STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING: _____ B. WING _____	C 08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

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S 000	Initial Comments Facility Reported Incident Investigation. FRI of 07/11/23/IL162448	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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 are not met as evidenced by: Based on interview and record review the facility failed to follow the fall prevention and management policy to develop and reevaluate individualized interventions to minimize the risk	S9999		

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S9999	Continued From page 2 for falls with injuries. This affected one of three residents (R1) reviewed for fall prevention. This failure resulted in R1 falling from bed, subsequently noted with pain and a large red bruise to the right thigh. An Xray shows impacted basi- cervical fracture of femoral neck. R1 was sent to the local hospital for treatment. Findings include: R1's face sheet denotes diagnosis of muscle wasting, malaise, unsteadiness on feet, weakness, unspecified dementia, age related nuclear cataract, lack of coordination, vitamin d deficiency, abnormality of gait and mobility. R1 MDS dated 7/01/23 denotes BIMS score of 6 (cognitive impairments). R1's follow-up investigation report denotes fall with injury, age 80, BIMS 6, mental status alertx1, dementia, schizophrenia, unsteadiness of feet, anxiety, current location of victim- (hospital name). Resident sustained subdural hematoma and impacted Basi cervical fracture of the right femoral neck with varus. Subdural hematoma and impacted Basi cervical fracture as reported to V9 (physician) and POA. Resident alert x1, able to state that he fell, however not able to elaborate on details. Summary of witness- Roommate upon interview the resident roommate (R5) stated that he observed resident trying to transfer from bed to wheelchair and that is when resident fell. (R5) stated resident got himself back on his bed. When R5 was asked if he informed anyone of the fall, he stated no. R5 stated he thought resident (R1) was okay. R5 also stated he does not remember the time or day of when the fall occurred. XX {sic} (LPN) writer states upon doing rounds she noticed resident grimacing and in pain. Upon further assessment XX {sic} noticed a	S9999		

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S9999	Continued From page 3 large red area on inner right thigh and patient shook upon touch. Vitals assessment, ROM assessed with pain to touch on right leg. PRN (as needed) Tylenol given, NP (Nurse practitioner) made aware with STAT Xray orders given and ordered to start Keflex 500 mg (milligrams) PO (by mouth) TID x 7 days, and STAT labs, CBC, CMP for next day. Bed positioned lowest to the floor with call light and floor mats in place at this time. STAT X ray obtained, new orders to send patient to ER for further evaluation. V8 (LPN) stated resident slept throughout the night upon her constant rounding on her shift. Follow up call placed to ER (emergency room) staff informed our staff that the patient sustained a subdural hematoma and fracture, then was transferred to (different hospital) hospital for further treatment. Resident is able to stand and pivot with and without assistance. Per hospital report resident sustained subdural hematoma and impact basal cervical fracture of the right femur neck with varus. Residents still at (different hospital) hospital at this time. After a thorough investigation was conducted by reviewing of statements medical records and observation it is concluded that it was an anticipated fall resulting in a subdural hematoma and or fracture. Per resident roommate resident fell while attempting to transfer himself from bed to wheelchair. Root cause analysis; due to the residents diagnosis of unspecified dementia with behavior disturbance resident gain a false sense of independence due to recently being on physical therapy. Care plan updated rounding at a minimum of Q 2 hours and prompt assistance to change in positions toileting offering fluids and ensure resident is warm and dry. R1's incident report dated 7/11/23 denotes in-part resident noted in bed with redness to inner right	S9999		

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thigh, with shakes and facial grimacing. Resident states with confusing I fell and put myself back to bed. Making AM rounds resident lying in bed seen with very large red bruise on inner right thigh and shakes with pain when touched, notified NP (Nurse Practitioner) who ordered Xray of right leg and hip to r/o (rule out) fracture, and for Keflex 500mg po TID (three times a day) for 7 days, also ordered a CBC and CMP for tomorrow. Resident vitals 152/88 HR (heart rate)70, temp 97.2, 92% RA, 18 resp. Tylenol given for pain, DON (Director of Nursing) also notified. (Radiology company) phoned for x-ray. Technician arrived in facility for Xray at 930am. Resident was later sent out to (hospital name) or further evaluation. Phoned residents responsible party to inform her that he was sent out for evaluation (phone number). Injury type, bruise, right thigh. Pain ,6. Mental status, confused/forgetful. Predisposing factors confused incontinent.

R1's radiology report dated 7/11/23 denotes in-part right hip Xray, 2 views, findings right hip, Examination reveals what appears to be an impact Basi cervical fracture of the right femoral neck with varus deformity and some demineralization degenerative arthritis changes.

R1's progress note dated 7/11/23 at 8:07am denotes in-part upon making AM rounds resident lying in bed seen with very large red bruise on inner right thigh and shakes with pain when touched, notified NP (Nurse Practitioner) whom ordered Xray of right leg and hip to r/o (rule out) fracture, and for Keflex 500mg po TID (three times a day) for 7 days, also ordered a CBC and CMP for tomorrow. Resident vitals 152/88 HR (heart rate) 70, temp 97.2, 92% RA (room air), 18 resp. Tylenol given for pain, DON (Director of Nursing) also notified. (Radiology company)

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phoned for x-ray. Technician arrived in facility for Xray at 930am. Resident was later sent out to (hospital name) or further evaluation. Phoned residents responsible party to inform her that he was sent out for evaluation (phone number).

On 8/12/23 at 12:31pm V1 (Nurse) said she was the morning nurse caring for R1 when she was summoned to the room to look at R1's thigh. V1 said she noticed a red bruise to R1's right thigh extending down R1's leg. V1 said R1 was in a lot of pain, noticed with facial grimacing. V1 said she notified the Nurse Practitioner who gave orders for Xray and antibiotics. V1 said she gave R1 Tylenol for pain. V1 said R1 had increased pain, and that's when R1 was sent to the hospital for evaluation. V1 said the radiology company came and did R1's X-ray but due to the increase pain, R1 was sent to the hospital before the results came back. V1 said her shift originally started on another unit and she was moved to the unit that R1 was on. V1 said R1 was in severe pain, R1 was shaking and grimacing.

On 8/12/23 at 3:50pm V3 (DON-Director of Nursing) said R1 had a fall from his bed. V3 said R1's roommate at that time saw R1 get himself up from the floor and get back in bed. V3 said the roommate was coming from the bathroom and observed R1 pick himself from the floor. The roommate said she did not know why he did not inform the nurse. V3 said she observed R1 with redness to the right inner thigh.

On 8/12/23 at 11:47am V6 (CNA-Certified Nursing Aide) said he did not work with R1 on 7/10/23, V6 said he is familiar with R1, V6 said he has worked with R1 in the past and he's learned R1's behavior of trying to get out of bed when he's wet, so he makes sure he keeps R1 dry

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S9999	Continued From page 6 when he works with him. V6 said R1 has behaviors of trying to get out of bed when he's wet. V6 said he has seen R1 wheel himself out of his room in the mornings when he's getting ready to leave for his shift (11pm-7am). V6 said he does not know if staff has gotten R1 up or not in the morning when he sees him up in his wheelchair. On 8/12/23 at 11:50am V2 (CNA- Certified Nursing Aide) said he worked with R1 on 7/10/23 during the 11PM -7AM shift, V2 said he did not see R1 fall, he did not pick R1 up from the floor. V2 said R1 does have behaviors of trying to get out of bed. V2 said R1 is not on the morning get up list for the night shift. V2 said he changed R1 at 5:00am and last saw R1 around 7:00am before his shift ended. On 8/12/23 at 3:27pm V8 (Nurse) said she was the nurse responsible for R1's care on 7/10/23 on the 11:00pm-730am shift. V8 said she did not see R1 fall, she did not assist with picking R1 up from the floor. V8 said R1 does try to get out of bed. V8 said she saw R1 sleeping that night, she saw R1 at 1am, 3am, 5am and before she left for her shift. V8 said R1 was sleeping every time except for the time she was summoned in his room by V1. V8 said V1 summoned her to R1's room to look at R1's thigh on the morning of 7/11/23. V8 said she noticed R1's right thigh with redness. V8 said she went home after making her observation. On 8/13/23 at 10:02am V4 (CNA- Certified Nursing Aide) said she worked with R1 on 7/10/23 during the 3-11pm shift. V4 said she did not witness R1 fall. V4 said R1 is a resident that like's to watch the news, eat his meals, and lay in bed. V4 said R1 does have behaviors of trying to get out of bed. V4 said she put R1 to bed after	S9999		

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S9999	Continued From page 7 dinner on 7/10/23 and provided incontinence care to R1 around 930pm. V4 said that was the last time she saw R1 for her shift. On 8/12/23 at 2:28pm V7 (MDS Nurse) said she initiated the care plans for medical diagnosis, R1's plan of care reviewed with V7 denoting alteration in hematological status related to vitamin D deficiency with initiated date of 9/1/2022, interventions fall risk assessment and increase vigilance for falls. V7 said she developed that intervention for R1 because R1 is at risk for falls. V7 said she don't do the fall care plans. V7 said vigilance for falls means checking on the resident as needed, V7 said she don't have a time frame, it's just as needed. On 8/12/23 at 2:56pm V5 (Restorative Nurse) said she was the restorative nurse, V5 said she initiates the fall care plans, updates the fall care plans, she does the fall evaluations also. V5 said R1 was able to stand and pivot with staff assist and cueing, V5 said there were days that R1 needed more assist from staff like touching and guiding with transfers. V5 said R1 was able to sit at the bed side. V5 said R1 had poor safety awareness that's why he needed assist with standing, pivoting, and transfers. V5 said she was not aware of R1's behavior of trying to get out of bed. V5 said the Nurses and CNAs should make her aware of R1's behaviors. V5 said R1 is a high fall risk now with a score of 13, and a prior score of 11. V5 said trying to get out of bed is not the same as a fall. V5 said trying to get out of bed puts R1 at risk for falls. V5 said the facility cannot physically restrain a resident to keep them in bed. V5 said if the staff would have made her aware of R1 trying to get out of bed she would have implemented putting more eyes on R1. V5 said more eyes on R1 means having someone in the	S9999		

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S9999	Continued From page 8 room with him or having someone near his room. V5 said she would have implemented checking on R1 every two hours. V5 was asked how they are checking on R1 every two hours different from the standard every two-hour check that the staff were doing before the fall? V5 said she would have implemented every two-hour checks on R1. V5 said the interventions that were initiated on 7/12/23 after R5 left the facility was to be put in place upon his return to the facility. R1 did not return to the facility. On 8/13/23 at 10:31am V9 (physician) said he was made aware of the incident regarding R1 sustaining a hip fracture. V9 said the nurse observed R1 with a bruise to the thigh, the nurse practitioner was made aware, the Nurse practitioner order Keflex and Xray. V9 said the Nurse practitioner initially thought it was cellulitis based on what the nurse reported that's why Keflex was ordered. V9 said R1 received an Xray and was sent to the hospital for further evaluation. V9 said a fracture is the result of trauma unless there's an underling condition that the resident is not aware of. V9 said R1 was doing fine before this fracture. V9 said initially the facility did not know what happened to R1's leg. V9 said during the facility investigation it was determined that R1 had a fall. R1's roommate at that time saw R1 get up from the floor. R1's fall risk assessment dated 2/24/23 denotes a score of 11, R1 has unsteady gait and/or use of ambulatory device, R1 has confusion, R1 is 75 and above for age, R1 has medications drugs that have a diuretic or increase GI mobility, Drugs that affect the thought process, Drugs that create a hypotensive effect. R1 is incontinent. R1 fall risk assessment did not denote predisposing condition of hypertension.	S9999		

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S9999	Continued From page 9 R1's plan of care with initiation date of August 2022 denotes in part fall, resident is high risk for falls cognitive deficits and use of psychotropic medications secondary to unspecified dementia with behavior disturbance, the goal is to remain free from injury related to falls through the next review date, interventions are to document signs and symptoms of adverse effects of medications on resident, encourage appropriate use of assistive devices, position, keep frequently used items within reach, monitor for any changes in condition, monitor resident for tolerance and endurance, scheduled task accordingly. Interventions with initiation date of 7/12/2023 denotes falling star program, floor mats in place while in bed, keep bed in lowest position R1 has a false sense of independence due to recently being on physical therapy, resident to be educated on seeking staff for assistance, the importance of complying with safety measures and possible complications of non-compliance, rounding at a minimum of Q (every) 2 hours and prompt or assist for change in position, toileting, offer fluids and ensure resident is warm and dry. R1's care plan for alteration in hematological status related to vitamin D deficiency with initiated date of 9/1/2022 denotes in-part, interventions fall risk assessment and increase vigilance for falls. R1 MDS dated 6/21/23 denotes BIMS score of 12 (cognitively intact). Facility policy titled fall prevention and management with last review date 7/2022 denotes in-part this facility is committed to maximizing each resident physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for	S9999		

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S9999	Continued From page 10 preventive strategies, and facilitate as safe an environment as possible. All falls shall be reviewed, and the resident existing plan of care shall be evaluated and modified as needed. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP (individualized service plan) with interventions with interventions implemented to minimize fall risk. Facility policy titled comprehensive care plan with last review date 3/2023 denotes in-part the facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the residents medical, nursing, mental and psychosocial needs. The comprehensive care plan should drive the care and services provided for the residents and allow for highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment. The comprehensive care plan should be reviewed with the residents and / or resident representative and changes made as appropriate. (A)	S9999		