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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their change of condition policy by not immediately notifying the physician or nurse practitioner of a white patches in the mouth and on the tongue for one resident for two days. This affected for one of three (R352) residents reviewed for notification. Findings include: 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. V7 (nurse) was made aware of concern during observation and confirmed observation. On 5/15/25 at 3:38PM, V41 (Infectious disease nurse practitioner) said she was notified today (5.15.25) of concern related to R352's mouth. V41 said R352 is dependent on staff to assist with oral care and at higher risk for oral infection due to medications and tracheostomy. V41 said R352 required prescription mouth wash for infection and would have expected to be notified when first observed. On 5/16/25 at 11:47AM, V44 (Medical doctor) said he was not made aware of any concerns related to R352's mouth until he saw him today (5/16/25). V44 said he would expect to be notified of changes to R352. If he was notified, he would have ordered medication immediately for R352. V44 said he agrees with the treatment V41 ordered. Facility policy revised 10/24 titled Change in Resident condition documents: it is the policy of the facility except in medical emergency to alert the resident, resident physician and resident responsible party of a change in condition. Nursing will notify the residents physician or nurse practitioner when there is a significant change in the residents physical, mental or emotional status.

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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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066 Based on interviews and records review the facility coded the MDS inaccurately by submitting a resident was discharged to the hospital instead of documenting the resident was discharged home. The facility failed to document accurate assessment information for PASRR identification. This affected five of five residents (R149, R3, R29, R65. R83,) reviewed for accuracy of assessments. Findings include: 1. On 5/15/25 at 1:33PM V32, MDS Nurse, said R149 MDS section A says she was discharged to short term hospital. V32 said R149's progress notes say she went home. V32 said it is a conflict. V32 said we will do a correction of this MDS. MDS assessment dated [DATE] section states R149 was discharged to short term general hospital (acute hospital). Progress notes dated 2/26/25 states R149 was discharged with family. 38796 2. R3's face sheet shows diagnosis of anxiety, and major depression. R3 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, and depression. Section A for identification information, A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. 3. R83's face sheet shows diagnosis of anxiety, and major depression. R83 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, and depression. Section A for identification information, A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. 4. R65 face sheet shows diagnosis of anxiety, and major depression. R65 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, and depression. Section A for identification information, A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. 5. R29 face sheet shows diagnosis of anxiety, depression, schizophrenia, and bipolar. R29 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, depression, schizophrenia, and bipolar. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Section A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. Facility PASRR review policy presented by V2 (Administrator) denotes in-part preadmission screening resident review, to prevent inappropriate placement of persons with serious mental illness, intellectual disability or other development disability and ensure that all nursing facility applicants and residents regardless of payor source are identified, evaluated, and determined to be appropriate for admission of continued stay and provide with specified services, if needed. Level 1 identify all applicants to a Medicaid-certified Nursing facility, regardless of payor source, who possibly have MI, ID/DD and identify all persons for a level 2 screening.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on interview and record the facility failed to refer a resident with serious mental illness for preadmission screening level 2 for two of two residents (R29 and R83) reviewed for appropriate PASRR screening. Findings include: 1. R29 face sheet shows diagnosis of anxiety, depression, schizophrenia, and bipolar, R29 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, depression, schizophrenia, and bipolar. Section A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. Request was made to review R29 PASRR level 2 assessment. During this survey the facility failed to provide a PASRR level 2 for R29. On 5/16/25 at 2:14pm V28 (social service) said R29 has diagnosis of serious mental illness, R29 should have been referred for a PASRR level 2. 2. R83 face sheet shows diagnosis of anxiety, and major depression, R83 MDS dated [DATE] section I for mood disorders shows diagnosis of anxiety, and depression. Section A for identification information, A1500 denotes is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No is checked. Request was made to review R83 PASRR level 2 assessment. V28 (social services) presents a level one PASRR for R83 dated May 13, 2024. During this survey the facility failed to provide a PASRR level 2 for R83. On 5/16/25 at 2:14pm V28 (social service) said R83 has diagnosis of serious mental illness, R29 should have been referred for a PASRR level 2. Facility PASRR review policy presented by V2 (Administrator) denotes in-part preadmission screening resident review, to prevent inappropriate placement of persons with serious mental illness, intellectual disability or other development disability and ensure that all nursing facility applicants and residents regardless of payor source are identified, evaluated, and determined to be appropriate for admission of continued stay and provide with specified services, if needed. Level 1 identify all applicants to a Medicaid-certified Nursing facility, regardless of payor source, who possibly have MI, ID/DD and identify all persons for a level 2 screening.

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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)

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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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 38796 Based on observation, interview and record review, the facility failed to follow physician orders and provide a Bipap machine for 5 days for a resident diagnosed with obstructive sleep apnea, and chronic respiratory failure for one of one resident (R13) reviewed for following physician orders. Findings include: On 5/13/25 at 12:15pm R13 said the Nurse keeps telling her that the face mask is broken for her CPAP machine. R13 said she did not have her CPAP placed on her last night (5/12/25) before she went to bed. A gray face mask, connected to a clear tube, was observed on R13's nightstand. V6 was made aware that R13 said her CPAP machine was broken. During a follow up interview, V6 said she did not check to see if R13 machine was broken. At 3:10p during a tour of R13 room with V6 (Unit manager) to identify R13 CPAP machine, V6 looked in all the drawers, and on the nightstand in R13's room, there was no CPAP machine noted. V6 said she did not remove any machine from R13's room. V6 said she informed respiratory therapy that R13 said her CPAP machine was broken. V6 said she did not have any further information. On 5/14/25 during survey tour with V51 to assess R13's skin, V51 observed R13 not easily arousable, R13 was observed with her eyes closed, not easily arousable. R13 did not have on her CPP/ BIPAP machine. A white machine was observed on the nightstand at R13 bedside. 5/14/25 V38 (Respiratory Director) said R13 uses a BIPAP machine not a CPAP machine. V38 said she after she was made aware yesterday (5/13/25), she retrieved R13's BIPAP machine from the storage room (the machine was placed in storage after R13 last hospital stay on 5/5/25). V38 said R13 had another BIPAP machine from the hospice company prior to her placing the machine in R13's room on 5/13/25. V38 said R13's BIPAP machine should be applied as ordered. R13's BIPAP machine was inspected with V38. V38 identified the machine was new, never used, no water had been placed in the machine for set up. V38 said she worked with R13 on another unit and R13 did not refuse to wear her BIPAP. V38 said she would expect the machine to be set up with water inside. V38 reviewed the serial number on the BIPAP machine and the delivery paperwork for R13. V38 said the BIPAP machine settings are specific to R13, and the company set up the settings specific to the resident orders. On 5/14/25 at 3:14pm V49 (Sanctuary Hospice Rep) said the hospice company picked up their BIPAP machine up from previous facility on 5/8/25 that was being used for R13. R13 was discharged from hospice services. R13 physician order sheet shows orders for AVAPS: TV 400, F 18, PS 10-15, EPAP +7 with full face mask. Patient to utilize it at night. Can utilize prn during the day. Staff to assist patient with applying it at night and removing in AM. (On at 9pm and off at 7am), every day and night shift for OSA (Obstructive Sleep Apnea). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/16/25 11:11am V32 (Care plan Coordinator) said R13 does not have a plan of care in place for obstructive sleep apnea, or use of BIPAP machine. V32 said she initiated the refusal care plan for R13 on 5/14 when she was made aware that R13 refuses the machine. V32 said she did not conduct an assessment of R13 to inquire if R13 is refusing her BIPAP machine. V32 said she is not aware that R13 did not have a BIPAP in place for her to use for 5 days from 5/8/25 to 5/12/25. V32 said R13 should have a care plan in place for obstructive sleep apnea and use of BIPAP machine and the plan of care should have been reevaluated if R13 was reusing the machine. V32 said R13 plan of care should be individualized to her. R13 care plan was reviewed, R13 does not have a plan of care in place for use of BIPAP machine and medical diagnosis of obstructive sleep apnea. Facility policy titled Physician Orders with last revision date 1/2023 denotes in-part physician orders may be written by the provider or received by telephone by a licensed nurse or other licensed or registered healthcare specialist who are legally authorized to do so.

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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)

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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)

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

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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)

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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.

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on observation, interview and record review, the facility failed to monitor and implement effective interventions for one resident at risk for malnutrition. This affected one of three residents (R113) reviewed for weight loss. This failure resulted in R113 sustaining a 34.8 percent unplanned weight loss in less than 6 months. Findings include: R113 was admitted to the facility on [DATE] with a diagnosis of diabetes, muscle wasting, dysphagia, seizures and gastrostomy status. R113 's Minimum Data Set, dated dated dated [DATE] documents substantial/maximal assistance with eating. On 5/15/25 at 2:00PM, R113 weight was taken via mechanical weight lift by staff. Weight scale was set to 0 prior to weighing. Resident weight was 133 pounds. R113's weight on 12 /25/24 documents 201 pounds; 2/5/25 documents weight of 199 pounds, 2/19/25 documents 132.2 pounds; 3/5/25 documents 132.8 pounds, 3/7/25 document 132.8 pounds; 4/1/25 documents 131.6 pounds; 5/6/25 document 129 pounds, 5/14/25 documents 129 pounds R113's 12/20/24 dietary note documents: R113 receiving continuous feeding with nothing by mouth status. R113's eternal feed order dated 1/16/25 documents eternal feeding 1.2 bolus 250 ml two times a day. (900 calories, 40 grams of protein) R113's dietary note dated 2/23/25 documents: enteral feeding 250 ml bid bolus (nutrient content 900 calories, 40.5 gm protein, 363 ml free water and water flush 250 ml four times a day. (total water 1363 ml) excluding oral intake. has puree 1:1 pleasure feeding order intake 50-75%. Weight history: 2.5.25 199, 12.9. 24 201, 11.6.24= 199, 10.9.24 = 200 Height 59 Body Max Index 40.2 estimated Kcals needs: 1420-1704 adjusted BW (25-30); estimated protein needs: 54-65 (1.0-1.2); estimated fluid needs: 1420-1704 (25-30 ml); Skin: intact; Plan: Continue Enteral Nutrition and water flush as ordered. Monitor tolerance to Tube Feeding and follow up as needed. R113 dietary evaluation documents high risk for malnutrition. Question accuracy of 199 weight on 2/5/25. Estimated caloric needs 1510-1812 calories. Under intake variable intake 50- 75 % is fed by staff. Under comments: significant change continues, artificial nutrition with no new orders or interventions documented. R113's dietary note dated 4/26/25 documents: EN: feeding 250 ml bid bolus (nutrient content 900 calories, 40.5 gm protein, 363 ml free water and water flush 250 ml Four times a day. (total water 1363 ml) excluding oral intake. has puree 1:1 pleasure feeding order intake 50-75%. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Weight t history: 4.1.25= 131.6, 2.7.25= 132.8, 2.5.25 199, 12.9.24 201, 11.6.24= 199, 10.9.24 = 200 Height 59 inches Body Max Index 29.6. Weight loss 34% in 180 days discussed in Nutrition at Risk meeting 4.9.25 and 3.12.25 and secondary to acute kidney failure estimated. Kcals needs: 1495-1794 kcal; estimated protein needs: 54-65 gm (1.0-1.2); estimated fluid needs: 1495-1794 cc; Skin: intact; Plan: Continue Enteral Nutrition and water flush as ordered. monitor tolerance to Tube Feeding and follow up as needed. On 5/16/25 at 10:09 AM, V45 (dietician) said R113 had a significant weight loss of 34 percent based on weight of 199 pounds to 131 pounds. V45 said R113 was on continuous artificial feeding and orders was changed in January to receive feeding twice a day which is about half of her caloric intake due to R113 eating by mouth. V45 said in February she questioned the weight and asked for reweight which indicate same weight. V45 said she begin to question the accuracy of all R113 weight from august 2024 through January 2025 saying she was unsure if R113 ever weighed 200 pounds and was always around 130. After a significant weight change depending on resident, we will monitor weights weekly, implement supplements or caloric counts. V45 was unable to provide any additional information related to any interventions or monitoring down for R113 weight and requesting to review her notes. At 11:29AM, V45 was not able to present any new information related to R113, except that she reviewed her hospital weights which did not match but said they do not use hospital weights calculate weight changes. V45 said R113's weight was stable at 130 pounds and no further interventions were placed. On 5/16/25 at 1:09PM, V50 (Nurse Practitioner) said he was not able to recall any concerns related to R113 having a significant weight loss. V50 recalls receiving reports of R113 not eating good possible to mood. V50 was shown R113 weights and was unable to explain the change or any interventions put in place. Facility weight management policy reviewed 6/24 documents: to establish a policy for the consistent, timely monitoring and reporting of resident's weights. Weekly weights will also be done with a significant change of condition, food intake decline or with physician order. The director of nursing will forward dietary recommendations to the physician or nurse practitioner will follow up with recommendations within 24- 48 hours.

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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)

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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.

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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)

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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)

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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 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.

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38796 Based on observation, interview and record review the facility failed to provide a safe home like environment and ensure that a power strip was not resting in the bed for one of one resident (R57), reviewed for safe home environment. Findings include: R57 face sheet shows diagnosis of hemiplegia and hemiparesis. 05/13/25 10:44 AM R57 observed resting in bed, a white power cord was observed resting in the bed, down towards the foot of the bed. R57 was not able to reach the power cord or any of the items that was plugged in the power strip. 5/13/25 at 10:50am V33 CNA said the power strip should not be in the bed. V33 identified the power strip was on (red light illuminating). V33 repositioned the power strip between the mattress and the wall. The power strip was still resting on the bed sheets. V33 identified that R57's hearing aides were also plugged in the power strip. On 5/15/25 at 2:04 pm R57's power strip was observed resting in the bed, down toward the foot of the bed. There were multiple items plugged into the power strip. The red light was illuminated on the power strip, indicting it was in the on position. V34 said the power strip should not be in the bed; it is a safety hazard. Policy for titled hazards and supervision with last revision date denotes the facility shall establish and utilize a systemic approach to address resident risk and environment hazard to minimize the likelihood of accidents.