

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 08/08/2025
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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to follow its abuse policy by having residents lose their bank cards and state IDs. This applies to 3 of 3 residents reviewed (R3, R4, and R2) for misappropriation of resident property in a sample of 9 residents. The Findings include: Findings include: 1. R3 is a [AGE] year-old female admitted on [DATE] with cognition intact as per the MDS dated [DATE]. On 8/6/25 at 3:00 PM, V1 (Administrator/Abuse Coordinator) stated, R3 came up with bed bugs, and we collected her belongings to freeze them. We found money (approximately \$ 40) and a state ID. There were no bank cards. When we spoke with the power of attorney (POA), she said she doesn't want to get anything back and trash everything. The housekeeping might have trashed everything. We reimbursed her money, but we couldn't locate her state ID. A review of the nurse's note dated 7/10/25 documents that the family couldn't locate R3's purse, and the facility was made aware of R3's missing purse upon discharge. On 8/7/25 at 1:40 PM, V18 (R3's concerned party) stated, R3 had her state ID with her. They couldn't find her state ID upon discharge. 2. R4 is an [AGE] year-old female admitted on [DATE] and having cognition intact as per the Minimum Data Set, dated [DATE]. On 8/6/25 at 9:20 AM, R4 stated, I had my bank cards in my bag here in my room. I am missing those cards, and I don't know who took them. I told my son (V10), who is my POA, and he told the administrator and then reported to the police. On 8/6/25 at 8:50 AM, V10 stated, My mom had three bank cards in her bag and was missing. When I reported it, they found one. The two cards that belong to my mom are still missing. It was stolen and used for unauthorized transactions but was declined. The card was suspended, and luckily, we didn't lose any money, and it could have been worse. A review of the reportable document for the facility-initiated investigation on missing bank cards on 7/27/25. The reportable document that V10 was claiming R4's credit card was missing, and the facility returned the debit card found in the laundry. On 8/6/25 at 1:55 PM, V11 (Registered Nurse) stated, On Sunday, 7/27/25, V10 told me that he is missing his mom's bank card. There was a card on V2's (Assistant Administrator) desk that we found from the laundry, and R4 was refusing to accept that card as she was saying it was not hers. When we returned that card to V10 on Monday, 7/28/25, he was saying his mom is missing two more cards. On 8/6/25 at 1:30 PM, V1 stated, V10 reported to me on 7/27/25 that his mom (R4) was missing her bank card. On Monday, 7/28/25, when I returned one card to V10, he was saying another card was missing. We didn't know about the second card until Monday (7/28/25). All residents have the right to be free from misappropriation of their belongings. On 8/6/25 at 2:10 PM, V1 added, The police officer told me that they are reviewing the video from the store where R4's card was used unauthorized, and they couldn't recognize the person making an unauthorized transaction using R4's bank card. 3. R2 is a [AGE] year-old female admitted to the facility on [DATE] and was discharged home on 7/27/2025 in stable condition. A review of the police report filed by V12 (R2's concerned party) on 7/29/2025 on a theft complaint. V12 noticed several unauthorized ATM cash withdrawals totaling \$3,809.50 from R2's account. All the unauthorized withdrawals occurred during R2's stay in the facility. R2 was in the facility between 7/12/2025 and 7/27/2025, and cash debit card ATM withdrawals occurred on 7/21, 7/22 and 7/23/25. A phone interview was conducted with V12 on 8/5/2025, 2:02 PM. V12 stated that they were not aware of the unauthorized withdrawals from his mom's account until R2 was discharged from the facility. V12 said he filed a police report on 7/29/2027 at 8:40 AM, two days after R2 went home. V12 stated R2 has a habit of writing her PIN on a piece of paper with her debit card. On 8/6/25 at 2:00 PM, V1 stated she is unaware of any missing debit card of R2. On 8/7/2025 at 1:09 PM, V1 added that she reached out to V12 today via a phone call to get further information about the unauthorized withdrawals. V1 said V12 told her that all the withdrawals happened while R2 was in their facility. On 8/7/25 at 11:00 AM, V1 stated, We don't know someone from our facility is stealing resident belongings. Since there are two more residents involved with theft, our guardian angels are making rounds and calling family members to see if the resident is missing any of their belongings. The residents should have a theft-free environment. The facility presented the abuse policy (reviewed 9-2017) document: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. This facility, therefore, prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its Fall Prevention and Management Guidelines by not implementing fall prevention interventions in place for high-risk fall residents. This applies to 2 of 2 residents (R1 and R5) reviewed for fall. The findings include:1. R1 is a [AGE] year-old female admitted on [DATE] with severely impaired cognition as per MDS dated [DATE]. A review of the fall log indicates that R1 had a fall on 4/8/25 and 5/5/25 with no injury.The record review on fall risk assessment dated [DATE] documents that R1 is at high risk for falls. On 8/5/25 at 1:45 PM, R1 was observed in her bed with floor padding not in place. Surveyor instructed R1 to push the call light but R1 was unable to use the call light. V15 (Minimum Data Set/MDS Nurse) requested R1 to push the call light but R1 was unable to use the push button call light. On 8/5/25 at 1:47 PM, in response to the writer's request, V15 pushed the call light button, and it was not working. Observed V15 push hard the call light chord to the wall and was working then. On 8/5/25 at 1:50 PM, V15 stated, The resident should have an alternate way, like a touch pad call light, to call if they can't push the call button to call. The floor padding should be placed at the bedside, instead of leaning against the wall.A review of R1's fall care plan document interventions, including floor mats will be placed on the side of the patient's bed to help prevent falls.2.R5 is a [AGE] year-old male admitted on [DATE]. On 5/8/25 at 10:40 AM, R5 was observed in his bed in an elevated position with floor padding 2 feet away from the bed. A review of the initial fall risk assessment dated [DATE] documents that the facility identified R5 as at high risk for falls.The facility presented a fall care plan that includes interventions, including floor mats while in bed and bed to the lowest position.On 8/7/25 at 11:50 AM, V4 stated, The residents with a score greater than 10 are at high risk for falls. R1 and R5 are at high risk for falls and fall care plan interventions should be in place.The facility presented the Fall Prevention and Management Guidelines document:A resident at risk for falls will have fall risk identified on the plan of care with interventions implemented to minimize fall risk.</p>		