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BRIA OF RIVER OAKS	14500 SOUTH MANISTEE BURNHAM, IL 60633

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S 000	Initial Comments Complaint Investigation 2497787/IL178518	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300. 1210a) 300. 1210b) 300.1210d)6) 300.1220b)2)3) 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 meet the resident's medical, nursing, and mental	S9999		

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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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional

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status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.
Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure staff was aware of a high risk falls resident required supervision and monitoring and failed to prevent a resident from falling from the wheelchair while on 1:1 monitoring by staff. This affected two of three residents (R1, R2) reviewed for supervision. This failure resulted in R1 suffering a left arm fracture after falling while walking in the hallway unsupervised or without monitoring, and R2 from falling from the wheelchair and sustaining a laceration to the right ear.

Findings Include:

1. R1 is a 67-year-old with the following diagnosis: dementia, schizophrenia, unsteadiness

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on feet, and displaced fracture of the left humerus.

A Nursing note dated 9/22/24 at 8:30 PM documents that the nurse was notified by staff that R1 was observed getting off the floor in the annex (hallway on the first floor). As the nurse was waiting for the elevator to go downstairs, R1 came off the elevator and ambulated to R1's room. The nurse immediately followed R1 to the room to assess R1, but R1 refused. R1 requested not to be touched and to be left alone. The physician was notified with an order to observe for 72 hours.

A Nursing note dated 9/22/24 at 10:20 PM documents that upon rounding, R1 complained of pain in the left upper arm. The swelling was noted in the left upper arm, but R1 refused any further assessment. The physician was notified, and an order was placed to send R1 to the hospital for an evaluation.

A Nursing note dated 9/23/24 documents that R1 was admitted to the hospital with a diagnosis of a humeral head fracture.

A Nursing note dated 10/3/24 documents R1 readmitted from the hospital and was alert and oriented times four. R1 had a diagnosis of a fracture related to a fall.

The Ambulance Run Sheet dated 9/22/24 documents R1 was transported to the hospital status post fall. There was a deformity noted to the left shoulder area.

The Hospital Record dated 9/23/24 documents that R1 is alert and oriented times four and arrived from a nursing home with a complaint of

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left shoulder pain. R1 reported being pushed and then fell. R1 was unable to raise the left arm upward. The x-ray of the left shoulder showed an acute displaced spiral fracture of the left proximal humeral shaft. The fracture extends through the left medial humeral head through the greater tuberosity of the left humeral head. There is associated soft tissue swelling. R1 was then transferred to a hospital with orthopedic capabilities.

The Hospital Record dated 9/30/24 documents R1 was a direct transfer from an outside hospital after being admitted there for left arm pain following a fall at a nursing home. R1 reported ambulating in the hall when R1 suddenly felt as if R1 was pushed towards the wall, resulting in a fall landing on the left side. Orthopedic surgery was performed, and R1 was discharged back to the facility on 10/3/24.

On 10/8/24 at 3:12 PM, R1 was laying in bed with a sling to the left arm. R1 requested not to move R1's left arm. There were four sites on the arm covered with gauze and a clear bandage. R1 stated R1 fractured the left arm and had a "rod" put in the arm during surgery to repair the arm. R1 stated R1 fell down in the hallway on the first floor. R1 reported feeling a push from behind, and R1 ran into the wall and fell to the floor. R1 denied a person pushing R1 but reported it was an "evil spirit" that pushed R1 into the wall. R1 stated a security guard helped R1 up off the floor, and R1 then walked to R1's room. R1 stated lying in R1's bed until the pain was too bad, and they had to be sent to the hospital. R1 reported that the nurse tried to come into the room to look at R1's arm, but R1 did not want anyone to touch R1's arm at that time, so R1 refused. R1 stated R1 also fell on 7/15/24. R1 reported an "evil spirit"

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that also pushed R1 into the wall at that time. R1 stated R1 is still able to get up and walk freely in the building without any assistance or supervision. R1 denied having any other interventions put in place after the most recent fall. R1's orientation was assessed, and R1 is alert and oriented times four. R1 was able to correctly state the date, president, date of birth, location, and what kind of building the facility is.

On 10/8/24 at 3:36 PM, V11 (Nurse) was not able to answer if R1 was a high fall-risk resident or not. The surveyor asked if there was a Fall Binder staff could reference, and V11 went into the cabinet and handed the surveyor the Fall Binder. R1 was not listed on the "High Fall Risk List," and no interventions were listed for R1 to prevent any falls. There was no date on the sheet indicating when the lists were last updated. V11 stated the binder was updated by the restorative department, but V11 did not know when the lists needed to be updated.

On 10/9/24 at 1:46 PM, V12 (Nurse) reported that R1 is now a high fall-risk resident since fracturing R1's arm. V12 was unaware of the details of the fall or what caused the fall. The surveyor asked V12 for the Fall Binder that is located at the nurse's station for staff reference. V12 was unable to find the binder at this time and stated that the restorative department is currently updating the binder.

On 10/9/24 at 3:06 PM, the surveyor asked V12 for the Fall Binder on the second floor. This time, V12 was able to hand the surveyor a binder for review. R1 was now listed on the "High Fall Risk List," but R1's fall interventions were not listed on the intervention sheet. There was no date on the sheet indicating when the lists were last updated.

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On 10/9/24 at 11:00 AM, V4 (Restorative Nurse) stated that management notifies staff of the fall risks on the floor by in-services, and staff is also supposed to monitor new admissions for falls. V4 reported that the restorative will notify the staff once the restorative evaluation is complete if a resident is at high fall risk. V4 stated that the nurses should also be aware of residents who are at high fall risk after completing the fall risk evaluation. V4 reported restorative CNAs round on the floor to make sure all fall precautions are in place as well as the hourly rounds nurses/CNAs perform. V4 stated the facility has a restorative binder that lists the high fall-risk residents so the staff can reference the binder if needed. V4 confirmed the binder is updated every time someone is added, discharged, or as needed. V4 reported that R1's fall was unwitnessed, but security did see R1 getting up off the floor. V4 reported that R1 walks around without any assistive devices and has no issues with gait. V4 stated due to R1's noncompliance, the facility was not able to determine the cause of the fall but denied interviewing R1 due to R1 being in the hospital. V4 reported that R1 came back about a week later, so the investigation was closed out based on staff interviews. V4 stated is a high fall risk now. V4 reported that R1 has had a previous fall, but there were no injuries from that, and staff is on alert to pay attention to R1 while R1 is walking. V4 stated that since this is the second fall, it is hard to discover why R1 fell, so R1's a high fall risk based on that. At this time, V4 was shown the copy of the "High Fall List Residents" from the binder on the second floor. V4 was not able to point out R1's name on the list. when asked why R1's name is not on the high fall risk list, V4 said the list probably hasn't been updated since R1's return, but R1 should be on

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the list.

On 10/9/24 at 1:20 PM, V6 (Nurse) stated V6 was in the middle of passing night meds around 8:30 PM when the secretary called to tell V6 that R1 was seen getting up off the floor. V6 reported as V6 was going down stairs, R1 came off the elevator and went to R1's room. V6 stated R1 told V6 that R1 fell and got up off the floor but then R1 requested to be left alone. V6 reported that R1 is alert and oriented at times two but also confused at times. V6 stated that R1 did not have any mental status changes that night and normally does not need much physical help with care. V6 denied R1 being a high fall risk at the time of the fall on 9/22. V6 then confirmed being able to look up on the computer which residents are a high fall risk and does not remember seeing that information in R1's chart. V6 reported that R1 had no interventions in place at the time of the fall because there was no need. V6 stated that R1 then reported pain, and V6 could see the left arm swelling through R1's clothing, so an order was placed to send R1 to the hospital. V6 confirmed that R1 had a fracture to the left arm. V6 denied making any changes to R1's plan of care since this fall. V6 stated that R1 is still able to walk around the building freely and was just doing so last night. V6 said, "I don't know about a fall binder at the nurse's station. They have never told me there is a binder at the desk to look at."

On 10/9/24 at 2:36 PM, V8 (Security) stated around 8:30 PM, R1 walked past V8, and from the look of it, R1 was reaching for the handrail and "missed it or slipped off it." V8 reported that there was a big boom that sounded like something had hit the wall. V8 stated the fall happened right after the kitchen doors going to the dining room. V8 reported walking to the area

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when the boom was heard the boom and saw R1 on the ground. V8 asked R1 if R1 was ok and went to tell the secretary to call the nurse. V8 reported R1 was a little "discombobulated" and was only able to tell V8 that R1 fell but not how. V8 reported that R1 was alone with no one staff or residents near R1. V8 stated staff tells security who is a fall risk. V8 denied thinking R1 was a high fall risk because R1 walks normal. V8 denied being aware of where V8 can look up information about high fall risks.

On 10/9/24 at 3:03 PM, V9 (DON) stated R1 is completely independent and doesn't normally have a problem with walking, but doe does have a diagnosis of unsteadiness of the feet. V9 was not able to recall if R1 was a high fall risk before the fall on 9/22. V9 reported high fall risk residents are identified by the Fall Risk Evaluation, with the score being greater than 10. V9 stated the Fall Risk Evaluations should be scored correctly so the facility can identify who is at high risk of falls. V9 said, "Every resident who has a fall is considered a high fall risk after that." V9 reported the facility has fall risk binders on each floor to let staff know who is a fall risk and what their interventions are. V9 stated the binder is updated based on each fall occurrence. V9 reported staff can refer to the binder if they are unsure who is a high fall risk. V9 reported Restorative is responsible for updating the binder.

On 10/10/24 at 1:34 PM, V14 (Primary Physician) stated R1 fell and was sent to the hospital. V14 reported a CT scan was performed when R1 was up on the floor, which showed R1 needed surgery, so R1 was transferred to a hospital with orthopedic surgery. V14 denied R1 having any issues with R1's gait but reported that R1 is very psychotic. When asked how this can affect a

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resident's gait, V14 stated that R1 is on psych medications, so R1 has a risk of falling on those medications. V14 remembers R1 falling in 07/2024 but could not remember the details. V14 was aware R1 did not have any injuries with that fall. When asked if a resident should be considered a high fall risk after a fall, V14 said, "It easy to say they should have considered her a high fall risk, but it is not easy to do." V14 reported if a resident has had weakness or has had a history of falls, then they need to be a high fall risk. V14 stated the staff should be aware of who is a high fall risk in the facility so they can monitor them.

The Final Facility Incident Report Form dated 9/27/24 documents that the nurse was notified by security that R1 was observed getting off the floor in the annex. The floor was dry and free of clutter. The nurse attempted to do a head assessment on R1 but refused. Later, R1 verbalized pain, and the physician ordered R1 to be sent to the hospital for a medical evaluation. R1 was admitted to the hospital with a diagnosis of a fracture of the left humerus. R1 is alert and oriented times two and was admitted to the facility with a diagnosis of weakness, unsteadiness on feet, and lack of coordination. R1 is able to express self and ambulates independently. After investigation, the fall was determined unavoidable. R1 is not complained with treatment plan the facility. Upon readmission, R1 will be re-educated on safety precautions with emphasis on treatment compliance.

The Fall Investigation Report 7/15/24 documents R1 fell onto the right shoulder in the hallway in front of the nurse's station at about 4:05 AM. R1 is alert and oriented times three. The root cause of the fall is documented as improper footwear.

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There is no documentation that R1 was not wearing the correct footwear in any other documentation.

The Fall Investigation Report dated 9/22/24 documents R1 was noted getting off the floor by security. This was an unwitnessed fall. R1 refused a head-to-toe assessment and was able to ambulate back to R1's room. Nursing staff encouraged R1 to take rest periods when walking long distances upon returning from the hospital. Physical therapy will evaluate and treat as needed. There is no root cause documented for this fall.

The Fall Risk Evaluation dated 7/15/24 documents the reason for this assessment as post-fall. The score of this assessment is documented at a two. A score of 10 or higher indicates a resident is at high risk for falls. On the assessment, it is documented that R1 does not have a history of falls within the past 1 to 6 months, even though R1 had a fall on this day. If the assessment was scored correctly, then R1 should have been considered a high fall risk on this day.

A Fall Risk Evaluation dated 7/30/24 documents the reason for this assessment is an initial/admission assessment. The score of this assessment is documented as a three. Again, this assessment documents that R1 does not have a history of falls within the past one to six months, even though R1 had a fall two weeks prior to this assessment. If this assessment was scored correctly, then R1 should have been considered a high fall risk again on this day.

The Fall Risk Evaluation dated 10/3/24 documents the reason for this assessment as

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initial/admission. It is documented that R1 has an unsteady gate and has a history of falls within the past one to six months. The score for this assessment is 15, indicating that R1 is now considered at high risk for falls.

The Physical and Occupational Therapy Evaluation were completed on 10/9/24, which indicates R1 is appropriate for both services. R1 has an impaired safety awareness and presents with impairments and strength, gross motor coordination, fine motor coordination, follow through, planning, problem-solving, self-modification, use of coping strategies, balanced, mobility, attention, self-monitoring, and dexterity resulting in limitations and/or participation restrictions in the areas of self-care, mobility, learning and applying knowledge, and general tasks and demands.

The Care Plan dated 6/21/19 documents that R1 is at high risk for falls. The interventions initiated on 9/23/24 document R1 is encouraged to rest when walking long distances. There is another intervention that was initiated on 7/15/24 that documents R1 is to have therapy evaluated and treated as indicated. A date of 9/23/24 is documented next to this intervention as well.

The Minimum Data Set (MDS) dated 9/11/24 documents a Brief Interview for Mental Status score as a ten (moderate cognitive impairment). Section GG of the MDS indicates R1 has no impairment on the upper or lower extremities and does not use a mobility device. R1 needs supervision or touching assistance with ADL care, bed mobility, transfers, and walking.

The policy titled, "Fall Prevention And Management," dated 08/2024 documents,

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"General: This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Upon admission: ...2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk."

2 .R2 is a 64-year-old with the following diagnosis: hemiplegia to the right side following cerebrovascular disease, epilepsy, aphasia, and vascular dementia.

A Nursing note dated 9/1/24 documents the CNA made the nurse aware that during meal time, R2 was observed sliding out of the wheelchair. To prevent a fall, the CNA slid R2 from the chair to the floor, where R2 rested on R2's buttocks. A skin tear was noted to the right ear. The physician was made aware and an order was placed to send R2 to the hospital for evaluation. R2 returned from the emergency department with a treatment order for the laceration.

A Nurse Practitioner note dated 9/4/24 documents that R2 was seen in the emergency department on 9/1 for a fall and received a prescription for the ear laceration. R2 has a sitter at the bedside who is in the room at all times. The plan is to continue the mupirocin and follow up with the physician outside of the facility. R2 is a fall risk and has a sitter at the bedside.

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	IL6001283	A. BUILDING: _____ B. WING _____	C 10/10/2024

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
S9999	Continued From page 13	S9999		

The Hospital Records dated 9/1/24 document R2 presented to the emergency department post fall with an ear laceration. Per the paramedics, R2 was being fed by a CNA when R2 slid forward and hit R2's ear on the dresser nearby. This caused a skin avulsion (a traumatic injury that occurs when layers of skin are torn or cut off, exposing the underlying tissue, muscle, or bone) to the top of the helix of the ear exposing cartilage. All imaging was negative for injury.

On 10/08/24 at 3:22 PM, R2 was lying in bed visiting with V13 (R2's family member). There is a raised scab on the top of the right ear, about one inch long and a quarter of an inch high. R2 was not able to answer many questions due to aphasia and cognitive impairment. V13 reported that R2 did have a fall in R2's room at the beginning of 09/2024. V13 stated that V13 was told by another family member that R2 slid out of the wheelchair before staff could grab R2. V13 reported that R2 cut R2's ear open somehow during the fall.

On 10/9/24 at 10:45 AM, V2 (Nurse) stated at the time of R2's fall, R2 was being monitored by a CNA (V5) during lunch. V2 reported that R2 required 1:1 monitoring and slid out of the wheelchair during the time of being monitored. V2 stated R2 began leaning out of the chair before V5 noticed and R2 was able to fall. V2 reported a laceration to R2's ear. V2 stated that R2 is dependent on all ADL care and cannot walk. V2 stated if 1:1 monitoring is done the proper way then a resident should not fall all the way out of the wheelchair.

On 10/9/24 at 11:40 AM, V4 (Restorative Nurse) stated that R2 was not able to speak, but through staff interviews, V4 was able to find out staff

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lowered R2 to the floor when R2 began sliding out of the wheelchair while being fed lunch. V4 was unaware that R2 began sliding out of the wheelchair, and V5 did not notice immediately. V4 said, "I don't know if she (V5) was attending to another person," while R2 was slipping and caught R2 as R2 was falling. V4 stated that R2 is a high fall risk due to the limitations of movement on one side of R2's body, which requires more monitoring.

On 10/9/24 at 12:58 PM, V5 (Former CNA) stated R2 was in a wheelchair facing the bed, and V5 was to the left of R2 feeding R2. V5 reported that R2 "did like a little jump up," but R2 was caught. V5 confirmed the wheelchair moved when R2 made the jerking movement, and V5 eased R2 down to the floor. V5 stated that on the way down, R2's ear scraped the bedside table or dresser. V5 reported the ear was bleeding due to the skin being open. V5 stated V5 was just told V5's assignment was to sit in R2's room with three other roommates and watch the 4 men. V5 reported it was to keep an eye on them so no one fell. V5 reported thinking all the residents in that room are high falls risks but V5 only worked at the facility about three weeks so V5 was not familiar with everyone. V5 stated the high fall risks were never explained to V5. V5 was not aware of how to find out which residents are high fall risks. V5 reported the facility took V5 off the schedule after the investigation due to "things didn't add up with their investigation and they didn't want me back."

On 10/9/24 at 3:03 PM, V9 (DON) stated V5 was feeding R2, and V5 said R2 slid out of the wheelchair. V9 reported that V5 told V9 that before V5 could grab R2 all the way, V5 broke the fall by lowering R2 to the floor. V9 stated

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according to what V5 said, R2 hit R2's ear on the dresser. V9 confirmed that at the time of the fall, R2 was a 1:1 observation, where a staff member stayed in the room to monitor the residents. V9 said, "I just didn't understand her reasoning of what happened." V9 reported that 1:1 monitoring can be different depending on the resident, but safety is the main importance when a resident is 1:1. V9 stated that R2 was a 1:1 monitoring resident before V9 started working at the facility, so V9 could not say why R2 needed 1:1 monitoring.

The Fall Investigation Report 9/1/24 documents that staff lowered R2 to the floor during the lunch meal when they noticed R2 sliding out of the wheelchair. A skin tear was noted in the right ear. The physician ordered R2 to the hospital for evaluation. Upon investigation, the CNA assisted R2 to the floor once they noticed R2 sliding from the wheelchair. An anti-slip mat was placed in the wheelchair to prevent R2 from sliding while sitting in the chair.

The Fall Risk Evaluation dated 9/1/24 documents the reason for assessment as post-fall. This evaluation's score is 22, indicating that R2 is at high risk for falls. Any score of 10 or greater makes R2 at high risk for falls.

The Enhanced Supervision Monitoring Tool 9/1/24 documents R2 is currently on one to one monitoring. The monitoring tool documents R2 was with staff at the time of the fall and did not have any behaviors.

The Care Plan dated 7/2/19 documents that R2 is at high risk for falls. There is no documentation on what kind of monitoring R2 requires in the interventions of the care plan.

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S9999	Continued From page 16 The Minimum Data Set (MDS) dated 9/4/24 documents a Brief Interview for Mental Status score as eight (moderate cognitive impairment). Section GG of the MDS documents that R2 has impairments to one side on the upper and lower extremities. R2 uses a wheelchair as a mobility eight. R2 is dependent with all ADL care and transfers. R2 is a substantial/maximal assist with bed mobility. R2 is not able to walk. The policy titled, "Fall Prevention And Management," dated 08/2024 documents, "General: This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Upon admission: ...2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk." (B)	S9999		