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	12/06/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39340 Based on interview and record review, the facility failed to follow their abuse policy by not reporting one resident's (R1) final abuse investigation results within five days to the Illinois department of public health for one of three residents reviewed for abuse. Findings include: R1's initial abuse reportable dated 10/29/24 documents: R1 reported CNA hit him in the mouth with bed remote control when putting him back to bed. On 12/6/24 at 9:30AM, V1 (administrator) said they were unable to locate or provide documentation of R1's final abuse reportable being sent to the Illinois department of public health. On 12/5/24 at 4:06PM, V1(Administrator) said they need to send a final report to the Illinois department of public health within five working days. Facility abuse policy reviewed 9/2017 documents under final investigation report: The administrator or designee will review the report and a final written report of the results of the investigation will be forwarded to the Illinois department of public health within five working days of the reported incident.

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

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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 0686 Level of Harm - 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** 41758 Based on interview and record review, the facility failed to prevent one resident (R3) who was admitted to the facility with healed scar tissue to sacrum and identified as moderate risk for skin breakdown from developing a facility acquired pressure ulcer measuring 2 centimeters (cm) length X 1.5cm width x 0.3cm depth within three days after admission for one of three residents reviewed for wounds. Findings Include: R3 diagnoses include paraplegia, moderate protein-calorie malnutrition, diabetes and osteomyelitis in the left foot. Brief interview for mental status dated 9/13/24 documents a score of fourteen which indicates cognitively intact. R3's face sheet documents: admitted [DATE]. On 12/03/24 at 11:16am, R3, who was assessed to be alert and oriented to person place and time, said she was left soiled with stool on the overnight shift twice when she was admitted which caused her to have an open wound on her buttock. R3 said she did not have an open wound on her buttock upon admission. R3 said she was devastated. She said she never thought she would be left soiled in feces. Wound care note dated 9/7/24 documents: Admission: R3 was admitted to facility with admitting diagnosis of rehabilitation related to Osteomyelitis. Head to toe skin assessment completed by wound team: Resident noted with healed scar tissue to sacrum. Barrier cream applied/initiated. Resident is incontinent of bowel and bladder, needing assistance with turning and repositioning. Resident may have a chair cushion, heel boots and will be turned/repositioned. Although interventions will be in place resident will continue to be at risk for further skin breakdowns due to unidentified factors. Pulmonary initial evaluation dated 9/10/24 documents: R3 was also found to have osteomyelitis of her foot. On 12/06/24 at 11:11am, V35 (treatment nurse) said she completed R3's skin assessment on 9/7/24. R3 had a healed scar tissue on her sacrum area. R3 was given barrier cream at that time. R3 did not have an unavoidability charting upon admission. Unavoidability charting is completed when the resident has a change in condition or worsened wound. R3 did not acquired unavoidability charting because she did not have any issues with her sacrum wound. R3 was found to have a facility acquired wound during rounds on 9/9/24 by V36 (treatment nurse) and V37 (wound doctor). Skilled Wound Expert Skin and Wound Note date of service 9/9/24 documents: Wound: 2, Location: sacrum, Primary Etiology: Pressure, Stage/Severity: Stage 3 Wound Status: Present on Admission, Odor Post Cleansing: None, Size: 2 cm x 1.5 cm x 0.3 cm. calculated area is 3 sq cm. Wound Base: 75-99% granulation, 25-49% slough Wound Edges: Attached, Peri wound: Intact, Fragile, Exudate: None amount of None. On 12/06/24 at 1:30pm, V36 (treatment nurse) said, R3 had a facility acquired a wound that was notice during round on 9/9/24 with V37. R3 was at moderate risk for skin breakdown to being very moist and incontinent of bowel and bladder. R3 was alert and able to report if she had any issues or concerns. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Braden Scale for predicting pressure sore risk dated 9/6/24 documents a score of thirteen with indicates: Moderate risk related to very moist: Skin is often, but not always moist. Unavoidability/ Avoidability Determination dated 9/19/24 document: R3's wounds were unavoidable. Unavoidability/Avoidability Determination dated 10/28/24 document: R3's wound were avoidable. Facility policy Skin Care Prevention revised 9/2023 documents: Resident will receive appropriate care to decrease the risk of skin breakdown. Clean skin at time of soiling and at routine intervals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow their mechanical lift policy by not utilizing two staff member to transfer one resident (R1) with a mechanical lift. This failure resulted in R1 hitting his head on the mechanical lift causing facial swelling around right eye for one of three reviewed for transfers. Findings include: R1 was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis affecting right side, lack of coordination, weakness, muscle weakness, anxiety, depressive disorder, contractures of right shoulder, left shoulder, right knee and left knee. R1's brief interview for mental status score dated 11/30/24 documents a score of 14/15 which indicates cognitively intact. R1's plan of care revision dated 12/11/23 documents under Activities of daily Living (ADL) R1 requires assist with daily care needs related to hemiplegia and hemiparesis affecting right dominant side. Resident is total assist of two staff members for transfers and toileting. Resident is extensive assist of two staff members for bed mobility. Under interventions documents: mechanical lift with 2 person assist with date initiated 10/14/16. R1 progress note dated 10/16/24 documents: On 10/16/2024 around 9:00 am, R1 informed writer of the following incident. On 10/15/2024, around 9:00 PM, Assigned V4 (Certified nursing aide, CNA) began to transfer resident from his power wheelchair to his bed. Resident asked the CNA to give him a moment to adjust his power wheelchair. The CNA did not allow resident time to adjust his power wheelchair. CNA proceeded to move the mechanical lift closer to the resident, which caused the top of the mechanical lift to hit resident on the front of his head, above his right eye. R1's skin screen dated 10/16/24 documents: Face slight swelling above right eye, no bruising or open area noted. Facility reportable documents: V4 (CNA) interview: V4 said I did transfer R1 from wheelchair to bed on 10/15/24. R1 cursed at me. When asked why the resident cursed at her, V4 said R1 bumped his head and blamed me. When asked how was R1 transferred, V4 said with a mechanical lift. V4 was asked who helped with the transfer, V4 reported she was alone with transfer. Under conclusion, facility documents the incident was substantiated. Based on the investigation, V4 (CNA) did not follow facility policy when using mechanical lift. Per facility policy, two staff members should be present when transferring residents with mechanical lift. This caused the top of mechanical lift to hit resident on upper right side of face and sustain mild swelling. V4 employee report dated 10/18/24 documents discharge due to procedure/rule violation. Under description, V4 transferred R1 using a mechanical lift without a second person/staff assist. This resulted in R1 hitting his forehead against the machine. This in violation against transfer protocol at the facility which is to have two person assist during a mechanical lift transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 12:36 PM, V2(Director of nursing, DON) said it's the facility policy to have two staff members to assist with any mechanical lift. Two staff persons are needed to ensure safety. One staff to move the lift and other staff to assist with body positioning. V4 (CNA) did not follow this policy and was terminated. Facility mechanical lift policy reviewed 10/2023 documents: one caregiver is to focus on the resident's head and body positioning while the other is operating the lift.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34072 Based on interviews and record reviews, the facility failed to follow its psychotropic medication policy and obtain informed consent from the resident and/or resident's family member prior to initiating a psychotropic medication. This failure affected one resident (R4) out of four reviewed for medications in a sample of 12. Findings include: On 12/5/24 at 9:51AM, V2 DON (director of nursing) stated that upon admission the nurse is expected to obtain information regarding any medication allergy, type of reaction, and level of severity of reaction (mild, moderate, or severe). V2 stated that the nurse is expected to notify physician of medication allergy and reaction. V2 stated that the outside pharmacy will flag a medication order and nurse will call physician to discuss, depending on severity. V2 stated that the medication allergy, reaction, and severity of reaction should be documented in the resident's progress notes by the physician and nurse. V2 stated R4's bupropion medication was prescribed from hospital stay on 10/4/24. V2 stated R4's allergy tab in R4's electronic medical record states reaction unknown. On 12/5/24 at 1:06 PM, V15 NP (nurse practitioner) stated he saw R4 on 10/3/24. V15 stated R4 was sad. V15 stated he was aware R4 had allergy to bupropion but reaction unknown. V4 stated he asked R4 and R4 denied an allergy to bupropion. V15 stated he should have documented in his note regarding medication allergy and discussion with R4. On 12/5/24 at 1:45 PM, V2 reviewed the signature on R4's psychotropic medication consent form signed on 10/5/24 with R4's signature on admission contract signed on 10/8/24. V2 stated the signature on the psychotropic consent form does not match the signature on R4's admission contract. V2 reviewed three of R4's signatures on R4's admission contract and stated that these signatures all match, none match the signature on the psychotropic consent. On 12/5/24 at 4:00 PM, V1 (administrator) reviewed the signature on R4's psychotropic medication consent form signed on 10/5/24 with R4's signature on admission contract signed on 10/8/24. V1 stated the signature on the psychotropic consent form does not match the signature on R4's admission contract. R4's medical record, dated 3/8/24 (prior admission to this facility), notes R4 with allergy to bupropion medication. R4's reaction to this medication is hallucinations; severity of reaction is not documented. R4's pre-admission hospital record, dated 9/20/24, notes R4 with allergy to bupropion medication. V15 NP (nurse practitioner) note, dated 10/3/24, notes R4 with allergy to bupropion medication, unknown reaction. V15 initiated bupropion 100mg (milligrams) by mouth twice daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is no documentation found in R4's medical record noting physician/nurse practitioner evaluated R4's allergy to bupropion or the severity of the reaction or discussed with R4 the risks of taking this medication. R4's medical record, dated 9/21/24, notes a consent form for memantine 10mg twice daily. The consent form is not signed by R4 or R4's family member or the nurse. R4's MAR (medication administration record), dated September and October 2024, notes R4 received memantine twice daily 9/21-10/2, once on 10/3 AM, once on 10/4 PM, 10/5 PM, twice on 10/6, 10/7 PM-10/23 AM. R4's family signed a consent to administer memantine twice daily on 10/28/24. R4's medical record, dated 10/5/24, notes a signed a consent for bupropion 100mg daily. This consent form was not signed by a nurse. The signature on this consent does not match R4's signature on his admission contract dated 10/8/24. R4's MAR, dated October 2024, notes R4 received bupropion twice daily 10/5-10/16 AM, 10/17-10/21 AM, and 10/22-10/23 AM. R4's progress notes, dated 10/28/24, V38 (former DON) noted she spoke with R4's family member to notify of R4's arrival to the facility and to obtain consent for the psychotropic medications. R4's family member stated to hold off on the bupropion because R4 is allergic to it. R4's family is not aware on what the severity of allergic reaction is to this medication. R4's family member gave consent for the administration of memantine 10 mg twice daily. This facility's psychotropic medication program policy, revised 01/2019, notes if a new order for a psychotropic medication is obtained, the resident, resident's representative, or power of attorney must be informed of the risks and benefits of the medication. The facility must obtain an informed consent.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34072 Based on interviews and record reviews, the facility failed to follow its medication administration policy and notify the physician of a medication not available from the outside pharmacy, failed to obtain an alternative medication to prevent a resident from missing any scheduled medication dosages, and failed to accurately document the medication was not administered in the resident's MAR (medication administration record). This failure affected one resident (R4) out of four residents reviewed for accuracy of documentation in the resident's electronic medical record in a sample of 12. Findings include: On 12/5/24 at 9:51AM, V2 DON (director of nursing) reviewed R4's medical record. V2 stated tolvaptan was ordered 9/21-9/29 and 10/10-10/28. V2 stated if the medication was not here, the nurse should have called the outside pharmacy to check on when the medication will be delivered and request an urgent delivery. V2 stated this facility has a convenience box that contains some medications. V2 stated the nurse should check the convenience box to see if tolvaptan medication is stocked in there. V2 stated the nurse is expected to notify the resident's physician if the resident is going to miss a dose day and ask if alternative medication should be given. V2 stated there should be a note in the resident's electronic medical record regarding medication not available, physician notified, and any orders given. V2 stated she will check the convenience box to see if tolvaptan is stocked there. V2 stated the nurse noted tolvaptan was unavailable on 9/22, 9/23, 9/24, or 9/28 but there is no documentation noting the nurse notified the physician tolvaptan was unavailable. On 12/5/24 at 3:15PM, V2 stated tolvaptan is not stored in the facility's convenience box. On 12/5/24 at 4:00PM, V2 stated a check mark in the resident's MAR (medication administration record) indicates that the medication was administered to the resident. V2 stated if the medication is not available from pharmacy or stocked in the facility's convenience box, the nurse is expected to notify the physician regarding missed dose and should enter chart code 9 (other/see nurses notes) in the MAR and document in the resident's progress notes reason medication not administered, the name of the physician/nurse practitioner notified, and any orders received for alternative medication. R4's POS (physician order sheet), dated 9/21/24, notes an order for tolvaptan 30mg (milligram) tablets, give 60mg by mouth one time a day for hyponatremia (low sodium level). This medication was discontinued on 9/29/24. On 10/10/24, tolvaptan 30mg was re-ordered to give two tablets by mouth one time a day for low sodium level. This order was discontinued on 10/28/24. R4's MAR (medication administration record), dated September and October 2024, notes tolvaptan 30mg tablets, give 60mg by mouth one time a day. On 9/25, 9/26, 9/27, 9/29, 10/11, 10/12, 10/13, 10/14, 10/15, 10/19, and 10/20 the nurse documented medication administered. R4's physician order audit report for tolvaptan medication notes this medication is on order. The outside pharmacy never sent this medication to the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at 11:44AM, V2 presented a photo of R4's tolvaptan medication showing ten tablets were delivered to this facility on 9/23/24. V2 presented a second photo of two tablets removed from the bingo card. V2 stated on 9/25/24 at 4:00PM V2 took a photo of R4's tolvaptan medication and sent to V33 (pharmacist). V2 stated on 9/29/24 V2 spoke with R4's physician regarding alternative medication, sodium chloride tablets. V2 stated R4's tolvaptan medication was discontinued on 9/29/24 after discussion with physician. V2 stated R4's bingo card shows two tablets removed indicating R4 received one dose of this medication. V2 is unsure which day, 9/25, 9/26, 927, or 9/29 medication was administered to R4. V2 is unsure why R4 did not receive the other four doses of this medication. The facility's medication administration policy, reviewed 04/2024, notes if medication is not given as ordered, document the reason on the MAR and notify the healthcare provider. If medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available obtain it from the convenience box. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner and a note should reflect the situation in the resident's medical record.