STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER: Bria of Palos Hills		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed follow sacrum treatment orders as prescribed, and failed to follow their plan of care for turning and repositioning and not placing an extra linen under residents. This affected one of three residents (R5) reviewed for pressure ulcer prevention. This failure resulted in R5 sitting a dialysis chair for over eight hours in pain, getting upset, feeling angry despite his request to be placed back in bed, this also resulted in R5 laying on a mechanical lift sling for over two hours. Findings Include: R5 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction, type II diabetes, acquired absence of left leg below the knee and right leg above the knee amputations. R5's Braden score dated 9/11/24 documents a score of 14 which indicates moderate risk for skin breakdown. R5's Minimum Data Set, dated dated dated [DATE] under section G roll left to right documents dependent. R5 progress notes dated 9/10/24 documents: R5 entered facility via paramedics from hospital. R5 alert and oriented times x3. R5 able to make needs known. R5 has foam dressings in place to right lower flank and sacral area. R5's skin and wound evaluation dated 9/11/24 documents a stage three pressure sore to right lower back measuring 1.2x 0.7cm and unstageable pressure sore to R5's skin and wound note dated 9/12/24 documents an unstageable pressure sore to sacrum 1.5 x 1.8 x 0.1 cm. On 9/20/24 at 11:22AM, R5 who was assessed to be alert and orient to person, place and time, said he went to dialysis on 9/13/24 and was not taken out of the dialysis chair for nine hours (3 hours at dialysis and 6 hours after). R5 was asked how he knew the time and he said he checked his cell phone. R5 said he hollered and begged staff to please take him out of the chair because his butt was sore. R5 said he was in so much pain. R5 said staff came into the room multiple times but did not reposition him, place pillows behind him to off load him in the chair or put him in bed no matter how many times he begged. R5 said he was upset, angry and in pain. (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: 145650	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 2:38PM, V23 (CNA) said she was the assigned Aide to R5 on 9/13/24. V23 said she picked up R5 from dialysis unit and transported him back to his room. At that time, staff were filling up air mattress. V23 said the nurse reported to her not to put R5 back in bed because he was going to be transferred to another room. V23 said R5 was requesting to be put back into bed. V23 said R5 was in the dialysis chair until end of her shift (300pm) and was still in the dialysis chair when she left. On 9/20/24 at 11:08AM, V24 (nurse) said she was the assigned nurse to R5 on 9/13/24. V24 said R5 room was being serviced for the mattress and air conditioning and was not able to go back in the bed. V24 said she was informed by another staff (unable to recall) that R5 would be moving to another room. V24 (Nurse) said she did inform the aide to not transfer R5 from dialysis chair back to bed because he was being moved to another room. V24 said she does recall R5 saying he wanted to go into the bed. V24 said she saw staff taking R5 to the new room around 1:00pm but unsure of exact time. V24 said R5 was moved before the change of shift at 3:00PM. On 9/20/24 at 12:30PM, V7 (ADON) said residents should not be in the dialysis chair for extended period of time because it puts them at greater risk for skin breakdown. If a resident request to be put in bed, staff should honor that request. R5's dialysis treatment information dated 9/13/24 documents: Treatment started at 5:35AM and ended 8:37AM. Care plan dated 8/7/24 documents: R5 has an actual skin complication related to impaired mobility, bowel and bladder incontinence and the presence of multiple comorbidities. admitted with sacrum -unstageable pressure sore. Interventions: Assist and encourage resident to turn and reposition to turn and reposition every one to two hours and as needed. R5's point of care charting dated 9/13/24 under chair/bed to chair transfer documents: 13:40 not applicable and 20:32 dependent. No other entries for 9/13/24. On 9/18/24 at 11:57AM, R5 was observed in his room in his bed on air mattress. R5 had incontinence product on, a sheet on the bed and body was under a mechanical lift sling. On 9/18/24 at 2:16PM, V7 (ADON) confirmed R5 was observed on incontinence product, a sheet on the bed and mechanical lift sling. V7(ADON) said R5 should not have the sling under him because it can affect the air mattress. On 9/19/24 1:08PM, V14(wound care nurse) said R5 should not have mechanical sling left under him with a sheet because it disrupts the air flow of the mattress and makes surface hard which can cause skin breakdown. On 9/20/24 at 11:32AM, R5 observed in bed alert and oriented. R5 said his dressing was soiled and removed after dialysis during incontinence care. V22 (CNA) confirmed R5 did not have a dressing on sacral area and was not in incontinence brief. V21(nurse) applied a new dressing to site. On 9/20/24 at 12:53PM, V6 (CNA) who was assigned aide to R5 on 9/20/24 said he did not recall seeing any dressing on R5 from the start of his shift. V6 said he was unsure if R5 needed a dressing to sacral area and did not tell anyone. (continued on next page)

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	145650	A. Building B. Wing	09/20/2024

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Bria of Palos Hills	10426 South Roberts Palos Hills, IL 60465

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5' s physician orders dated 9/19/24 documents: sacrum and buttocks with normal saline, apply Zinc Oxide and cover with a bordered foam dressing. Change as needed if soiled or removed. Facility skin care prevention policy reviewed 9/2023 documents: All residents will receive appropriate care to decrease the risk of skin breakdown.