

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000648		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/29/2025	
NAME OF PROVIDER OR SUPPLIER RIVAYA CARE OF DES PLAINES				STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD , DES PLAINES, Illinois, 60016			
(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) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation 2599033/2623873						
S9999	Final Observations		S9999				
	Statement of Licensure Violation:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	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.						
	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.						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on interviews and record reviews, the facility failed to follow fall policy related to prevention of falls and implementation of resident-centered fall interventions on a resident with cognitive impairment. This failure affected one (R1) of five residents reviewed for accidents and supervision and resulted in R1 falling while walking without staff assistance and sustaining a right intertrochanteric hip fracture with associated intramuscular hemorrhage. Findings include: R1 is a 64-year-old, male, originally admitted in the facility on 08/20/25 with diagnoses of End Stage Renal Disease; Unsteadiness on Feet; Other Abnormalities of Gait and Mobility; Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. According to R1's census report, R1 was admitted in the facility on 08/20/25 and was discharged on 08/22/25. On 09/10/25, he came back in the facility and was considered new admission. MDS (Minimum Data Set) dated 09/19/25 documented R1 has memory problem and his cognitive skills for daily decision making is severely impaired. His functional abilities recorded that he needs supervision or touching assistance when walking 10 feet; and partial/moderate assistance when walking 50 feet with two turns. MDS also indicated that he uses a manual wheelchair. Fall risk assessment dated 09/11/25 categorized R1 as			S9999			

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S9999	Continued from page 2 high risk with a score of 15. R1's admit/readmit evaluation dated 09/11/25 documented: E. Neurological: Comments – confusion M. Mobility/Safety: a. walk in room: self-performance – supervision b. walk in corridor: self-performance – activity did not occur g. wheelchair i. gait disturbance/unsteady gait Facility's incident report dated 09/19/25 recorded: R1 had an unwitnessed fall in the hallway. R1 was observed laying on the floor on his back with his walker on the side of him. Staff did full body assessment and R1 was complaining of pain. Pain medication was offered and given. Family and on call doctor were notified and order was given to send R1 out for further evaluation. Upon checking on R1's hospital status nurse on duty spoke with emergency room nurse and was informed that R1 was being admitted for a right hip fracture. R1's hospital records dated 09/19/25 documented: Xray of hip 2 views right and pelvis: Final result – Impression: Acute comminuted displaced and angulated right intertrochanteric fracture. CT (Computed Tomography) chest abdomen pelvis without contrast: Findings: Right intertrochanteric hip fracture with associated intramuscular hemorrhage. R1 was diagnosed with closed trochanteric fracture of right femur with nonunion and acute traumatic injury of cervical spine. On 09/24/25 at 2:18 PM, V10 (Certified Nurse Assistant, CNA) stated, "On 09/19/25 at 1:30 AM, I was by the nurses' station and just heard a sound like something dropped on the floor. Immediately, I stood up and went to the direction of the sound and saw him (R1) on the floor by his room. I called nurse immediately, who was at the other side of the hallway, on the east side. Nurse came immediately. R1 said he wants to walk around. He complained of pain on his hip, right side. The time he fell, he was walking out from his room. I didn't see if he was using his walker at that time. I don't remember. I didn't hear any alarm. When I did my rounds around 12ish he was sleeping on bed. That time it happened; I was the only staff on that side (west			S9999			

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S9999	Continued from page 3 wing) where R1 was. That time it was only me and the nurse worked on the west wing. Normally, he (R1) ambulates with a walker. there's no assistance needed because he can do it by himself. He can walk around by himself. He doesn't need assistance to walk around. He has no chair or bed alarm, not that I know of." On 09/24/25 at 2:53 PM, V11 (Licensed Practical Nurse, LPN) said, "That time of incident on 09/19/25, I was on 1 East, because one nurse left at 1 AM and I was the only nurse on the first floor. I had two CNAs - one in west and one in east. CNA was sitting at the nurses' station. I heard CNA called me, I went there, and I saw R1 on the floor. I did assessment. I asked him (R1) and said he was walking. I asked him about pain and showed me his right hip. I gave him PRN (when needed) pain pill. I called physician he was sent out as ordered." V11 said, "He is alert, oriented to self, time and place, able to verbalize needs. he never uses call light; always sitting in his room. His room is somehow close to nurse station. At night, sometimes, he was awake and will call "nurse, nurse". He usually sits in bed and will call "nurse, nurse". When we go to his room, he doesn't say anything. If you tell him to sleep, he will lie in bed. I don't know if he is a fall risk, it was the second time I took care of him. I've never seen him walking with a walker, only time he had was when he had the fall." R1's room was observed across nurses' station (1West). R1's door is on the side across nurses' station. On 09/25/25 at 10:25, V12 (Registered Nurse, RN) stated, "R1 is very much confused; he talks nonsense. Not able to use call light. He is very much a fall risk patient. His room was just across the station. We always monitor and check on him at least every two hours. CNAs do their rounds also. RNs and CNAs do monitor at least every two hours. I always tell my CNAs to monitor him. I do my rounds then CNAs, so more or less he is monitored and checked every hour. He gets up, he has a rollator. He is able to use rollator with supervision from staff. He uses his rollator with reminders but if not, he won't use it. His legs are weak and has unsteady gait. He needs monitoring/supervision frequently and make sure he uses the rollator when he walks." On 09/25/25 at 10:52AM, V14 (CNA) verbalized, "R1 is alert but confused. Able to verbalize needs. He is not able to use call light, he uses a rollator. He is supposed to use a wheelchair. We always redirect him. He always wanted to use the rollator. He is a fall risk. We have to monitor and check on him pretty often,		S9999				

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S9999	Continued from page 4 at least every 2 hours and when we do rounds, we check on him. He has no alarms. bed should be lowered. He has a behavior of getting up and walk, needs redirection. He needs to be reminded to use the wheelchair not rollator." On 09/25/25 at 11:14 AM, V5 (LPN/Restorative Coordinator replied, "On 09/19/25 at 1:30 AM, he got up from bed, attempted to self-transfer. Did not tell nurse where he was going. The CNA heard him fall, the CNA said she was doing patient care in another patient's room. When the CNA heard it, she went to the room and found him lying on his right side, the walker was next to him. The nurse came and assessed him, he was in pain to his right hip. The nurse called the doctor and R1 was sent out to the hospital. Cause of the fall – R1 was getting up and due to unsteady gait, he fell. Staff should have done rounding/monitoring at the time to ask if he needs something. Rounding/monitoring should be every hour like nurse simultaneous with CNA doing rounds; he might need to go to the bathroom at the time because it was around 1:30 AM but no one was around, cognitively he forgot to use the call light, and he did not know his limits and walked. He gets up when he wants to and walk. He uses a walker with staff assistance. R1 definitely has confusion. Somebody has to monitor and do an hour rounding on him." R1's care plans documented the following: 1. Requires restorative walking program due to his limitation in walking related to weakness (dated 09/12/25): Interventions: Discuss ambulation program with resident and responsible party. Provide staff assist with ambulation at level resident requires (e.g. set up, oversight, encouragement, cueing, physical assistance). Remind resident to not ambulate without assistance. 2. Resident is high risk for falls (dated 09/11/25): Interventions: Anticipate and meet the res needs. Be sure the resident (R1) call light is within reach and encourage the resident (R1) to use it for		S9999				

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S9999	Continued from page 5 assistance as needed. The resident (R1) needs prompt response to all requests for assistance. Educate the resident (R1)/family/caregivers about safety reminders and what to do if a fall occurs. Follow facility fall protocol. The resident (R1) uses (specify: chair/bed) electronic alarm. Ensure the device is in place as needed. R1's care plan interventions focused on his (R1) education, reminders and use of call light when assistance is needed. However, R1 is confused and forgetful. R1's Progress notes dated 09/11/25 documented in part but not limited to the following: R1 was observed up in chair, in no acute distress, eating breakfast, denies pain currently, alert and oriented to self, with noted confusion, requiring redirection per staff. On 09/25/25 at 1:19 PM, V2 (Director of Nursing) stated, "He is a fall risk. He came from the hospital because of a fall. He is alert, in and out, able to hold a conversation with you. He can tell you his needs and wants but detailed conversation and remembering things, not really. He needs to be redirected. He had a fall early in the morning, like at 1:30 AM, he got up and walked. His legs gave out when he was walking using the walker. It was unwitnessed fall, so he could not be redirected." Per admit evaluation note dated 09/11/25, R1 uses a wheelchair due to gait disturbance and unsteady gait. Per care plan, R1 uses electronic alarm, but was not implemented. On 09/25/25 at 10:46 AM, V13 (Nurse Practitioner) stated, "R1 is confused with place and time, he has dementia, able to verbalize needs. He sits in the wheelchair. I have not seen him walk. He is a fall risk. Rounds/monitoring should be done; making sure bed is locked; wheelchair locked; wearing non-skid socks; and follow the facility fall protocol." Facility's policy titled, "Falls Guideline", dated 8/2024 documented in part but not limited to the following: Purpose: To consistently identify and evaluate			S9999			

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S9999	Continued from page 6 residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for fall prevention to: To achieve each resident's maximum potential of physical functioning. To prevent or reduce injuries related to falls. To enhance residents' dignity and self-worth. The intent of this guideline is to ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: I. Identification of hazards and risks II. Evaluation III. Implementation IV. Monitoring V. Analysis Fall risk evaluation: a fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually and with a significant change in condition. Residents evaluated as at risk for falls will be identified and individualized fall precautions developed for each resident. Preventative measures shall be taken to decrease the number of falls whenever possible. Purpose: 1. To consistently identify and evaluate residents who fall and to treat or refer for treatment appropriately. 3. To prevent or reduce injuries related to falls. 6. Individualize interventions for each resident. Evaluation may include: Residents with recent surgery or new admission; fall history; cognitive status 1. If the evaluation finds the resident at risk, implement resident specific interventions/precautions. 7. All residents identified as at risk for falls will			S9999			

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S9999	Continued from page 7 be reviewed for individualized interventions. Fall Prevention is achieved through an IDT (interdisciplinary team) approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls. Facility staff across all departments together with resident representatives and residents provide resourceful information with individualizing care and approaches. Understanding contributing and predicting factors that present will assist with determining individualized care approaches. Systems approach – Tips for Compliance: Involve interdisciplinary team (IDT) on: Individualized assessment for safety; identification of hazards; Development and implementation of interventions to reduce accidents. (A)			S9999			