time it was because I was using both of my hands to push him away. It might have only been two minutes, but to me it felt like 15 minutes or even

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 06/29/2023

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
S9999	Continued From page 5	S9999		

longer. Nobody looked at me for injuries or asked if I wanted to go to the hospital. I lived in this facility two to three years ago and [V3] bothered me then. He touched me a couple years ago, and I told a staff member then, but nothing happened so that is why I left the facility."

The facility does not have documentation to show an investigation was completed for R1's abuse allegation from her previous admission in the facility.

On June 21, 2023, at 10:20 AM, V8 (NP) said, "I have been seeing [R1] because she is in therapy for leg pain. On June 7, 2023, I was in the hallway and [R1] said she wanted to talk to me. We went to her room and we were talking. At the end of our conversation, [R1] became teary eyed and said someone is bothering her and came into her room and touched her. I asked who touched her and she said [V3]. I have seen [V3], but I have never talked to him. She knew he was the head of maintenance and knew him from the last time she was here. I encouraged her to talk to the social workers, but [R1] said her case manager was a guy and she was uncomfortable with that. I told [R1] she could speak with [V6], but [R1] said nothing is going to happen if she tells them. It seemed like she wasn't going to talk about it, so I asked permission to talk to [V6]. I went straight to [V6]'s office and told her what happened. I only examined her leg while we were in her room because she has neuropathy, I did not do a head-to-toe assessment. I see [R1] once or twice a week. [R1] has never made allegations like this before to me. She is cognitively intact."

On June 20, 2023, at 1:10 PM, V6 (Social Services Director) said, "I was told about [R1]'s

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 06/29/2023

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
S9999	Continued From page 6	S9999		

abuse allegation by [V8]. I started talking to a few staff and other residents. I looked at the security camera footage to see if the story correlated. [R1] had told us at first that [V3] was in her room for 15 minutes, but the camera showed it was two minutes. That was the only discrepancy in her story. I had called the [local police] and they came out soon after I called. I do not think [V3] should come back to work in this facility. [R1] is here for a heart condition and diabetes. [R1] is not here for mental health issues. She is very alert and aware and independent. The other residents I interviewed for the investigation are scattered between the first and second floor. I just made a random selection of residents. I chose some residents that are alert and aware, I tried to get a variety of residents. There have been previous allegations against [V3] in the past, one by a staff member and one by [R9] this past December. The allegation by [R9] came out unsubstantiated because it was in the resident room and there was no other proof, no roommate, and no video footage of it happening. [R1]'s allegation is unsubstantiated because we could not find any hard proof evidence of sexual abuse occurring. After the allegation by [R9], [V3] was told not to go into resident rooms alone, but I don't know if he was following that. [V3] was by himself the day he went into [R1]'s room."

On June 21, 2023, at 12:30 PM, V6 said, "I went to [V1]'s office around noon on June 7 to notify him about [R1]'s allegation. After I spoke with [V1], I went to speak with [R1], but she was eating lunch, so I let her finish lunch. I spoke with [R1] in her room after she finished lunch."

On June 21, 2023, at 2:22 PM, V6 said, "I would assume one of the nurses assessed [R1] following her allegation, but I am not sure if

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 06/29/2023

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
S9999	Continued From page 7	S9999		

anyone did. I wrote in the report [R1] had no injuries because she told me she did not have any injuries. I am not sure if the nurses checked [R1]. This allegation would have been substantiated if there was video evidence or a witness of it. I don't think unsubstantiated means it didn't happen, but there is no concrete proof to show it did happen. When I finish my final investigation reports, I send them to [V1] to review, he gives me the go ahead to submit the report to IDPH. I called the non-emergency police number to report [R1]'s allegation. We did not call an ambulance. I typed the interviews I conducted with the staff and residents. I interviewed three case workers, three CNAs (Certified Nursing Assistants) working the day of the incident. I also interviewed the receptionist, she is the one sitting behind the glass at the front door. The last person I interviewed was the scheduler, she works upstairs, but walks around the facility a lot. I never interviewed [V7(LPN/Licensed Practical Nurse)], [R1]'s nurse at the time of the incident. Before I started working here, there was an incident with a nurse and [V3]. [V3] attempted to kiss her in a storage or supply room. The nurse does not work here anymore."

On June 20, 2023, at 3:03 PM, V3 said "I usually take [V14 (Maintenance)] in resident rooms with me, but I needed to move this bed right away, so I went in without him. I was told before to have someone go in resident rooms with me. It was because of the previous abuse allegation with another resident that I was supposed to have someone with me when I was going into resident rooms."

On June 20, 2023, at 3:11 PM, V1 (Administrator) said "[V3] was told be careful with female

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 06/29/2023

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
S9999	Continued From page 8	S9999		

residents. [R1]'s abuse allegation was unsubstantiated because we do not have any witnesses. [R1] did say [V3] was in her room for more than 15 minutes, but it was about two minutes. The abuse allegation was unsubstantiated because of the time discrepancy. I have not brought [V3] back to work because I did not feel comfortable. Just because the allegation was unsubstantiated doesn't mean it didn't happen. I cannot substantiate abuse based on just one statement."

On June 21, 2023, at 1:37 PM, V13 (Police Officer) said, "This allegation is considered battery, and [R1] is pressing charges against [V3]. I got to the facility on June 7, 2023, at about 2:45 PM. I arrived shortly after they called the police department. They waited hours to call, they usually call right away."

On June 21, 2023, at 10:45 AM, V9 (NP) said, "I was not aware of [R1]'s allegation of sexual abuse. This is the first I am hearing about this. I saw her last week. Nobody from the facility contacted me about this. [R1] is cognitively intact. [R1] has never made allegations about anybody. [R1] does not regularly make false statements."

On June 21, 2023, at 10:52 AM, V10 (Physician) said, "I am [R1]'s physician. I am unaware of [R1]'s sexual abuse allegations. I would expect the facility to inform me of this. I have not heard from anyone from the facility. It is my expectation [R1] is free from abuse. Her wellbeing is my priority."

On June 21, 2023, at 2:07 PM, V2 (DON) said, "I was only a part of the second questioning during the investigation. That was before the final report

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 06/29/2023

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
S9999	Continued From page 9	S9999		

was submitted. I spoke with [R1] with [V6] on June 12, 2023. I did not perform a physical assessment on [R1]. I do not think anyone assessed [R1]."

On June 20, 2023, at 12:58 PM, V7 (LPN) said, "I was not aware of [R1]'s abuse allegation until [R1] told me about it days later. I was [R1]'s nurse on June 7, 2023. I was never interviewed by anyone about [R1]'s allegation. I did not perform a head-to-toe assessment of [R1] on June 7, 2023."

On June 20, 2023, at 3:47 PM, V12 (RN/Registered Nurse) said, "I am unaware of the allegation of abuse regarding [R1] and [V3]. I have only heard rumors. I was [R1]'s nurse on June 7, 2023 for second shift. I did not do a head-to-toe assessment on [R1] on June 7, 2023 because she did not require one."

The facility does not have documentation to show a facility staff member completed a head-to-toe assessment of R1 following her allegation of sexual abuse. The facility does not have documentation to show R1's primary physician was notified of her sexual abuse allegation.

On June 26, 2023, at 4:33 PM, V1 said V3's job duties included maintenance throughout the entire building.

The facility's job description for maintenance director, signed by V3 on February 11, 2020, shows main duties of assuring proper maintenance throughout the facility including resident rooms.

Facility documentation shows V6 interviewed 16 residents on June 8, 2023 between 1:00 PM 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 06/29/2023

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
S9999	Continued From page 10	S9999		

2:00 PM and June 9, 2023, from 10:45 AM to 11:30 AM. The EMR shows two of the residents interviewed (R10 and R11) are male residents residing on the second floor of the facility (R1 resides on the first floor of the facility). R3 was interviewed on June 8, 2023. R3's MDS dated June 7, 2023, shows R3 has moderate cognitive impairment. R12 was interviewed on June 9, 2023. R12's MDS dated June 7, 2023 shows R12 has moderate cognitive impairment. R13 was interviewed on June 8, 2023. R13's MDS dated May 31, 2023, shows R13 has moderate cognitive impairment, and has inattention and disorganized thinking. R14 was interviewed on June 8, 2023. R14's MDS dated May 3, 2023, shows R14 has moderately impaired cognitive skills for daily decision making, and has short term and long term memory problems.

2. R4's EMR shows a progress note dated June 13, 2023, at 2:42 PM, by V11. V11 documented, "Resident is being accused by another resident of entering room without authorization and kissing same resident without consent (spoke to co-resident about issue). PRSC (Psychiatric Rehabilitation Services Coordinator) attempted to speak to resident about issue but refused to talk. Will continue to work on issue."

On June 21, 2023, at 11:11 AM, R3 said, "[R4] came into my room and kissed me when I didn't want him to. I told a social worker about it."

On June 20, 2023 at 4:49 PM, V6 said, "I am unaware of [R3] saying [R4] kissed her. [V11] never reported that to me. This is something that would be investigated."

On June 21, 2023, at 12:16 PM, V11 (Case Worker) said, "My director told me is [R4] 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 06/29/2023

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
S9999	Continued From page 11	S9999		

going into [R3]'s room and we didn't know why. On June 13, I went to [R3] and she said [R4] would come into her room and give her snacks. The part we found inappropriate was [R4] would kiss [R3] and it had been going on for a while. I reported this to [V6] on either June 13 or the day after. I informed [V6] because I didn't want it to become a bigger issue. I am not aware if anything has been put in place to ensure this doesn't happen again."

On June 21, 2023, at 2:21 PM, V6 said, "I don't remember [V11] telling me about [R3] and [R4]. I don't remember this coming up. I have not started an investigation on this."

As of June 22, 2023, at 9:53 AM, the facility does not have documentation to show an investigation was initiated or a report was sent to IDPH regarding R4 kissing R3.

R3's EMR shows R3 was admitted to the facility on November 21, 2020, with multiple diagnoses including paranoid schizophrenia, insomnia, and asthma.

R3's MDS dated June 7, 2023, shows R3 has moderate cognitive impairment.

R4's EMR shows R4 was admitted to the facility on January 3, 2022, with multiple diagnoses including paranoid schizophrenia and hypothyroidism.

R4's MDS dated May 3, 2023, shows R4 is cognitively intact.

R4's Identified Offender care plan dated on December 29, 2021, shows "[R4] is a 69 year old male who admitted on December 8, 2020.

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 06/29/2023

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 12	S9999		

Criminal history consisted of convictions for criminal trespass/remain on land; and unlawful window peeping. He was sentenced to 12 months conditional discharge. He is diagnosed with a major psychiatric disorder and has a history of alcohol/drug abuse. Facility personnel reported no incidents of aggression since admission, although, he has hallucinations, becomes easily agitated, and may be difficult to redirect. His compliance with psychiatric treatment and abstinence from alcohol/drug use should be closely monitored. In view of his psychiatric condition, frequent agitation, and current legal circumstances (conditional discharge) a moderate risk supervision status is recommended. When discharged, the identified offender program will be notified." The care plan continues to show multiple interventions dated December 29, 2021, including, "[R4] is determined to be a moderate risk and requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on the time limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient."

3. R5's EMR shows R5 was admitted to the facility on April 26, 2023, with multiple diagnoses including: lung cancer, diabetes with chronic kidney disease, chronic obstructive pulmonary disease, anxiety disorder, and major depressive disorder.

R5's MDS dated May 3, 2023, shows R5 is cognitively intact

The facility's undated "Final Incident Investigation

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 06/29/2023

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 13	S9999		

Report Form" submitted to IDPH on May 12, 2023, completed by V6 shows, "The incident happened on 5/10/2023 at approximately 1:00 PM in the resident's room. The alleged perpetrator is [V16 (CNA)]. The report was written on 5/10/2023 at approximately 2:00 PM after PRSD was made aware of allegation. There are no witnesses to the occurrence and no injuries were noted. Resident stated that [V16] yelled at her to 'be patient' and kicked over her trash can. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: Verbal abuse is unsubstantiated as follows: Upon investigation it was found that [V16] did not kick [R5]'s garbage can or yell at her. [R5] pulled her call light because she needed to use the bathroom. [V16] answered resident's call like and asked what she could do to help her. [V16] helped resident use the bathroom and asked if there was anything else she could do. Resident stated no and [V16] then grabbed the trash can to throw things away and walked out of the room. PRSD did not see trash can spilled over on floor when talking to resident about incident and no one heard [V16] yelling ..."

On June 26, 2023, at 9:46 AM, V6 said, "I was really busy, and didn't have time for investigating [R5]'s allegation. I know I am supposed to do interviews, but I did not have the time."

The facility does not have documentation to show staff were interviewed during the investigation of R5's allegation.

4. R6's EMR shows R6 was admitted to the facility on November 22, 2022, with multiple diagnoses including: major depressive disorder,

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S9999	Continued From page 14	S9999		

schizoaffective disorder, and hypertension. The EMR continues to show R6 was discharged from the facility on May 31, 2023.

R6's MDS dated April 12, 2023, shows R6 is cognitively intact.

The facility's undated "Final Incident Investigation Report Form" submitted to IDPH on January 21, 2023, completed by V6 shows, "Resident reported the allegation on Tuesday 1/17/2023 at approximately 1:00 PM to [V6]. Time of report was 1:40 PM. Time of the incident is unknown. The incident happened in the resident's room. The alleged perpetrator is a staff member, [V16]. There were no other witnesses to this incident and no injuries noted. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: mistreatment is unsubstantiated, as follows: [R6] stated that staff member, [V16], was verbally inappropriate with her in her room. [V16] walked into resident's room and noticed a strong scent of urine. [V16] then asked [R6] if she wet herself. [R6] replied confirming she urinated her pants. [V16] asked [R6] why she wet herself and stated that she was not able to go to the bathroom on her own. [R6] did not reply so [V16] started to change resident. While CNA was changing [R6], she started to urinate again. [V16] again explained to [R6] that she is capable of using the bathroom on her own and was unsure why she was urinating all over herself. [V16] denied being disrespectful to [R6]. CNA was trying to educate resident on being independent and there was a misunderstanding in communication. [V16] has been educated on professionalism and using appropriate language when talking to residents ..."

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S9999	Continued From page 15 On June 26, 2023, at 9:46 AM, V6 said, "In January, I did not know I was supposed to be conducting interviews during investigations." The facility does not have documentation to show interviews were conducted during the investigation of R6's allegation. The facility's "Abuse Prevention Program - Toolkit" dated November 17, 2017, shows, "Investigation Procedures: Regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion or exploitation), the investigation shall consist of: ... Interview of staff members having contact with the alleged victim and alleged perpetrator during the period of the alleged incident; If the alleged perpetrator is an employee, interview of the other residents the alleged perpetrator provided care on the same shift as the alleged incident; If the alleged perpetrator is an employee, interview of other employees who worked the same shift of the alleged incident ... Sexual Abuse Incident Response Guide Definition: Sexual abuse is non-consensual contact of any type with a resident. Determine if the allegation involves verbal sexual harassment or physical sexual contact with or without penetration. If the allegation involves verbal sexual harassment, refer to the Verbal Abuse Investigative Path. If an allegation of sexual contact is involved: Immediately contact local law enforcement authorities (e.g. telephoning 911 where available) as required in Section 300.695 in the following situations: for sexual abuse-sexual penetration, intentional sexual touching or fondling, or sexual exploitation; or for sexual	S9999		

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S9999	Continued From page 16 abuse of a resident by a staff member, another resident, or a visitor. Call an ambulance provider and move the survivor, as quickly as possible, to a private environment to ensure privacy and ensure safety while waiting for emergency or law enforcement personnel to arrive ... If the facts do not indicate that sexual contact occurred after a thorough investigation, proceed to submit the Final Incident Investigation Report. Document the specific reasons sexual harassment or sexual contact is not suspected. Ensure notification to the Department of Public Health within two hours of the report ..." The facility's undated "Abuse Prevention Program Facility Procedures" shows, " ... V. Internal Reporting Requirements and Identification of Allegations Employees are required to report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear about, or suspect to the administrator or the person in charge of the facility acting on behalf of the administrator. Or an immediate supervisor who must then immediately report it to the administrator ... (B)	S9999		