

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2024
NAME OF PROVIDER OR SUPPLIER Bria of River Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 14500 South Manistee Burnham, IL 60633	

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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>02569</p> <p>Based on observation , interview, and record review, the facility fails to provide a safe, functional, sanitary, and comfortable environment for residents in 10 of 12 resident rooms observed for maintenance of interior surfaces.</p> <p>Findings include:</p> <p>The following was observed on 6/8/24 with V7 (Maintenance Director) .</p> <p>R15's room wall damage next to toilet room door. Metal door jamb is rotted through.</p> <p>R11's room wall damage at floor wall junction.</p> <p>R12's room wall damage at floor wall junction.</p> <p>R13's room large hole in wall behind headboard of bed.</p> <p>R3's room wall behind toilet large hole rotted through wall .</p> <p>R4's room wall damage in toilet room.</p> <p>R5's room hole in wall at floor wall junction in toilet room .</p> <p>R8's room holes in walls at wall floor junction.</p> <p>R9's room holes in walls at floor wall junction.</p> <p>R10's room holes in wall behind headboard of bed.</p> <p>On 6/9/24 at 1PM, V7 (Maintenance Director) stated, I am aware of the wall damage in the residents rooms. We are currently re-doing resident rooms and common areas throughout the facility.</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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Facility policy titled General Policy For Environmental Services, dated 6/2015, states Policy Statement : This policy outlines the guidelines and procedures for maintaining cleanliness , hygiene , and proper repair within the premises of the skilled nursing facility . The policy aims to create a safe and comfortable environment for residents, staff , and visitors , while also complying with applicable regulations and standards.</p>		