

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052795		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/17/2025	
NAME OF PROVIDER OR SUPPLIER RIVER VIEW REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 50 NORTH JANE , ELGIN, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000			12/04/2025	
	Complaint Investigation 25710263/2647713						
S9999	Final Observations		S9999			12/04/2025	
	Statement of Licensure Violations						
	300.610a)						
	300.1210b)						
	300.1210d)5)						
	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 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:						
	5) A regular program to prevent and treat pressure						

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 sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to assess for, report, and document a resident's acquired pressure wounds prior to the wounds becoming unstageable. This failure resulted in R3 acquiring unstageable pressure injuries to the sacrum measuring 8 x 7 x 0.1 cm (centimeters, measuring length x width x depth) and right medial heel measuring 5.5 x 6 cm x unknown depth. This applies to 1 of 3 residents (R3) reviewed for pressure injuries. The findings include: R3's EMR (Electronic Medical Record) said he was admitted to the facility on 4/25/2025 with multiple diagnoses, including paraplegia, degenerative disease of the nervous system, hereditary and idiopathic neuropathy, neuromuscular dysfunction of the bladder, presence of urogenital implant, ataxia, and impaired mobility. R3's EMR said he was dependent on staff for his ADLs (activities of daily living) care needs, including for toileting and transfers. The EMR said R3 was incontinent of bowel and required substantial staff physical assistance with his transfers. R3's admission Braden scale assessment dated 4/25/2025 said he was at risk for pressure injuries, although R3's 5/2/2025 MDS (Minimal Data Set) said based on his clinical assessments and his Braden Scale, he was not at risk for development of pressure injuries and had none present during the look-back period. On 11/17/2025 at 1:15 PM, V9 (R3's Family Member) said R3 was transferred to the facility because his progressive neuromuscular dysfunction disorder required him to need staff assistance with his care, including toileting and transfers. V9 said R3 had a history of pressure injuries to his hip area and right heel prior to admitting to the facility. V9 said she was informed weeks after he admitted that he had acquired extensive		S9999				

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S9999	Continued from page 2 wounds to the sacral area and right heel. V9 said R3 was transferred to the hospital on 5/26/2025 and then went to another facility. V9 said R3 was currently receiving ongoing aggressive treatment for his acquired pressure injuries at the facility. On 11/17/2025 at 12 PM, V11 (Wound Care Nurse/WCN) said she was aware of R3's history of pressure injuries prior to admission. V11 said on 5/19/2025, when assessing R3's healed left buttock non-pressure wound, she identified a new wound on his sacral-coccyx area. V11 said the wound was full-thickness and measured 7.6 x 6.8 x 0.1 cm with moderate serous exudate. V11 said she did not classify R3's wound type and did not document the wound's tissue because she wanted to have V16 (Wound Physician) assess R3 on 5/22/2025. V11 continued to say R3 was dependent on staff for his toileting hygiene and, at times was incontinent of bowel. V11 said staff was expected to assess resident's skin daily during care and report any abnormalities to prevent further skin complications. V11 said R3's sacral wound was not reported prior to her identifying it on 5/19/2025. On 11/17/2025 at 11 AM, V19 (Wound Physician) said he assessed R3 on 5/22/2025 and staged his sacral pressure wound as unstageable due to the necrotic tissue present. V19 said the wound measured 8 x 7 x 0.1 cm and had 40% thick necrotic tissue and required debridement. V19 said he then assessed R3's skin and identified a new wound to his right medial heel. V19 said the wound was also unstageable and presented as DTI (deep tissue injury) with a blood-filled blister. V19 said R3's right heel measured 5.5 x 6 cm x unknown depth. V19 said skin breakdown on residents at risk should be identified early to aid in preventing potential deterioration. V19 said he expected the facility staff to follow their pressure injury prevention and wound assessment policy to ensure residents at risk could be managed appropriately. R3's comprehensive care plan did not indicate he was at risk for skin breakdown prior to 5/19/2025. The care plan was updated on 5/19/2025 to indicate R3 had new facility-acquired wounds to his sacrum on 5/19/2025 and right medial heel on 5/22/2025. R3's ADL report from 5/01/2025-5/26/2025 showed he required limited to extensive assistance with his toileting needs. R3's Bath and Skin Report Sheet for May 2025 showed his weekly (every 7 days) comprehensive skin check was last done on 5/12/2025. The following scheduled skin assessment on 5/19/2025 was not documented. R3's Treatment Nurse Initial Skin Alteration Review		S9999				

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S9999	Continued from page 3 (Wound Nurse) report dated 5/19/2025 said R3 had a new facility identified open wound to his coccyx area. The wound measured 7.6 x 6.8 x 0.1 cm. The assessment did not indicate the type of wound and the type of tissue present. R3's Specialty Physician Initial Wound Evaluation and Management Summary report dated 5/22/2025 said R3 had a facility-acquired "unstageable (due to necrosis) sacrum full thickness" wound. The wound had 40% necrotic tissue with moderate serous drainage and measured 8 x 7 x 0.1 cm. The report also said R3 had another facility acquired "unstageable DTI of the right medial heel undetermined thickness" wound. The wound measured 5.5 x 6 cm x unknown depth due to blood blood-filled blister. The facility's policy titled Pressure Injury and Skin Condition Assessment Policy, dated 09/2016, said the policy was established to provide guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure, and other ulcers and assuring interventions were implemented. The policy said "each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the Charge Nurse, who will perform the initial assessment." Skin notifications include redness/swelling, blisters, skin discoloration, bleeding, wound drainage, any type of lesion, and changes in skin temperature. The policy said that at the earliest sign of pressure injury or other skin breakdown, and initial assessment and documentation, should be completed in the resident's clinical record. A licensed nurse was responsible for assessing, measuring, and recording pressure wounds in the Wound Assessment Form. The form documentation should include the site, stage of the pressure ulcer, and a comprehensive description of the wound. (B)		S9999				