

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  04/06/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38796</p> <p>Based on the interview and record review, the facility failed to protect the resident's right to be free from physical assault/abuse for a resident R9 by the V10 (Activity Aide/CNA). V10 grabbed R9 by the arms, took R9 down to the floor, landed on his back, and held R9 down. This failure resulted in R9 subsequently complaining of pain, He was sent to the hospital and diagnosed with acute bilateral lower back pain and elbow and thumb pain; R9 said he was scared this would happen again. This affects one of three residents (R9) reviewed for physical assault/abuse.</p> <p>Findings include:</p> <p>R9 face sheet shows R9 has muscle wasting and atrophy, anxiety, and right ankle contracture. MDS dated [DATE] section show other behaviors symptoms not directed towards others.</p> <p>On 4/4/25 at 10:11am R9 was observed to be alert to person, place, time and situation. R9 said V10 hit him and slammed him to the floor. R9 said this happened by the fire extinguisher near the Nurses station, R9 escorted surveyor to the area. R9 identified V10 as the perpetrator. R9 said V10 did this to him because V10 told him he (R9) was talking sh#. R9 said all he wanted to do was smoke. R9 observed with unsteady gait, R9 can make his needs known, some sentences R9 must take his time to explain. R9 said his back hurts. R9 observed with an abrasion to the right elbow area the size of a dime.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/4/25 at 10:30 am, V10 (activity aide/CNA) said around 7:40am on Tuesday (4/1/25), V12 (LPN) informed him that R9 could not smoke because he refused to get his blood drawn or something with the lab. V10 said he observed V12 walking and pointing her finger at R9, saying that R9 could not smoke. V10 alleges that R9 was walking behind V12, saying he wanted to smoke and that he has a right to refuse a blood draw. V10 said that's when he intervened and approached R9 by standing in front of R9. V10 demonstrated that he and R9 were inches away from each other's space. V10 alleges R9 was became aggressive by making some movements with his gait. V10 said he has observed R9 having those movements in the past. V10 said R9 had his tablet in one hand and alleges R9 swung on him. V10 said he grabbed R9 bilaterally by the arms. V10 demonstrated that he was holding R9 arms just below the wrist. V10 said he took R9 down to the floor onto his back. V10 said he held R9 down to the floor and continued to hold R9 arms/wrist. V10 said he heard someone yell security. V10 said security came and continued to hold R9 down (V10 demonstrated how he observed V18 kneeling down on one side of R9, holding R9). V10 said he performed CPI (Crisis Prevention Intervention) on R9. V10 said he don't know the whereabouts of the Nurse when asked why the Nurse didn't assist you with CPI. V10 then said everybody came to the incident. V10 said he doesn't know staff names, only V18 (Security) name. When asked to whom he reported this incident, V10 said the social worker V14 (Social Worker) and a short lady knew about it. V10 said the social worker asked him if he was okay and if he needed to get checked out. V10 was asked why he didn't step back when R9 was allegedly aggressive and swung at him; V10 said R9 swung but didn't contact him because he grabbed R9's arms. V10 said he's not going to let any resident hit him. V10 was asked if he had the ability to step away from R9 before R9 allegedly swung at him. V10 said R9 tablet was on the floor somewhere. V10 was asked why he didn't call a code if R9 was displaying aggression. V10 said someone called security. V10 said he was not trained to take a resident by their arms and take them to the ground in the manner that he demonstrated for R9.</p> <p>4/4/25 at 11:08am V18 (security staff) said he did hold R9 down, he heard someone call security, he responded, he got between R9 and V10 and escorted R9 to his room. V18 said R9 was already standing when he got there. V18 said he don't know who picked R9 up from the floor. V18 said he don't recall who all was at the scene of the incident. V18 said he don't know why V10 involved him in that incident.</p> <p>On 4/5/25 at 1:25pm, V14 (Social Worker) said she was off duty on April 1st, and V10 did not report anything to her.</p> <p>On 4/5/25 at 3:03pm V6 (social service Director) said she was the social worker that asked V10 was he okay and if he needed to go get checked out. V6 said V10 did not inform her that he grabbed R9 by the arms and took R9 down to the floor and held R9 down CPI. V6 said that is not how CPI is performed, V6 said the staff is trained on CPI. V6 said if a resident is being aggressive the staff should announce a code yellow. V6 said code yellow for when the staff needs all staff to respond, it could be for behaviors it could be for aggressive residents, it could be for anything. V6 said its not a policy it is a protocol. V6 said she did not come on duty until 8:30am on 4/1/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/4/25 at 1:15pm, V12 (LPN) said she did not tell V10 that R9 could not smoke. V12 said the lab staff reported to her that R9 did not want to get his blood drawn and she went into R9's room to educate R9 on importance of getting his blood drawn, V12 said R9 continued to decline the blood draw. V12 said R9 said he wanted to smoke. V12 said her and R9 left the room at the same time. V12 said did say he wanted to smoke. V12 said she went into the Nurse medication room, to finish up. V12 omitted that R9 continued walking behind her in any threatening manner. V12 said a little while after she was summoned to give R9 a PRN (as needed medication for behavior). V9 said V10 did not inform her that he initiated and performed CPI on R9. V12 said V10 did not inform her that he grabbed R9 by the arms and took R9 down to the floor onto his back. V10 said when she administered R9 the medication she only witnessed R9 pacing his room and wanting to come out the room. V12 said R9 did not leave his room.</p> <p>4/4/25 at 11:45am during a phone interview with V2 (acting administrator) V2 said she was not aware that V10 initiated and performed a crisis prevention intervention technique on R9 on Tuesday morning. 4/5/25 at 9:52am, V2 said V10 should have reported to the Nurse or DON that he performed CPI on R9. V2 said V10 informed her that he grabbed R9's arm and took R9 down to the floor. V2 said she has an idea of how V10 did it. V2 said V10 should not grab R9 by the arms, take him down to the floor, and hold him down. V2 said she will educate the staff on CPI and in-service staff on reporting. Facility's initial report to the department was reviewed with V2; V2 said the staff reported to her that the incident occurred around 7:30 am, not 6:30 am, and the staff reported that it happened near the smoking patio door inside, not on the smoking patio. V2 said the 6:30 am was a typo. V2 verified that the two errors were not reported to her by the surveyor.</p> <p>On 4/5/25 at 10:40AM, V11 (Activity Director) said V10 informed her on Thursday 4/3/25 (V10 came to her office) and stated that there was a situation with him and R9 and he did CPI on R9. V11 said she did not ask details and V10 did not provide further details. V11 said she only mentioned in stand-up meeting that there was a situation, she did not inform V17 (Assistant administrator) or V3 (Director of Nursing) that V10 performed CPI on R9. V11 said V10 should not have grabbed R9 by the arms and taken R9 down to the floor unto his back and held him (R9) there. V11 said that is not CPI. V11 said that is not how V10 was trained to do CPI.</p> <p>On 4/5/25 at 9:18am V3 (Director of Nursing) said she was not aware that V10 (activity aide/ CNA) initiated and performed a crisis prevention intervention technique on R9, by grabbing R9 by the wrist bilaterally and taking R9 down to the floor and holding R9 in that position. V3 said the Nurse called her that morning and it was not mentioned that V3 performed CPI on R9. V3 said she should have been made aware because it should have been documented and R9 should have received an assessment to check for injuries, the actions of V10 would have been reviewed and the number of staff responded would have been reviewed.</p> <p>On 4/5/25 at 1:43pm V16 (RN) said on Tuesday, 4/1/25 she heard commotion in the hallway, she came out the med room to see what was going on, V16 said it wasn't her patient, so she did not pay attention, and she went back to the Nurses medication room. Review of V16 timecard it is denoted that V15 punched out at 8:00am</p> <p>Using a reasonable person concept is reasonable to believe V16 observed something to know that it was not her patient involved in the commotion.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/5/25 at 2:07pm V15 (Security Staff) said on Tuesday 4/1/25 he heard commotion, saw people standing around but he didn't go down there because he was on his way out the door, V15 said this was around 7:10am-715am, this is a round about time. Review of V15 timecard it is denoted that V15 punched out at 7:30am.</p> <p>R9 progress note dated 4/3/25 at 4:19pm denotes in-part resident came to the nurse station and complained of pain on his right elbow, the writer assessed the resident no swelling noted around resident elbow only little redness noted around, writer immediately notified NP (Nurse Practitioner) new order call x-ray for right elbow for pain. Portable x-ray called, order noted and carried.</p> <p>R9 hospital after visit summary dated 4/3/25 denotes in-part today's visit reason for visit assault and battery, elbow pain, back pain. Diagnosis: acute bilateral low back pain, elbow pain, and thumb pain (left).</p> <p>R9 emergency room record dated 4/4/25 denotes in-part [AGE] year-old male from nursing home after concern of physical altercation 3 days ago. He is complaining of right elbow pain, left thumb pain, lower back pain. Denies LOS loss of consciousness or head trauma. Was requesting X-ray at the facility however did not receive one so wanted to come to ER. States his pain is controlled. Physical exam shows right elbows chamois and tenderness, left thumb chamois and tenderness, no midline lumbar spinal tenderness or chamois. Musculoskeletal positive for pain.</p> <p>The facility abuse prevention policy dated 1/31/25 denotes in-part 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 in order to do so the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that it is within its control to prevent occurrences of abuse neglect exploitation misappropriation of property and mistreatment of residents. This facility is committed to protecting our residents from abuse neglect exploitation misappropriation of property and mistreatment by anyone including but not limited to facility staff, other residents', consultants, volunteers' staff from other agencies providing services to the individual family members or legal guardians friends or any other individuals. Internal investigation all incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident's property occurred, was alleged or suspected.</p> <p>The resident rights for people living in the long-term care facilities denotes in-part your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.</p> <p>Using a reasonable person concept R9 felt humiliated and scared when V10 grabbed him and took him down to the floor and held him down.</p> <p>During this investigation it is conclude that the facility staffs a Nurse, a Security staff observed and heard commotion and did not respond to protect R9 and respond to gather information that could have been reported to the Administrator, Director of Nursing, pertinent information to conduct abuse or mistreatment investigation and potentially remove a perpetrator from duty on 4/1/25.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38796</p> <p>Based on interview and record review the facility failed to follow their behavior management policy and facility practice and document an incident of performing crisis prevention intervention techniques for one of one residents R9 reviewed for behavior management and documentation.</p> <p>Findings include:</p> <p>4/4/25 at 1:15pm V12 (LPN) said she was R9's nurse on 3/31/25 going into that morning of 4/1/25. V12 said V10 did not inform her that he initiated and performed crisis prevention intervention technique on R9, by grabbing R9 by the wrist bilaterally and taking R9 down to the floor and holding R9 in that position.</p> <p>4/4/25 at 2:16pm V13 (LPN) said she was R9 Nurse on 4/1/25 during the morning shift and V10 did not report to her that he initiated and performed crisis prevention intervention technique on R9, by grabbing R9 by the wrist bilaterally and taking R9 down to the floor and holding R9 in that position.</p> <p>4/4/25 at 11:45am during a phone interview with V2 (acting Administrator) V2 said she was not aware that V2 initiated and performed a crisis prevention intervention technique on R9 on 4/1/25. During a follow up interview V2 said V10 made her aware after surveyor informed her of allegation of abuse.</p> <p>On 4/5/25 at 9:18am V3 (Director of Nursing) said she was not aware that V10 (activity Aide/ CNA) initiated and performed a crisis prevention intervention ( CPI) technique on R9 on 4/1/25, by grabbing R9 by the wrist bilaterally and taking R9 down to the floor onto his back and holding R9 in that position. V3 said the Nurse called her that morning and it was not mentioned that V3 performed CPI on R9. V3 said she should have been made aware because it should have been documented and R9 should have received an assessment to check for injuries, the actions of V10 would have been reviewed and the number of staff responded would have been reviewed.</p> <p>On 4/5/25 at 10:40AM, V11 (Activity Director) said V10 informed her on Thursday 4/3/25 (V10 came to her office) and stated that there was a situation with him and R9 and he did CPI on R9. V11 said she did not ask details and V10 did not provide further details. V11 said she only mentioned in stand-up meeting that there was a situation, she did not inform V17 (Assistant administrator) or V3 (Director of Nursing) that V10 initiated and performed CPI on R9. V11 said V10 should not have grabbed R9 by the arms and taken R9 down to the floor onto his back and held him (R9) there. V11 said that is not CPI. V11 said that is not how V10 was trained to do CPI.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy titled Behavior Management dated 9/2023 denotes in-part the goal of the facility is to provide a safe, secure environment. In order to foster a safe environment, a consistent staff approach to behavioral problems and emergencies are necessary. The goal is least restrictive behavioral interventions and move through the steps at increments necessary to maintain a safe environment. Staff should remain calm and professional at all times. Demonstrate empathy and offer reassurance of safety. I understand your situation, you are safe here, you don't need to be afraid. Set verbal limits: please keep your voice down, stop swinging your arms etc. Escort to private area: a quiet room with decreased external stimulation for a short amount of time may help calm the resident and provide privacy. After the incident document in the nursing notes: the resident behavior and/symptoms at the onset. An assessment of the resident. Notification of family/physician and subsequent orders.</p> <p>The facility abuse policy with last revision date 1/31/25 denotes in-part Internal investigation all incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of residents' property occurred, was alleged or suspected.</p>		