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	05/16/2025

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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41758 Based on interview and record review, the facility neglected to follow their policy and procedure to ensure staff provided incontinence care at least every two hours for a resident identified as dependent on staff for toileting. This affected one of three (R131) residents reviewed for neglectful care and services. This failure resulted in R131 being exposed, soiled with feces, crying, verbally distraught, begging for help and feeling uncomfortable. Findings Include: R131 was diagnosis with mixed/urinary incontinence, rash and other nonspecific skin eruption, malignant neoplasm of vulva and obesity. Minimal Data Set (MDS) section C (cognitive patterns) dated 5/8/25 brief interview for mental status documents a score of thirteen which indicates cognitively intact. Section GG (functional abilities) documents R131 was dependent with toilet hygiene (helper does all of the effort). Resident does none of the effort to complete the activity or the assistance of two (2) or more helpers is required for the resident to complete the activity. Care Plan initiated on 1/31/25 and 5/8/25 documents: R131 has a self-care deficit in bed mobility related to decrease ability to position or reposition self in bed and turn from side to side without staff assist. At risk for abuse and neglect. On 5/13/25 at 4:53pm, R131 who was assessed to be alert to person, place and time said, she was left in her feces from 2am until the police arrived. R131 said, she called V37 to report staff was not answering her call light and she needed to be cleaned up after a bowel movement. R131 said, her vaginal area was exposed and there was so much diarrhea. R131 said, she felt bad and just wanted some help while starting to tear up. R131 said, she was falling in and out of sleep due to her nightly medication and was not provided incontinence care until the police arrived. Facility provide statement for R131 dated 5/14/25 documents: I woke up. I had a mess on my hands because I was in diarrhea. I pressed the call light to be changed. No one was coming so I called my son and V37. I just remember being uncomfortable and needing to be changed. (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
	145650	A. Building B. Wing	05/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/15/25 at 10:03am, V37 (family) said, R131 called him crying, upset, verbally distraught begging for help early Monday morning at 2am complaining of staff not answering her call light on the night shift. Not changing her after she had a bowel movement. R131 has a wound from radiation in her groin. V37 said, R131 called him back multiple time between 3am -5am to report staff still hadn't come to her change/provide incontinence care. V37 said, he called the facility with no answer. V37 said, after the multiple calls from R131 due to her not receiving care, he called the police for a well check. R131 was left soiled and saturated in urine and feces for four hours. The facility tried to say R131 tore of her adult brief. R131 does not have any behaviors. Facility provided concern form dated 5/12/25 (9:37am) documents: V37 stated he had concerns regarding care. Wasn't able to reach anyone. Stated he called police. All parties notified. Facility provide statement for V37 dated 5/14/25 (2:41pm and 4:08pm): V37 said, that he received a phone call from R131 early Monday morning and that she mentioned she was waiting for someone to come and change her. V37 also mentioned that he called the police because he said he [NAME] like R131 was being mistreated. (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	05/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Police Report dated/time report 5/12/25 at 6:31am documents: Last known secure 5/12/25 at 3:00am. On 5/12/25 at 6:52am, police responded to nursing home in reference to a citizen assist complaint. V37 informed them that he was requesting a well-being check on his wife, R131. V37 stated that he tried calling the facility several times and no one was answering. Additionally, V37 informed Southwest Central Dispatch (S.W.C.D) that he spoke with R131 who stated she was sitting in her own feces and had open wound. V37 explained that he was unhappy with the care R131 was getting. Upon police arrival, police observed a female subject standing behind a nurse's cart, dressed in scrubs. In the hallway for two hundred rooms. Police inquired, if she was the nurse for the wing, at which point she informed police she was and assisted police with the location of R131's room. Upon entering R131's room, police could smell the strong odor of feces. Police then observed a female subject, later identified as R131, lying on the bed closest to the entry door of the room. R131 did not have any undergarments on, was lying on her back, and her vaginal area and groin area appeared to have a large amount of feces on it. R131 was holding a bed sheet that also appeared to have feces on it. Police spoke with R131, who explained the following in summary but not verbatim: She/R131 had been lying in that condition since May 12 2025 between the hours of 2:00am -3:00am. R131 further advised that she called her husband to report the condition and also her son. Police asked, R131 if she had a call button located near her, to contact staff. R131 informed police there was call button beside her bed, but no one had come to assist her. Police relocated back into the hallway and spoke with the female subject standing behind the nurse cart, dressed in scrubs. Police informed her of R131's condition, at which time the female subject standing behind a nursing cart, dressed in scrubs advised that she was not a CNA (certified nurse's assistant). Police relocated to the administrative area and knocked on the doors. Police was met by a male subject, dressed in what appears to be a doctor coat. Police informed him of R131 condition and what the female subject standing behind a nurse cart, dressed in scrubs explained to police. The male subject dressed in what appears to be a doctor's coat immediately relocated to R131 room and then contacted another individual. Upon the arrival of a second female staff member, she did not enter R131's room and began working on her schedule paperwork. Police inquired with the female staff member if she needed police assistance getting another staff member to assist her, due to R131 sitting in her feces since 2:00am. After some time had passed a third female staff member arrived at the location where the second female staff member was. The third female staff member explained that she was gathering an undergarment adult brief for R131. Police inquired with the third female staff why R131 did not have an undergarment on at this moment. The second female staff member answered and advised that it was due to R131 having behavioral problems. Upon the second/third female staff entering R131's room, the second female staff member began question R131 about her notifying the police and who she contacted about her condition. Police advised R131 that she did not have to answer the questions, at which time the second female staff member became agitated and informed police that R131 was obligated to answer her questions, due to the second female staff member being in charge of the floor. Police advised the second staff member that R131 had been lying in her feces for some time and that assisting R131, prior to question R131, would be her best interest. On 5/15/2025 at 11:27am, V28 (social service) said R131 did not have any behaviors related to refusing incontinence care nor is any charted in the care plan with seventeen pages. V28 said, she would assume R131 would want to be changed after a bowel movement like anyone else. (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	05/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/15/2025 at 3:15pm V35 (nurse) said, she was assigned to R131's unit on the night shift (11pm -7am) for 5/11/25. V35 said, she was an agency nurse and had never worked with R131 before. V35 said, there wasn't an evening (3pm -11pm) nurse on R131's unit to get report from. V35 said, when she started her shift at 11pm, there were two certified nursing aides that introduced themselves to her. V35 said, she thought those two aids were assigned to her unit. V35 said, two hours into her shift she realized a lot of call light were going off. V35 assumed the aides were in other resident's room providing care. V35 said, R131's family called to complaint that R131 was soiled. V35 said, she went into R131's room at 1:00am. V35 said, R131 was soiled with feces and needed to be changed. V35 said, she needs another staff member to assist with R131 due to her size. V35 said, she did not have any staff to assist her with R131 incontinence care. V35 said, there wasn't any aides on her unit. V35 said, she started to check all of her assigned resident to make sure they were alive. V35 said, she called V10 (manager on duty/nurse) and informed her that there was no CNAs on her shift and only one nurse on the opposite unit. V35 said, residents were soiled and neglected. V35 said, the facility put her licensed and the residents at risk. On 5/15/25 at 5:06pm, V10 (IP Nurse) said, she worked upstairs on the second floor on the 3-11 shift. V10 said, she was the manager on call from Sunday night (5/11/25). V10 said, she was short staff on the night shift of 5/11/25 going into the early morning of 5/12/25 on R131's unit. V10 said, on R131's unit there was only one nurse and one certified nursing assistant working on the 11-7am for the long term care unit/R131's unit. V10 said, two (2) nurse and (4) four CNA are needed for the long term care unit. One nurse and two CNA should have been on R131's unit. On 5/16/25 at 1:16pm, V48 (CNA) said, she was short staffed on the night shift on (5/11/25) Sunday night. V48 said, she worked with V47 (CNA), and they provided incontinence care for R131 two to three times that night with the last time being around 4:30am- 5:00am. V48 said, she did not see the police. V48 said, she did not chart the care provide to R131. Facility provided witness statement from V47 dated 5/14/25 documents: V47 was a CNA on the night 5/11/25. V47 was not assigned to R131. V47 did not take care of R131 on 5/11 night shift. Statement given by V47 via phone on 5/15/25 at 11:20am. On 5/16/25 at 4:20pm, V9 (nurse) said, she was the nurse on the south unit. V9 said she worked the day and evening shift on 5/11/25. V9 said, she was in the facility charting until 1:30am -1:45am because she sent a resident to the hospital. V9 said, at the end of her double shift she was not providing any patient care. On 5/16/25 at 12:13pm, V2 (Administrator) said, if staff was aware that R131 needed incontinence care and failed to provide it, that failure is neglect. V2 said, residents should be changed every two hours and as needed. V2 said, she did not view the camera to determine if staff responded to R131's call light. Surveyor requested to view the video footage of staff entering and exiting R131's room. V2 did not present any video footage for review during the survey. (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	05/16/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/16/25 at 1:47pm, V4 (ADON) said, she came into the facility on [DATE] at 2:00am, that morning. V4 said she was informed around 11:45pm that a nurse was needed on the south unit on long term care side. V4 said, she spoke agency nurse, who informed her that the south unit nurse had just left. The nurses are not supposed to leave without being relived or giving report to another nurse. The long term care unit had two nurses when she reported for work, ideally it should be three nurses assigned to the long term care unit. V4 said, she did not interact with the police. Abuse policy dated 9/2017 documents: This facility affirms the right of our resident to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Neglect means the failure of the facility, it employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain or mental anguish or emotional distress. Further, neglect means a facility's failure to provide or willful withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident.

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	05/16/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed follow their policy and offer a shower at least weekly and failed to ensure effective oral care was provided. This affected two of three residents R148, R352 reviewed for activities of daily living. This failure resulted in R352 to be observed with yellow mucus and patches on the tongue area. Findings include: 1. R352 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure, tracheostomy status, weakness and lack of coordination. R352 Minimum Data Set, dated dated dated [DATE] documents a brief interview for mental status score of 12/15 which indicate cognitively intact. Under oral hygiene documents R352 requires supervision or touching assistance which indicate helper provides verbal cues and or touching and or contact guard. On 5/13/25 at 12:20PM, Surveyor observed yellow mucous and raised white/ yellow patches on R352 tongue and roof of mouth. R352 said he has not had any oral care in two weeks. On 5/13/25 at 12:33PM, V7(nurse) said she observed what appeared to be thrush (yellow or white patches) in R352's mouth. On 5/13/25 at 12:48PM, V38 (respiratory director) said all staff are responsible for providing oral care to the residents. V38 said she observed yellow raised spot on R352's tongue. V38 provided oral care to R352 with sponge. R352 upper mouth had large yellow pieces of what appeared to be mucous removed from his mouth. On 5/15/25 at 3:38pm, V41 (Infectious disease nurse) said she was notified today of concern related to R352 mouth. V41 said R352 is dependent on staff to assist with oral care and at higher risk for infections due to medications and tracheostomy. V41 said R352 required prescription mouthwash at this time to help with the infection. 40066 2. On 05/13/25 at 11:21AM R148 said, I haven't' had a shower since before being in the hospital. I would really like a shower. I had my hair washed by the beauty shop, nearly 2 weeks ago. R148 looks oily and clumped together. R148 said, I would like a shower, I would not refuse one. V55, R148's son, present during interview and said she could be bathed or washed more or better. R148 cognition assessment dated [DATE] identifies a score of 15, cognitively intact. 5/15/25 at 11:47AM V56, CNA, was asked if she gave R148 a shower. R148 said, I don't really remember who she is, I don't work that side often. If they refuse a shower, we document it. I may have given a bed bath. We document bed bath or shower and give the shower sheet to the nurse. (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	05/16/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/15/25 11:51 am V57, CNA, said, We know who our shower is by the green binder. Showed the surveyor the binder. V57 said R148's showers are on Thursday and Saturday evenings. Shower sheets for R148 dated 4/24- 5/10 do not indicate a shower was given, not if a bed bath or refusal was provided. Shower sheets dated 5/1 and 5/13/25 identify a bed bath was given. On 5/13/25 11:48AM V39, CNA, said therapy got her R148 today. V39 said, I changed her. Her pad was soiled after her therapy and then she wanted to be changed again now. I washed her up now. R148 is in the bed, fully dressed. On 05/15/25 at 12:11 PM V46, Restorative Nurse, said, I don't do anything with showers. The Unit manager or maybe wound care is in charge of that. It is not restorative job to determine if the patient can receive a shower or bed bath. On 05/15/25 at 12:34 PM V39, CNA, said, I gave R148 a bed bath on 5/13. That is what R148 wanted. I have given R148 bed baths before. On 5/15/25 at 12:36PM V6, Unit Manager, said unless an order is written that a resident is not safe to have showers, then the resident is considered to be safe to have a shower. V6 said, Showers are offered three times per week. If the resident refuses, the CNA is to notify the nurse, the nurse will speak with the resident, and if not resolved then I will be notified the resident is refusing to shower. The shower sheet should be marked refused. The nurse will attempt to determine if the resident is refusing because they have preferences for a different time, date, or something. We should then documents this in the progress notes. I am not sure if the shower preferences get care planned, but it could be helpful. No one has reported that R148 has refused showers. It could be they see the bed bath as the same as a shower. A bed bath is not the same as a shower. Even if a patient is on contact isolation, they can get showers in their rooms. R148's room has a private shower. R148 would need 1 person to assist her with showers. The facility shower schedule identified R148 to be showered on Tuesday, Thursday, and Saturday evenings. R148's functional ability assessment dated [DATE] identifies she requires substantial to maximal assistance with showers and assistance with transfers for showers. No documentation was presented as evidence that R148 has been offered a shower or that she refused. No documentation of R148 bathing/shower preferences was provided or found in the records reviewed. The care plan for R148 does not address bathing/shower and level of assistance required. The facility policy for Activities of Daily Living dated 9/24 states in part a program of ADL is provided to prevent disability and return or maintain residents at their maximal level of function based on their diagnosis. a program of assistant and instructions in ADL skills is care plan and implemented. Showers or baths are scheduled, and assistance is provided when required. The facility Bathing policy dated 9/24 states all residents are offered a bath or shower at least once per week.

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	05/16/2025

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 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** 41758 38796 Based on interview and record review, the facility failed to follow the plan of care for assistance with hygiene for a dependent resident. This affected one of three residents (R57) reviewed for activities of daily living for dependent residents. Findings Include: On 5/13/25 at 10:44am R57 was observed resting in bed, alert. R57 observed with long beard hair, unkept. R57 said the staff is always busy, so he has been shaved. R57 said he would like his beard shaved. R57 said he does not want his hair cut. R57 said he does not know when the last time he was shaved. R57 said his nails needs to be cut down also. R57 said they staff are too busy. R57 said he cannot shave himself. On 5/14/25 at 10:56am R57 observed with long beard hair, unshaved. On 5/15/25 at 10:30am R57 observed with long beard hair, unshaved, and nails observed long and unclean. 5/15/25 Vx (CNA) said she was R57 aide, and she didn't notice anything about R57 needing to be shaved. R57 care plan dated with initiated date of 11/15/2023 denotes in-part ADL (Activity of Daily living: R57 requires assist with daily care needs r/t limited ROM (range of motion) and mobility he has a dx (diagnosis) of L (left) Hemiparesis. He has weakness r/t (related to) HTN and COPD he requires rest periods. Total assist of two person assists for transfers, extensive assist x two with dressing, bed mobility, hygiene and bathing. Limited assist of one with eating. Interventions denotes, one assist dressing, bed mobility, hygiene and bathing. R57 MDS dated ,d+[DATE], section GG for functional abilities requires substantial/maximal assist. Facility policy activities of daily with last review date 9/2024 denotes in-part resident self-image is maintained. Facility policy title comprehensive care plan with last review date of 3/2024 denotes in-part the facility must develop a comprehensive person-centered plan for each resident. The care plan will include focus measurable goal, and interventions specific to the residents medical nursing, mental and psychosocial needs.

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	05/16/2025

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 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** 39340 Based on interview and record review, the facility failed to prevent one resident with a tracheostomy, who was identified as high risk for skin breakdown and dependent on staff for care, from acquiring a wound, and failed to follow their policy to develop and implement interventions individualized based on the resident's condition for one resident at high risk for skin breakdown with 18 impaired skin areas. This affected two of three residents (R111, R122) reviewed for pressure sore. This failure resulted in R122 sustaining an open wound to the left side of the neck measuring 7 cm x 1cm x 0.5 cm at the tracheostomy collar. Findings include: 1. R122 was admitted to the facility on [DATE] with a diagnosis of respiratory failure, type II diabetes, abnormal posture and tracheostomy status. R122's Minimum Data Set, dated dated dated [DATE] documents R122 is dependent on staff for rolling left to right and for all activities of daily living. R122's Braden scale for predicting pressure sore risk documents score of 8. A score of 9 or below indicates very high risk for skin breakdown. On 5/15/25 and 5/16/25 at 10:46 AM, R122 was observed in bed with head leaning to left side. R122 had tracheostomy collar in place. A tracheostomy collar is a soft, clear mask that fits over the tracheostomy tube to deliver oxygen that has a green thin strap that goes around the neck. R122's skin and wound evaluation dated 5/4/25 documents in house acquired laceration to left side of neck measuring length 6.5 (centimeters, CM) x 0.7 CM). R122's wound assessment report dated 5/6/25 documents: Resident was in bed for wound evaluation. Resident has Respiratory Failure, and Cerebral Infarction. Resident is status trach/vent, incontinent, and poor bed mobility. Resident has laceration injury to the neck due to trach collar. Injury was picked up and is being treated. Primary Etiology: Skin Tear/Laceration. Stage/Severity: Stage 3. Size: 7 cm x 1 cm x 0.5 cm R122's wound note dated 5/13/25 documents: Resident has laceration injury to the neck due to trach collar. Injury was picked up and is being treated. Primary Etiology: Skin Tear/Laceration Stage/Severity: chronic On 5/16/25 at 12:27PM, V43(Wound NP) said R122's wound was classified as a laceration due to the shape of wound being straight and linear. The opening was caused from resident moisture causing the skin to became softer and easier for foreign force to cause breakdown. R122 trach collar was determined to be the cause of opening along with moisture. V43 said it was classified as laceration and skin tear which are the one in the same and can be used interchangeable. V43 said the wound stage three on initial note was done in error. (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	05/16/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/16/25 at 10:59AM, V3 8(Respiratory Manager) said R122's had a wound to left neck which could have been caused by friction from the trach collar. V38 said staff are supposed to ensure the strap is placed on pad the to ensure it does not irritate the skin. On 5/15/25 at 2:20 PM, V30 (wound nurse) said R122's wound is a laceration from the tracheostomy collar. Laceration is a cut in the skin from trauma like friction from the tracheostomy collar. Facility policy reviewed 9/23 Pressure injuries documents: to prevent or reduce the incidence of pressure injuries, standards of practice should be implemented. A pressure injury may be defined as any lesion caused by unrelieved pressure that results in damage to the underlying tissue, although friction and shear are not primary causes of pressure injuries, friction and shear are important contributing injuries to pressure Injuries. A pressure injury is localized damage to the skin and or underlying tissue usually over a bony prominence or related to a medical or other device. The injury occurs as a result of intense and or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. [NAME] l device related pressure injury. Use staging system to stage. This describes the etiology of the injury. Medical device related pressure injuries result from the sue of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. 40066 2. R111 diagnoses include but are not limited to fracture of lumbar vertebra, diabetes, protein calorie malnutrition, and attention to gastrostomy. R111 is not verbally or physically responsive when spoken to or while staff providing care. On 05/14/25 at 10:35 AM V15, CNA, said, I check and change R111 every 2 hours. We check and change everyone every 2 hours. On 05/14/25 at 12:53 PM V30, wound nurse, accompanied surveyor to see R111. R111 in his bed laying mostly on his right side. R111's right ear was resting on his shoulder and pillow. A visible 4x4 foam dressing was over his left ear. V30 said R111 has deep tissue injuries to his left ear, elbows, sacrum, ischium, feet, and left lateral neck/head areas, skin tears and lacerations over his right hand. V30 said interventions for pressure relief include a horse shoe shaped neck pillow, heel boots, and an air mattress set to his weight. The neck pillow was not on R111 neck and was at the top of the mattress. V30 said interventions include turn every 2 hours for all residents who can't reposition themselves. V30 did not make any movement or response during observations and conversations at this time. (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	05/16/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/15/25 at 1:55PM V30, Wound care, said R111's right ear wound was identified on 5/1/25 and present on readmission. V30 said the wound was unstageable. On 5/12/25 the right ear measured 0.7 x 1.0 x 0.1 deep, and at stage 3. V30 was asked specifically what intervention were put in place for V30's ear pressure ulcer. V30 said interventions include turn and reposition, every 2 hours, wedges in his room help him be elevated off his sides and bottom, and an air mattress, protein supplements were added. V30 said these wounds were present since before his readmission. V30 said R111 has always had an air mattress originally delivered on 12/26/24. V30 said interventions are appropriate for R111. V30 said they are repositioning R111 enough. The surveyor asked if the facility completed a tissue tolerance test for R111. V30 said a tissue tolerance test has not been done to V30's knowledge. The surveyor asked V30 if R111's care plan includes the use of his neck pillow. V30 said it's not on there. V30 was asked if bolsters are on the care plan and V30 said they are not on there. V30 said they have heel boots and turn and reposition every 2 hours on the care plan. V30 said R111 has about 18 skin impairments (without counting). V30 said we complete unavoidable documents we fill them out and the nurse practitioner reviews and signs them. V30 said R111 has unavoidable documentation for his sacrum and left ear but not the right ear because it did not develop in the facility. On 5/16/25 at 11:42 AM V32, MDS Nurse, said the purpose of the care plan is how they know what care and services to provide to the residents. V32 said the action part of the care plan is the interventions, what we are doing. V32 said the care plan is individualized based on resident needs and preferences. V32 said anyone providing care to the resident has access to the care plan. On 5/16/25 at 11:52AM V44, Doctor, said R111's prognosis is poor. R111 is a bedbound patient. R111 said interventions for pressure relief should be followed. The surveyor discussed the unavoidable assessment completed by the facility for R111's ear with the intervention for heel protectors. R111 said, I don't see that applying to an ear wound. V30 provided a list with R111 skin impairments including left ear unstageable pressure ulcer acquired in house and right ear stage 3 pressure ulcer. There are 18 impairments on the list for R111. On 5/16/25 at 11:46AM V30 said we use Braden scale for everyone. V30 said R111 is at high risk for pressure ulcers. Review of R111 wound progress notes date 5/12/25 identify sacrum pressure ulcer, right knee, right hand, right lateral foot, and left leg vary from pressure to venous. Wounds on bilateral ears and left side of head and breakdown on various sites of body. Right ear pressure ulcer stage 3 size 0.7 x 1 x0.1, peri wound skin is fragile. Left ear pressure unstageable size 2.8 x 1.9 x 0.1 granulation and eschar present. Peri wound fragile. Pictures include in document of left ear. Care plan provided to the surveyor by the facility for R111 reviewed and does not include use of wedge/bolster, neck pillow. There is no intervention for turning or repositioning or frequency. There is no intervention specific to R111 left and right ear to relieve pressures, except for treatment. An Unavoidability/Avoidability Determination for R111 ulcer site left ear, unstageable onset 4/21/25. Diagnosis identified Severe PVD, Urinary and Bowel incontinence, and history of pressure ulcers. Interventions include moisture barrier after each incontinent episode, pressure relief mattress, low air loss, turn and reposition every 2 hours, supplements, and tube feeding. (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	05/16/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few	The policy for Skin Management: Treatment/General Wound Treatment dated 4/2024 states, in part, treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. The facility recognizes that the selection of treatment protocol is individualized based on the resident condition and practice patterns .implement prevention protocol according to resident needs. Mobility: turn and reposition as needed using a person centered approach.

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	05/16/2025

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 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** 38796 Based on interview and record review the facility failed to provide effective supervision for a resident with a diagnosis of right-side hemiplegia, lack of coordination, abnormal posture, displaying agitation while in dining room, and failed to ensure effective interventions to include supervision and monitoring were implemented to prevent a resident from falling out of bed. This affected two of three residents (R59, R65) reviewed for safety, supervision, and falls. This resulted in R65 falling from the wheelchair, R65 was sent to the local hospital for treatment of a clavicle fracture, and resulted in R59 sustaining a closed head injury, abrasion to the top of the scalp and left upper extremity (arm) with diffuse swelling. Findings include: 1. R65 face sheet shows diagnosis of hemiplegia and hemiparesis following non traumatic subarachnoid, type 2 diabetes, aphasia, lack of coordination, abnormal posture, unspecified dementia. R65 incident report dated 3/13/2025 denotes in-part fall, date of incident 3/13/25, location dining room, during lunch resident was in the dining room while his room was being cleaned. Resident became agitated and he reached for the door and fell . Resident unable to give description. Was this incident with incident witnessed, N documented. Description took vital signs, informed Doctor, and family. Neuro check initiated with normal findings. The resident initially denied pain, but after 30 minutes c/o (complain of) pain to left arm. MD was updated and ordered Xray of left shoulder, arm, and elbow. Pain level -one. Mental status-confused/ fearful, orientated to person. Non complaint to safety guidance. Resident had a misunderstanding with his sister who was visiting and was agitated and hard to redirect. On 5/14/25 at 2:17pm V21 (LPN) said she was the Nurse for R65 on 3/13/25 when R65 fell in the dining room. V21 said on this day, R65 room was being deep cleaned and R65 had to get up from bed and come to the dining room until the room was finished being cleaned. V21 said R65 was in a manual wheelchair. V21 said R65 usually stays in his room and watch his movies. V21 said R65's sister did visit that day, and during that visit R65 was agitated because he wanted to go back to his room. V21 said R65 sister was upset that R65 was agitated. V21 said R65 sister was not in the dining room when R65 fell , she was lingering in the hallway. V21 said she asked several times if she could put R65 back in his bed because of the agitation. V21 said R65 reached for the door in the dining room, to open the door and that's when he fell from the wheelchair. V21 said the Director of Nursing at that time allowed her to watch the video and she observed what happened on the video. V21 said she watched the video, but she can't recall if someone was in the dining room when R65 fell . V21 said she does recall that she observed two aides in the hallway. V21 said staff are supposed to monitor the dining room. Facility presented assignment sheet for 3/13/25 (day of R65's fall). (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	05/16/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	V52 (CNA) was identified as one of the aides that was standing in the hallway. On 5/14/25 V52 said herself and V54 were in the hallway, and the other aides were setting up for lunch services. V52 said she thinks a nurse was in the dining room when R65 fell , but she doesn't recall. V52 said R65 was having behaviors because he wanted to go back to his room. V52 said you could hear R65 banging on the door. V52 said herself and the other aide were planning to put R65 back to the bed, but he had the fall prior to them putting back to bed. V52 said R65 does not usually get out of bed, he prefers to be in his room and watch his movies. V52 said staff are supposed to monitor the dining room when residents are in there. 5/16/25 at 1:42pm V53 (CNA) said she was not in the dining room when R65 fell , she was taking her 15 minute break. V53 said the dining room supposed to be monitored, she thought it was. V53 said she doesn't know who was monitoring the dining room. 5/16/25 at 2:14pm V9 (LPN) said she was not in the dining room when R65 fell , she was passing medications. R65's emergency room after visit summary dated 3/14/25 denotes you was seen diagnosis clavicle fracture. Upon exit of this survey the facility failed to identify who was monitoring the dining room when R65 fell from the wheelchair. Facility fall policy prevention management policy with last review date 8/2024 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 prevention strategies, and facilitate as safe an environment as possible. All falls shall be reviewed, and the residents existing plan of care shall be modified as needed. 41758 2. R59 has diagnoses with Dementia, history of falling and unspecified fracture of left humerus shaft with routine healing. Brief interview for mental status dated 3/6/25 documents a score of eight which indicates moderate cognitive impairment. Fall risk evaluation 2/27/25 documents score of twelve. Scoring a ten of higher makes resident high risk for falls. Minimal data set dated [DATE] documents: roll to left and right; R59 requires substantial/maximal assistance (helper does more than half the effort), lying to sitting on side of bed: R59 is dependent. On 5/14/25 at 3:15pm, R59 who was alert to self only said, she fell out of bed but could not elaborate on the events prior to the fall. On 5/14/25 at 3:22pm, V22 (nurse) said R59 had two unwitnessed falls from the bed. R59 was observed on the floor face down both times. V22 said she was not sure how R59 fell . V22 said she got report that R59 did not move. V22 said R59 did not have any injuries the first fall. The second fall R59 complained of arm pain. V22 said R59 was sent to the hospital both times. (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	05/16/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5-15-25 at 1:54pm, V46 (restorative directive) said R59 was high risk for falls. R59 was dependent on staff for repositioning in bed. R59 was unable to turn and reposition herself. V46 said she is not sure how R59 fell since she was unable to reposition self without staff assistance. V46 said R59's fall intervention was ineffective to prevent her from falling out of the bed. R59 was given a fall mat after the first fall which was an ineffective because R59 had a second fall from the bed. Fall mats do not prevent falls from the bed. Fall mats decrease the chance for injuries if the resident falls onto the floor. V46 said R59 sustained abrasion to the scalp and left toe with the second fall. V46 said she does not know what R59 hit to obtain the abrasions nor is it documented. Nursing note dated 4/8/25 document: Resident (R59) observed laying in a prone position (flat on their stomach, with their face downward or turned to one side), on the floor next to the bed. Resident states, I fell out the bed. Left upper extremity edema, no visible injures, bed was at the lowest position and call light still attached to the resident. Fall incident dated 4/8/25 documents: R59 has poor bed mobility, positioning and requires assistance from staff. R59 has old left arm fracture with routine healing. Will maintain be in the lowest position. Floor mat given. Round at a minimum of every two hours and prompt or assist for change in position, toilet, offer fluids and ensure resident is warm and dry. Hospital after visit summary dated 4/8/25 documents: fall from bed. Nursing Note dated 5/5/2025 documents: Resident (R59) observed laying prone position on the floor near bed. R59 states, I rolled out bed. Left upper extremity edema, abrasion to left top of head. Complains of pain 8/10. Fall event dated 5/5/25 documents: During rounds, the nurse on duty observed the resident laying prone position on the floor on the floor mat. Injury: Abrasion top of scalp and left third toe. Hospital paperwork dated 5/25 documents: Resident presented to the emergency department at this time for evaluation after experiencing a fall out of her bed. According to the patient, the patient was sitting on the edge of the bed and fell off of the bed. R59 has a history of dementia. Physical Exam Finding: Left upper extremity with diffuse swelling, contracted, sling. Closed head injury, Abrasion of scalp. Fall Prevention and Management Policy dated 5/2015 documents: The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.

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	05/16/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34072 Based on observations, interviews, and record reviews, the facility failed to discard expired intravenous fluid, house stock and resident specific medications; failed to ensure open date and expiration dates were labeled on multi-dose insulin and tuberculin vials; and failed to ensure residents medications were stored per policy in the medication room, medication cart and medication refrigerator. This affected four of four residents (R4, R74, R75, R452) reviewed for medication storage and labeling. Findings include: On 05/13/25 10:00 AM, the medication storage room on the long term west nursing unit was checked with V4 ADON (assistant director of nursing). There were (2) one liter bags of intravenous fluids, D5.45, that expired April 2025 and (1) 1 liter bag of intravenous fluids, D5, that expired January 2025. There was one intravenous catheter kit that expired on 5/1/25. The refrigerator contained: (1) small container of vanilla pudding that was not labeled or dated. (2) containers of applesauce that were not labeled or dated. (32) Dulcolax suppositories with an expiration date of 06/2024. (1) opened 1ml (milliliter) vial tuberculin solution that was not labeled with date opened or expiration date. (1) Humulin R multi-dose vial opened that was not labeled with date opened or expiration date. (1) bottle of Ready Care dairy milk -- 32 ounces with an expiration date of 11/6/24. R4's medication, atropine 1%, administer sublingual with an expiration date of 4/23/24. On the floor near the refrigerator were individual packets of residents' medication and house stock medication: R452 -- (3) gabapentin 300mg tablets (1) glipizide 5mg tablet (1) clopidogrel bisulfate 75mg R74 -- (1) clonidine 0.3mg tablet (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	05/16/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) clopidogrel bisulfate 75mg R75 -- (3) metoprolol tartrate 25mg (1) opened 1ml vial tuberculin solution that was not labeled with date opened or expiration date. On 5/13/25 at 10:30 AM, the medication room on the vent nursing unit was checked with V4. There were (2) 30 ounce bottle of UTI-STAT (supplement for the management of urinary tract health) with an expiration date of 2/28/25. On 5/13/25 at 10:45 AM, the medication room on the first floor nursing unit was checked with V4. There was an opened container of house stock medication, mucus relief, 400mg tablets with an expiration date on 12/24. On 5/13/25 at 11:30 AM, the second floor nursing unit medication cart was checked with V6 (unit manager). There was an opened house stock container of cetirizine 10mg (milligrams) tablets. Above the expiration date of 01/25 the nurse noted date opened 5/1/25. It is a 300 tablet container with 294 tablets remaining. On 5/13/25 at 10:45 AM, V4 ADON stated that the intravenous fluids should have been returned to the pharmacy. V4 stated the pudding and applesauce should have been labeled with date placed in the refrigerator. V4 stated the nurse is responsible for checking the medication refrigerator for any expired medications and returning them to the pharmacy. V4 stated multi-dose vials should be labeled with date opened and expiration date. V4 stated residents' medications should not be on the floor. On 5/13/25 at 11:50 AM, V4 ADON was questioned about the date opened and expiration date on the bottle of cetirizine, V4 stated that maybe the nurse did not see the expiration date. On 5/14/25 at 1:55 PM, V5 DON (interim director of nursing) stated the nurses are responsible for checking for expired medications. The facility's medication storage policy, reviewed 06/2024, notes refrigerated medications are to be stored separate from applesauce and other foods used in administering medications. Outdated drugs will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists. Medication storage areas are kept clean, well lit, and free of clutter.

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	05/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34072 Based on interviews, observations, and records reviewed the facility failed to implement their policy for contact isolation precautions for residents with positive multidrug resistant organisms and failed to clean the Glucometer between resident use for blood sugar checks. This affected ten residents (R13, R52, R99, R123, R148, R152, R153, R48, R133, R154) in the total sample all reviewed for infection control practices in the sample. Findings include: On 5/13/25, R13, R99, R123, and R153 were observed to have contact isolation signs and an over-the-door hanging isolation container on their doors. On 5/13/25 at 3:45 PM, V19 CNA (certified nurse aide) was observed entering a contact isolation room. No hand hygiene was performed, or PPE (personal protective equipment) donned prior to entering R13's room with a non-disposable portable blood pressure machine and obtain R13's vital signs. A staff member was observed at R13's room and informed V19 to don PPE due to the State Surveying Agency staff were in the facility. V19 was observed exiting R13's room, no hand hygiene performed; V19 donned gown and gloves and re-entered R13's room went to R99's bed, obtained vital signs. R13's privacy curtains were closed. At 3:55 PM, V19 removed gown, pushed open R13's privacy curtains and threw gown in R13's garbage can next to her bed. V19 exited room, no hand hygiene performed and placed blood pressure cuff on the nurse's medication cart without disinfecting. R13's POS (physician order sheet) does not note an order for contact isolation. R99's POS, dated 5/9/25, notes an order contact isolation precautions for infection or suspected infection with C. Auris. On 5/13/25 at 3:50 PM, V25 (restorative aide) was observed carrying two floor mats and enter R152's contact isolation room. No hand hygiene was performed, and no PPE donned prior to entering R152's room. V25 was observed moving equipment in room to place the floor mats on each side of R152's bed. V25 was observed touching R152's television remote and assisting R152 with the buttons. At 3:57 PM, V25 was observed exiting R152's room, no hand hygiene was performed. V25 was observed asking V17 LPN (licensed practical nurse) what R152 was in isolation for and V17 responded that she did not know. On 5/13/25 at 4:10 PM, visitors were observed in R123's contact isolation room and R153's isolation room, no PPE donned, or hand hygiene performed before entering or after exiting rooms. On 5/13/25 at 4:20 PM, V17 LPN (licensed practical nurse) was observed checking R48's blood sugar level with glucometer. V17 did not clean the glucometer after its use. On 5/13/25 at 4:35 PM, V17 LPN was observed checking R133's blood sugar level with glucometer. V17 did not clean the glucometer after its use. On 5/13/25 at 4:45 PM, V17 LPN was observed checking R154's blood sugar level with glucometer. V17 did not clean the glucometer after its use. V17 placed glucometer in medication cart. (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	05/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/25 at 8:10 AM, R52 was observed to be on enhanced barrier precautions. R52's POS, dated 5/13/25, notes an order for vancomycin 125mg (milligrams) via gastrostomy tube two times a day for C-Diff (clostridium difficile) positive. On 5/14/25 at 10:45 AM, V10 (infection prevention nurse) stated that residents with the same multidrug resistant organism can reside in the same room. V10 stated residents with C-Diff infection are placed in a room by his or herself. V10 stated residents are immediately placed in contact isolation if C-Diff infection is suspected. V10 stated staff should don gown, gloves, and mask prior to entering a contact isolation room. V10 stated staff are expected to perform hand hygiene before and after contact with residents. V10 stated staff should perform hand washing for residents in contact isolation for C-Diff. V10 stated disposable stethoscope and vital sign equipment should be kept at bedside for residents in contact isolation. V10 stated if non-disposable equipment is used, it should be cleaned with bleach wipes between each resident usage. V10 stated that for residents on EBP (enhanced barrier precautions), staff should don gown, gloves, and mask when providing care. V10 stated staff do not have to wear gown or mask if not providing direct resident care for residents in contact isolation. V10 stated obtaining a resident's vital signs is not direct resident care. V10 stated staff are expected to clean the glucometers with disinfecting wipes between each resident usage. On 5/14/25 at 1:55 PM, V5 DON (interim director of nursing) stated staff are expected to perform hand hygiene before and after resident contact. V5 stated staff are expected to don gown and gloves before entering a contact isolation room. V5 stated staff are expected to don gown and gloves when providing direct resident care in EBP rooms. V5 stated obtaining a resident's vital signs is providing direct resident care. V5 stated the off-going nurse should be informing the oncoming nurse of the reason a resident is in isolation. V5 stated the nurse is responsible for knowing what type of isolation and the reason for it for assigned residents. V5 stated staff are expected to clean the glucometers with disinfecting wipes between each resident usage. This facility's transmission based precautions policy, revised 03/2024, notes contact precautions are used for residents with suspected or known infections of colonized microorganisms that can be transmitted by direct contact with the resident or indirect contact. Examples of such illnesses includes but is not limited to clostridium difficile. Also includes, but not limited to: infections or colonization with multidrug resistant organisms, KPC, CREs. Gloves are to be worn when entering the room and gloves must be changed after contact with materials that contain high concentrations of microorganisms. Gowns are to be worn when entering the resident's room if direct care is to be provided or when potential for clothing to be contaminated exists. Resident care equipment should be dedicated to the use of a single resident or cohort of residents infected or colonized with the same pathogen. Common equipment needs to be cleaned and disinfected before each use. CDI: isolate residents who are actively infected, having diarrhea. CDI: do not require re-culturing to discontinue isolation. Isolation precautions will be discontinued once diarrhea has fully stopped for 3 consecutive days. On 5/13/25 at 11:21AM R148 was in her room, no contact isolation sign on the door. R148 said she has been incontinent of stool. At 11:48AM V39, Certified aid, was in the room with basin on bedside table with water and foam from soap, towels on the table, and R148 in bed. V39 not wearing gown. V39 said, I just gave her a bed bath and I had changed her brief after therapy this morning. (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	05/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/14/25 at10:25 AM R148's room observed with sign for Enhanced barrier precautions on the entry door. On 05/14/25 at 10:29 AM V13, RN, said R148 is on isolation for C-diff. On 05/14/25 at 10:35 AM V15, CNA, contact precaution sign on door room for R13. V15, certified aid, was in the room with no gown or gloves on. V15 said, I didn't do patient care. I don't need the equipment and I answered the call light while I was in the room. V15 said when entering contact isolation room, if you are not doing patient care there is no need for gown and gloves. On 05/14/25 at 10:44 AM nurse V16, Nurse, said for isolation rooms, we gown and glove only with patient care. On 05/14/25 at 10:49 AM V10, Infection Preventionist, said, I get informed if we need isolation by staff notifying me and I can run a report. For Contact Precaution every time they, staff, enter the room, they should gown, glove and mask. When entering they should don the personal protective equipment. Per the policy, staff should at least don gloves when entering the room of a person on contact precautions. Anyone with active infections, such as CRE, VRE, and C-Diff, those types of bugs, are placed on contact isolation precautions. R148 came in over the weekend and she just got positive for c-diff. On 05/14/25 at 12:25 PM V40, Doctor, came out of room R152's and into R13, no hand hygiene performed and no gloves. R152 has contact isolation sign on her door as does R13. V40 said, I am doing resident reviews, which includes a face to face visit. No one told me about the signs (contact isolation). I don't know if they have any infections. I was seeing R13 in her room. On 5/14/25 at 12:30PM V12, CNA, entered R102's room with contact isolation sign on the door. V12 did not don PPE upon entering. V12 remained in the room assisting with R102's meal. At 12:44PM V2, Administrator, entered R102 room, donning gloves and gown. V2 said V12 should be wearing a gown. Surveyor said to V2 that staff reported they only need to wear PPE when providing cares. V2 said that is false. On 05/14/25 at 01:25 PM V10 said when we suspect c-diff the staff should have put the contact isolation sign up. V10 said they should have put R148 on isolation on 5/9/25. On 5/16/25 at 11:00AM V10 said if staff is not following isolation precautions the risk is contaminating themselves and residents. V10 said if staff is not cleaning equipment between resident use the risk is cross contamination. V10 said if staff is not washing their hands or performing hand hygiene the risk is cross contamination to residents. R148'sl ab results collection date 5/10/25 with results reported 5/12/25 positive for C. Difficile antigen. R148s' order summary report dated 5/13/25 notes contact isolation precautions for infection with c-diff. R148's care plan for infections last updated 4/25/24 do not include interventions or focus for c-diff, multidrug resistant organism, or contact isolation precautions.