STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145650	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Palos Hills	10426 South Roberts Palos Hills, IL 60465

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41758 Based on interview and record review, the facility failed to prevent an incident of staff to resident abuse for a resident assessed to be at risk for abuse. This affected one of three residents (R4) reviewed for abuse. This failure resulted in V6 (certified aid) calling R4 a mother f**cker and pushing R4 onto the bed and R4 bumping his head on the wall. Using a reasonable person concept, R4 would have felt scared, victimized, intimidated and unsafe. Findings Include: R4 was diagnosis with anxiety and depression. R4 care plan dated 2/16/24 documents: patient is at risk for abuse and neglect related to being in a skilled rehab facility. Minimal data set section C (cognitive patterns) dated 5/14/24 documents a score of eight which indicated moderately impaired. On 8/21/24 at 3:27 pm, V5 (CNA) said, the incident with V6 (CNA) and R4 started in the dining room. V6 wanted R4 to speak to R12 his new roommate. R4 would not. V6 became upset. V6 told R4, R12 spoke to him, and he did say anything. R4 replied, he didn't have to say anything. R4 was a peaceful resident who avoids confrontation. R4 asked if he could leave the dining room. R4 went back to his room. V6 went into R4's room and called R4 a mother**cker. R4 jumped up, asked V6 what did you call me? V6 (CNA) replied, she was talking to staff, not R4. R4 was in V6's face. V5 said, she witnessed V6 put her hands on R4's shoulders and forcible pushed R4 on his bed causing R4 to hit his head on the wall. V5 said, if staff wants R4 to sit down all they have to do is ask. On 8/21/24 at 3:45pm, V15 (CNA) said, R4 was in the dining room when V6 came in and informed R4 that he was getting a new roommate (R12) and don't be messing with R12. V6 was initially playing/joking with R4 about not messing with R12. V6 kept repeating herself. V6 stopped joking and got serious. V6 stood with her legs apart, hands crossed in front of her body, a few feet away from R4 and said, don't mess with my resident (R12). R4 replied to V6 stating, 'why you are bothering me? It's intimidating'. V6 informed R4 that he was intimidating her. R4 was mad, he got up from his seat and walked away. V15 said, when V6 took her stance, it was threatening. It was not a joking matter anymore. V15 said V6 took it too far. V15 said he is not sure what happen after R4 and V6 left the dining room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/21/24 at 3:55pm, R4 who just woke up, was assessed to be alert and oriented to person, place and time said, the incident started in the dining room with V6. R4 said, he stumbled backward and hit the wall. R4 wasn't able to recall the events that occurred in the dining room or the event that led to him hitting the wall. R4 said, the incident happen so long ago he can't remember all the details. On 8/23/24 at 1:43pm, V2 (DON) said, verbal abuse is yelling, screaming at the resident and calling the resident names. V6 was not assigned to R4 and should have walked away when R4 became agitated. Facility reportable dated 7/21/24 documents: R4 was allegedly pushed by staff to his bed and hit his head on the wall during de-escalation of resident's aggressive behavior. (7/26/24) documents: V5 was interviewed and stated, V5 observed V6 arguing with R4. Witnessed statement undated written by V5 documents: V6 came in the room behind me/(V5) and said, this ignorant motherf**cker. R4 got up and said, what did you call me? They (V6/R4) were going back and forth. That's when the nurse (V7) came in and said what's going on? V7 said, R4 sit down. V6 said, get out my face R4. She (V6) grabbed R4 and pushed him down and he (R4) hit his head on the wall. V5 did not intervene. Facility abuse policy and prevention program 2022 dated 10/22 documents: The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching and kicking. Verbal abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident and families or within hearing distance regardless of an individual's age, ability to comprehend or disability. Examples include, but not limited to, threat of harm, saying things to frighten a resident. Mental abuse includes but not limited to humiliation, harassment, threats of punishment and deprivation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed to provided incontinence care for one resident(R9) who was identified as dependent on staff for toileting for more than 2 and half hours for one of three residents reviewed for incontinence care. Findings include: R9's was admitted on [DATE] with a diagnosis of multiple sclerosis, weakness, needed for assistance with personal care, neuromuscular dysfunction of bladder. R9's Minimum Data Set, dated dated dated [DATE] documents under brief interview for mental status documents a score of 15/15 which indicates cognitively intact. Under toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. documents dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity). Under urinary incontinence it documents a score of 3. A score of 3 indicates always incontinent. On 8/22/24 at 12:04PM, V13 (Nurse) verified on facility call light monitoring screen located at nursing station that R9's call light was pulled at 9:41AM and was still on. R9's call light in room was still illuminated above door and in the room. On 8/22/24 at 12:08 PM, R9 who was alert and oriented x3 said he pushed his call light this morning after breakfast because he needed assistance with incontinence care. R9 said the nurse did come into the room to administer medications but was trying to complete all her tasks and does not recall if he informed her about care needed. On 8/22/24 at 12:15PM V12(CNA) provided incontinence care to R9. R9 incontinence brief was saturated in urine and confirmed with V12 (CNA). There was a strong urine smell observed by surveyor and R9. R9's gown was observed to be wet. Facility incontinence care policy revised 9/2023 documents: incontinence care is provided to keep residents dry, comfortable and odor free as possible, it also helps in preventing skin breakdown. Facility call light response policy revised 9/2023 documents: answer the patient call light as soon as possible.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41156 Based on interview and record review, the facility failed to follow hospital discharge medication order and ensure that Temozolomide (TMZ, Chemotherapy Medication) was discontinued on 02/22/2023. This affects one resident of three residents (R7) reviewed for hospital discharge instructions. This failure resulted in R7 receiving 8 additional dosages of a chemotherapy (Temozolomide) medication. Findings Include: R7 was with diagnoses of but not limited to Non-[NAME] Lymphoma, extra [NAME] and solid organ sites. admitted in the facility on 2/22/23. R7 has an order of Temozolomide 140mg by mouth one time a day along with Temozolomide (TMZ, Chemotherapy Medication) 180mg for a total of 320mg, with an order date of 2/22/23 and start date of 2/23/23. Medication Administration Record shows that R7 received Temozolomide 320mg on 2/23/23, 2/26/23, 2/27/23, 2/28/23, 3/1/23, 3/3/23, 3/4/23 and 3/5/23 for a total of 8 dosages. Hospital discharged record for hospital stay of 1/25/23 to 2/22/23. After visit shows R7 has a primary diagnosis of Lymphoma of Central Nervous System. Future appointments 3/2/23 for Neuro Oncology. Medication list Temozolomide 140 mg with 180 mg for total of 320mg by mouth daily. Neuro Oncologist team will provide instructions on taking your next cycle of Temozolomide. Added Temozolomide 5 days per month as new chemotherapy. On 8/23/24 at 12:10 V22 (R7 complainant) stated R7 had a fall in the facility and V22 believes after V22's own investigation that the fall was due to R7 receiving the chemo medication when R7 was not supposed to be given it in the facility. The medication was already given in the hospital, 5 day cycle and was supposed to be restarted in 23 days. V22 found out about R7 receiving the medication in the facility when she was doing her own investigation and reviewed the 'My Chart'. V22 noted that V41 (Attending Physician) had asked V42 (Oncologist) how much TMZ should be in upon discharge and V42 said to take R7 off (stop the medication). V22 said, that is when V22 knew R7 received the medication in the facility. V22 tried calling V3 (ADON), but no return call. On discharged day V22 spoke to V41 and nothing was said to V22 about R7 getting TMZ while in the facility. V22 spoke to Oncologist nurse (V20) and confirmed that R7 was not supposed to get any TMZ in the facility and that the next cycle is not until after 23 days. V20 informed V22 that they will conduct an investigation. On 8/23/24 at 11AM. V20 (Nurse) from V42 oncologist clinic that R7 received the extra dose of Temodar. V20 stated R7 had already received the set of medication while in the hospital. The plan was to restart in a month. V42 confirmed with V20 that R7 was given extra dose in the facility and R7 was not supposed to receive during her stay in the facility. R7 already completed her cycle during her hospital stay. The plan was after a month from the last cycle of 2/21/23. Plan if for the resident to resume the medication after discharged . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Home Visit note dated 2/2/23 by V41 (Attending Physician) reads in part: Recommendation was ibrutinib and TMZ. R7 received inpatient 2/17/23 through 2/21/23. R7 will needs follow-up outpatient for further treatment recommendations and palliative care was consulted. Nursing Home Visit note dated 3/2/23 by V41, reads in part: Treated with TMZ 2/17/23 through 2/21/23. Follow up neuro-oncology for further treatment regimen today. V20 (nurse from Oncology) provided documentation dated 3/9/23 that reads in part: Discussed the oral chemo TMZ, the extra doses R7 received. TMZ 5 doses at hospital and 9 doses at the facility (2/23/23 to 3/6/23). Documentation dated 3/7/23. Reads in part: Communicated with V43 (NP) in the facility where R7 will be discharged from today. According to their records R7 received TMZ 320mg/day from 2/23/23 to 3/6/23 but 2 days were missed so R7 received 9 doses today this cycle. Order Audit Report reviewed and on 3/6/23 Temozolomide 320mg was discontinued, ordered by V43. Reason for this order stated therapy completed per oncology order. On 8/27/24 at 9:00AM, V2 (DON) stated that the unit manager and/or manager assigned in PAN program should review the medication list from hospital discharge paperwork after admission in the facility to triple check the admission assessments and medication list. V2 stated that V2 was not yet an employee during the stay of R7 in the facility. On 8/27/24 at 12:50PM, V3 (ADON) stated that the next on coming nurse will review the admission process and after the three checks it goes to management for follow up review. V3 said, I can't remember if I checked R7's admission, but I assumed I did review R7's admission order, because most likely I would review PAN (short term stay) patient. While R7 was here I probably found out that R7 was in the chemo medication. But I do not recall exactly if did, but if I was made aware I would have helped the nurse in making corrections and calling doctors and family. I do not recall having conversation with the attending physician or NP about chemo medication that she was receiving in the facility. Admission/Re-Admission policy dated 4/2024, reads in part: All medication should be reconciled with the resident and verified with the primary physician or nurse practitioner. Physician order sheet should reflect any standing orders specific to the resident as well as medication and treatment that are ordered throughout the stay.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to monitor one high risk for skin breakdown resident (R1) with a history of pressure sores who was admitted to the facility with skin intact for blanchable redness to sacrum. This affected one of three resident (R1) reviewed for pressure sores. This failure led to R1 developing an unstageable wound measuring 4 x 3cm within 12 days of being admitted to the facility. Findings include: R1 was admitted to the facility on [DATE] with a diagnosis of severe protein calorie malnutrition, atrial fibrillation, pressure ulcer of sacral area stage three (dated 2/2/24), adult failure to thrive, vascular dementia and Parkinson's. R1's Braden score dated 2/10/24 documents a score of 12 which indicates high risk for skin breakdown. R1's progress note dated 2/11/24 documents: Head to toe assessment was completed by wound team. Resident noted with red dark but blanchable discoloration to sacrum. Barrier cream applied/initiated. Resident noted with healed scratches to left and right rear thigh. Resident noted with healed surgical scar to left hip. Otherwise, skin intact. Resident is incontinent of bowel and bladder, has foley catheter in place, able to assist with turning and repositioning, Resident may have heel boots, chair cushion, treatment orders in place for redness and will be turned and repositioned. Although interventions will be in place, resident may continue to be at risk for further breakdowns due to unidentified factors. Wound care will continue the plan of care. R1's progress note dated 2/12/24 documents: Reason for visit: The resident is being evaluated today for a comprehensive skin assessment. SKIN: warm and dry, intact, no open wound. Blanchable redness to sacrum. The patient is at an increased risk of skin breakdown. Recommend good hygiene and skin care to prevent skin breakdown. Recommend continuing with moderate assistance with ADLs as needed. Recommend application of emollients daily. No open wounds on today's skin assessment; please keep the patient's skin clean and dry, apply barrier cream as necessary to prevent skin breakdown, and avoid pressure on any bony prominence by adhering to turning protocols and floating heels as applicable. R1's skin assessment dated [DATE] in progress documents: Moisture Associated Skin Damage (MASD) to sacrum inhouse acquired new. No measurements documented. No other documentation of this area. R1's skin assessment dated [DATE] in progress documents: Moisture Associated Skin Damage (MASD) to sacrum inhouse acquired new. Measuring 6.4 length and 2.1 width cm. R1's February medication and treatment records do not document any weekly skin assessments. R1's medical record did not document any skin assessments from 2/12/24 until 2/22/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's care plan dated 2/12/24 documents R1 is at risk for skin complications related to bowel/bladder incontinence, impaired bed mobility, impaired nutrition, impaired circulation, impaired cognition, depression. Interventions dated 2/12/24 include: skin assessment weekly. R1's progress note dated 2/26/24 documents: SKIN: warm and dry, wound/skin condition noted. See wound assessment below. Wound: 1 Location: coccyx Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: New Odor Post Cleansing: None. Size: 4 cm x 3 cm x 0 cm. Calculated area is 12 sq cm. Wound Base: 0% epithelial, 0% granulation , 100% slough , 0% eschar Wound Edges: Unattached Peri wound: Fragile, Erythema Exudate: None amount of None Wound Pain at Rest: 0 Surgical Wound Debridement Location: coccyx Pre-Debridement Measurement: 4 x 3 x 0 cm . Calculated area is: 12 sq cm. Post-Debridement Measurement: 4 x 3 x 0 Percent of Wound Debrided: 100 Indications: Removal of necrotic tissue. On 8/28/24 at 10:47AM, V14 (wound care) said R1 was admitted to the facility with skin intact but had a dark red blanchable area to her sacrum. Floor nurses will do a weekly skin assessment on all residents without wounds and document in the medication or treatment record to monitor the area. On 8/28/24 at 1:06PM, V2 (DON) said facility monitors residents skin for breakdown by having assigned floor staff conduct weekly skin checks that is documented in the medication or treatment record for residents without wounds. Facility policy Skin Care Prevention revised 9/2023 documents: Resident will receive appropriate care to decrease the risk of skin breakdown.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to implement new and effective fall interventions after a fall for one high fall risk resident (R11) with a diagnosis of dementia and history of falls. This affected one of three residents (R11) reviewed for fall and fall prevention. This failure resulted in R11 sustaining another unwitnessed fall a week later that required a hospital stay with 6 staples to the left side of the head. Findings include: R11 was diagnosis with Dementia, Alzheimer, and repeated falls. Minimal data set section C (cognitive patterns) dated 8/9/24 documents a score of six which indicates severe cognitive impairment. Fall risk evaluation dated 8/2/24 documents a score of twenty-six. Scoring a ten or higher makes resident high risk for falls. Mentation: Impaired memory or judgement. History of fall in the past one to six months. Interim baseline care plan dated 8/2/24 documents: Impaired cognition related to a decline in cognitive functioning. Use task segmentation to support short-term memory deficits. Fall Interventions: Call light within reach, provide clutter-free environment, encourage use of assistive device and provide proper, well maintained footwear. Care plan dated 8/3/24 documents: resident is at risk for falls. Anticipate and meet the resident's care and safety needs. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Care plan dated 8/7/24 documents be sure residents call light is within reach and encourage to use it for assistance as needed. Nursing note dated 8/7/24 documents: Patient (R11) was found on the floor on the side of her bed. Bed was in lowest position with the rails up; call light was within reach, and table was within reach. Assessment was completed, skin check was completed. Vitals were completed when patient was on the floor, when the CNA and I transferred her to the bed and when we transferred her to her wheelchair. Skin is intact. No complaints of pain, vitals within normal limits. Neuro checks in progress. Fall report dated 8/7/24 documents: Mental status: confused/forgetful, not oriented. Predisposing Physiological factors: noncompliant with safety guidance, impaired memory, recent illness and weakness/fainted. Predisposing situation factors: Ambulating without assist. Notes: resident had a change in plane. Resident was observed sitting next to bed on buttocks. Resident stated she was okay she was just trying to get up. Encourage resident to keep call light within reach and use it for assistance. On 8/27/24 at 3:29pm, V36 (nurse) said, she was not given report that R11 was a fall risk. R11 would not remember to use the call light related to her cognition/Dementia. R11 was alert to self. R11 did not have any fall intervention in place. The bed was not low it was approximately a foot off the ground. V36 said, she went to give R11 her medication, and R11 was reaching over trying to get out of bed. R11 was repositioned and place in bed. V36 said she left the room to find the aide to help transfer R11 to wheelchair to bring to common. Aide went to get another resident to help transfer resident and that's when R11's roommate put on the call light. V36 said, when she entered R11's room. R11 was on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/27/24 at 1:54Pm, V2(DON) said R11 is alert to self and has periods of confusion. Intervention implemented after first fall was to be sure residents call light is within reach and encourage to use it for assistance as needed. Call light in reach was also documented in baseline care plan as well so the new intervention should have said to reeducate R11 on call light use. Nursing note dated 8/14/24 documents: At 5:50 pm-6pm, I (V36) gave the resident (R11) her scheduled medications. Call light was within reach; however, the resident did not utilize it and was attempting to exit the bed without assistance. Redirection and reorientation to surroundings was provided. At 6:45pm the resident was observed on the floor by the CNA. I was notified. The resident was conscious and alert. Gauze was applied to the site. Writer interviewed patient's roommate re: this incident. According to the roommate, she heard a loud thud that sounds like a chair that fell off. Roommate is uncertain about what time it happened, but roommate said she pressed the call light right away. Roommate did not hear anything else aside from the loud thud. Staff is able to answer the call light promptly per roommate's report and roommate only found out that the patient has fallen when she saw the nurse coming in immediately, and after a while, she heard the nurse saying, Let's put her back to bed. Fall report dated 8/14/24 documents: Injury type: Laceration, Injury Location: Back of head. Mental status: Confused/forgetful not oriented. Predisposing Physiological factors: Confused, noncompliant with safety guidance, impaired memory, recent illness and weakness/fainted. Predisposing situation factors: Ambulating without assist. Notes: R11 was alert to self only. R11 is mod assist times one with activities of daily living and transfers. It was determined that the fall was unavoidable. Root cause: unassisted transfer. Floor mats given and to be used when resident is in bed. After care visit dated 8/14/24 documents: revisit for visit: fall/ head laceration. Diagnosis head injury, Dementia Facility reportable dated 8/15/24 documents: R11 admitted on [DATE]. R11 is alert to self only. R11 sent to hospital and returned to six staples to left side of her head. Fall prevention and management policy dated 5/2015 documents: The facility will identify and evaluate those residents at risk for fall, plan for preventive strategies and facilitate as safe an environment as possible. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely, quality laboratory services/tests to meet the needs of residents. 41156 Based on interview and record review, the facility failed to ensure that laboratory tech retrieved a sputum specimen within 24 hours after notification. This affected one (R6) of three residents for reviewed for laboratory services. This failure resulted in R6 having a 6 day delay of the sputum specimen arriving to the laboratory for testing. Findings Include: R6 has an order for sputum collection on 7/26/24. R6's respiratory notes documented and dated 7/26/24 reads in part: Sputum culture was collected and sent to the lab due to change in color of the patient's secretions. Her son wanted a stat X-ray done but writer suggested getting a sputum sample first and the son was okay with the ideal. Laboratory report reviewed and noted that R6's sputum collected on 7/26/24. Sputum was not picked up until 8/1/24, as the report says that the received date was on 8/1/24 and that the reported date of result was dated 8/3/24. By 8/3/24, R6 was out of the facility since 7/28/24 for hospitalization and did not return in the facility. On 8/27/24 at 2:20PM, V2 (DON) staff will inform the labs that there is a specimen that needs to be picked up, usually within 24 hours or earlier. They placed it in the refrigerator for lab tech to pick up. On 8/27/24 at 2:45PM, V40 (Laboratory Representative) stated that if picking up a specimen in the facility, it's usually within 24 hour. They have lab tech every day from Monday to Friday, and at times even on weekends. Lab techs are trained to check the specimen refrigerator in the facility. In general, the facility practice is to place the order in the computer, they have two tabs, one they can click on to notify the laboratory to inform of specimen pick up, second is to click on the tab stating specimen collected send to lab. There could be multiple factors that could have happened for the late pick up of the specimen. It's possible the lac tech that came in the facility those days was not our regular tech for that facility. V40 stated V40 was almost positive that the nurses probably missed clicking the tab button for specimen pick up. Confirmed with V40 that the report in the lab that says collected time is the time and date the specimen is labeled and received date is the date that the laboratory received the specimen in their lab facility. On 8/28/24 at 2:20PM, facility provided Laboratory contract. Laboratory Contract 2023 reads in part: I will provide Laboratory services for patients and their attending physicians through the Facility. Laboratory Services will mean clinical laboratory and pathology services provided to Facility including, but not limited to, analyses in the area of clinical chemistry, hematology, serology, microbiology, cytogenetics, immunology, endocrinology, toxicology, histology, virology, and cytology. I will make its best efforts to complete all routine tests within twenty-four (24) hours from receipt of specimen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145650	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Palos Hills	10426 South Roberts Palos Hills, IL 60465

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	When any Laboratory Service is ordered, I will provide a written report to the Facility and attending physician, which report will include the results of the test, normal reference ranges for the test and comments deemed necessary by Simple Lab. I will comply with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, as amended, the Medicare and Medicaid programs, and any applicable state statutes and regulations. It is further agreed that upon request of the Facility, I will provide to the Facility, verification of such licensure, as requested from time to time.