Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001283	A. BUILDING: ______ B. WING ______	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF RIVER OAKS	14500 SOUTH MANISTEE BURNHAM, IL 60633

(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 2195273/IL136359	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.3240 c) 300.3240 f) 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. Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.	S9999	Attachment A Statement of Licensure Violations	

s Department of Public Health
RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 These requirements were not met as evidenced by: Based on observations, interviews, and record reviews, this facility failed to prevent a resident to resident physical attack, affecting one resident (R4) out of 7 residents reviewed for allegations of abuse in a sample of 7. This failure resulted in R4 being physically attacked by R7 and sustaining lacerations to head requiring sutures and staples at the local hospital. Findings include: Review of R7's abuse and neglect screening, dated 5/4/21, notes R7 with psychiatric history and possible misinterpretation of events and the intentions of others and history or presence of dysfunctional behavior (e.g., provoking aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peers rooms/personal space. Review of R7's psychiatric note, dated 7/6/21, notes R7 symptomatic of poor impulse control. Review of R7's medical record, dated 7/9/21, notes "(R7) presents with paranoia and delusions. Pacing the hallway talking to himself. Denies hearing voices however appears to be responding to internal stimuli. (R7) displays verbal aggression towards staff without provocation. Threatening to cause bodily harm to staff if they enter (R7's) room when rounding. 1:1 provided by social service and ineffective. Unable to redirect. Displaying bizarre and unpredictable	S9999		

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S9999	Continued From page 2	S9999		

behaviors. Placed on 1:1 behavior monitoring."

Review of R4's progress notes, dated 7/19/2021, V15 (nurse) noted R4 was observed sitting in R4's wheelchair profusely bleeding from his head and nose. Upon assessment, R4 stated R4 was attacked by two other residents. Owing to the bleeding, R4 was cleaned with normal saline and wrapped with gauze. R4 was transported to the hospital for evaluation. V2, DON (Director of Nursing), and V1 (Administrator) were notified. The oncoming nurses were made aware, including the oncoming supervisor. On 7/20/21 at 3:23am, R4 was alert and responsive, returned from the hospital with diagnosis: closed head injury, three staples left side head, three sutures front of head. Order to perform daily wound dressing changes. Keep wound clean and dry.

Review of this facility's abuse investigation, dated 7/19/2021, notes incident occurred at 10:30pm. It was reported by charge nurse R4 had been hit. R4 sustained cut to forehead. R7 interviewed by V1. R7 stated R7 didn't know what happened to R4. R4 stated R7 came in his room with another resident and one of them hit him. R4 refused to file a police report.

There is no documentation found noting R4's physician or family were notified of this incident on 7/19/21. R4 was not provided any well being checks/counseling between 7/20 and 7/26/21.

On 7/27/2021 at 11:58am, V2, PRSD (Psychiatric Rehabilitation Services Director) stated R7 gets along with staff and peers. V2 denied R7 has any history of aggressive behaviors. V2 stated V2 is unaware of any allegations of physical assault involving R7 and R4.

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S9999	Continued From page 3 On 7/27/2021 at 2:30pm, R4 is observed to have three sutures to forehead and three staples to the top of head. R4 is observed to have discoloration under left eye and a yellow and green bruise to left upper arm. On 7/27/2021 at 2:30pm, R4 is not able to state how R4 received injuries. On 7/28/2021 at 9:55am, V4, ADON (Assistant Director of Nursing) stated R4 was in an alleged fight with a peer on 7/19/2021. V4 stated V4 was not involved in the abuse investigation. V4 stated R7 has a history of exhibiting aggressive behavior due to R7's mental illness. On 7/28/2021 at 10:20am, V6, LPN (Licensed Practical Nurse) stated this facility's abuse protocol is to respond to any incident immediately. V6 stated the residents involved are assessed head to toe, and have vital signs checked. V6 stated the residents' families and physicians are notified. V6 stated all incidents are documented in the resident's progress notes. V6 stated all residents involved will be sent out to the hospital for evaluation. On 7/28/2021 at 11:10am, V10, CNA (Certified Nursing Assistant) stated R4 sustained the discoloration to left eye and the lacerations to head during an altercation with another resident. On 7/28/2021 at 11:20am, V11, CNA (Certified Nursing Assistant) stated V11 has witnessed R7 exhibit aggressive behaviors towards residents. V11 stated V11 has heard R7 verbally threaten other residents. On 7/28/2021 at 11:45am, V1 (Administrator) stated V1 is not aware of any previous aggressive	S9999		

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S9999	Continued From page 4 behaviors exhibited by R7. V1 stated V1 interviewed V20 (Residential Services/Security) regarding the altercation involving R4. V1 stated V20 informed V7 that R7 hit R4. When asked what interventions were put in place after altercation, V1 stated R4 was transported to the hospital for repair of lacerations, and upon returning, R4 was placed on another nursing unit. V1 stated R4 requested to return to previous room. V1 stated since R7 was out of facility, R4 was allowed to transfer back. V1 stated R7 was placed on 1:1 supervision until R7 was transported to the hospital. On 7/28/2021 at 3:37pm, V20 (Residential Services/Security) stated on 7/19/21, R4 called out to V20. V20 stated V20 saw R4's face bleeding. V20 stated R4 had open areas on forehead and top of head. R4 informed V20 that R7 entered R4's room and hit R4. V20 stated R7 hit R4 with the arm rest from R4's wheelchair multiple times. V20 stated V20 asked R7 what happened; R7 informed V20 that R4 provoked R7. V20 stated R7 has gotten physically aggressive and verbally aggressive with other residents and staff. V20 stated during dinner on 7/19/21, R7 went to R4's table and was yelling at R4. V20 stated staff informed V20, and V20 responded immediately to the dining room. V20 stated both residents were separated. V20 stated R7 returned to R7's table and finished meal. V20 stated R7 was still angry. V20 stated R7 went outside to smoke, and was bullying the other residents outside. V20 stated R7 was instructed to go to R7's room. V20 stated R7 frequently bullys other residents. V20 stated the residents do appear fearful of R7. On 7/29/2021 at 9:30am, V2, PRSD (Psychiatric Rehabilitation Services Director) stated well being	S9999		

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S9999	Continued From page 5 checks are done on all residents weekly, and documented in the resident's medical record. V2 stated V2 did a well being check on R4 on 7/26/2021. Review of R7's medical record notes R7 was transported to the hospital for evaluation until 7/21/21. There is no documentation in R7's medical record noting an altercation occurred between R7 and R4, R7's physician was notified, social services followed up with R7 regarding behaviors, or that R7 was placed on 1:1 monitoring. Review of this facility's abuse policy, dated 09/2017, notes this facility affirms the right of its residents to be free from abuse. (B)	S9999		