STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145898	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Chicago Heights	120 West 26th Street South Chicago Height, IL 60411

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on interview and record review the facility failed to follow their hypoglycemia protocol by not administering glucagon to a resident (R248) with a low blood sugar that was unresponsive for one (R248) out of three residents reviewed for change in condition in a total sample of 20. Findings Include: R248 is a [AGE] year old with the following diagnosis: type 2 diabetes, metabolic encephalopathy, and hemiplegia following a cerebral infarction. A Nursing note dated 1/23/24 documents R248 was observed unresponsive to verbal stimuli. Supplemental oxygen was placed on R248 at 3 L via nasal cannula. 911 was called and R248 was transported to the hospital. A Change in Condition dated 1/23/24 documents R248 was sent to the hospital for altered mental status. The most recent blood glucose test at 9:15AM was 45. There's no documentation that any interventions were performed to address the low blood sugar before the ambulance arrived. The Fire Department record dated 1/23/24 documents the paramedics arrived on scene at 9:13AM for a call of an unresponsive resident that was found ten minutes prior. The first set of vital signs were pulse 144 (normal is 60 to 100), blood pressure 126/78, respiratory rate 24 (normal 12-16), and oxygen level was 95% on room air. Upon arrival, granulated sugar was found in R248's mouth and staff confirmed pouring sugar in R248's mouth when the blood sugar was 60. Glucose was tested at 9:16AM and was 20 (normal blood sugar is 60-100). Intramuscular glucagon was given, and the blood sugar was still low but came up to 48. R248 had a slight improvement to responsiveness at this time. The Hospital Records dated 1/23/24 document R248 arrived to the emergency department at 9:37AM and came in due to being unresponsive after blood sugar was found to be in the 20s by EMS. While in route, EMS gave R248 glucagon, and the blood sugar improved to the 40s. In the ER, R248 was given 1 ampule of D50 and R248 had better improvement to responsiveness. R248 was admitted to a general medicine floor with a diagnosis of hypoglycemia. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 2:29PM, V4(RN) stated V4 was passing morning medication when V16 (CNA) alerted V4 that R248 was unresponsive. V4 reported finding R248 unresponsive and when the blood sugar was checked, it was in the 40s. V4 stated V4 called 911 and a code blue and waited for the ambulance. V4 denied giving R248 glucagon because it wasn't in the med cart. V4 reported that is normally where glucagon is kept, and it was not there so V4 stayed with R248 until ambulance arrived. V4 stated when the ambulance arrived, they gave R248 glucagon and took R248 to the hospital. V4 said, Usually the rule is if they are alert, and their blood sugar is below 80 then you give them some juice to drink to bring it back up. If they are not alert, then you give glucagon. We didn't have any, so I didn't give any. On 4/17/24 at 4:53PM, V16 stated V16 was passing breakfast trays in the morning and noticed R248 was not responding as much as normal. V16 told V4 about R248 having a change in condition and V16 continued passing trays. V16 reported R248 is able to state R248's needs but this morning R248 was not able to speak. On 4/17/24 at 5:04PM, V17 (Nurse) stated R248 did not show any signs or symptoms of hypoglycemia the night before and was sleeping at 5AM during the last rounds. V17 reported nurse's have to give glucagon if the resident's blood sugar is low (less than 60) and they are not responding. V17 stated, if the resident is alert and the blood sugar is low then orange juice is given and to retest again in about 30 minutes. V17 reported glucagon is stored in the pyxis in the medication room and that is where staff need to go to get the medication during an emergency. On 4/18/24 at 9:49AM, V2 (DON) stated V16 was passing breakfast trays and found R248 unresponsive. V2 reported V16 told V4 and V4 found the blood sugar to be low. V2 stated if blood sugar is low, and a resident is unresponsive then glucagon must be given to help raise the blood sugar. V2 reported in this situation glucagon should have been given due to R248 being unresponsive and the blood sugar being in the 40s. V2 stated glucagon is located in the emergency medication box in the medication room that all nurses have access to. The Physician Order Sheet documents an order for blood sugar checks to be done three times a day. There was an order for Humalog insulin placed on 1/7/24. That is a sliding scale to be given with meals. Instructions in the medication order document to notify the physician and initiate the hypoglycemia protocol if blood sugar is less than 70. The Medication Administration Record dated 01/2024 documents the sliding scale Humalog insulin ordered blood sugar checks with each dose to be given. The blood sugar on 1/23/24 at 7:30 AM was 45. The blood sugar was noted to be low at 45 when taken at 9:15AM on 1/23/24 per the vital sign's documentation. The SBAR Communication Form dated 1/23/24 documents R248 had an altered mental status that began this morning. R248 is a diabetic and had a blood sugar of 45. R248 has an altered level of consciousness. The Hospital Transfer Form dated 1/23/24 documents the key reason for transfer was respiratory arrest. R248 has a heart rate of 146, respiratory rate of 24, blood pressure of 115/81, and oxygen level of 97%. R248 was alert but not oriented and cannot follow simple instructions. R248 does not have any skin concerns. 3 L of oxygen via nasal cannula was given. R248 was unresponsive and lethargic. Neither of these forms have any documentation addressing what the facility did for the low blood sugar while waiting for the ambulance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 12/6/23 documents R248 is at risk for hypo/hyperglycemia related to type 2 diabetes. An intervention documented is to monitor/document/report to the physician any signs or symptoms of hypoglycemia that includes sweating, tremors, increased heart rate, nervousness, confusion, slurred, speech, lack of coordination, and staggering gait. The policy titled, Hypoglycemia Protocol, dated 09/2022 documents, General: To provide guidelines for residents who were presenting with hypoglycemia signs and symptoms. 1. Hypoglycemia is defined as blood glucose of less than 70 .3. If semiconscious, unconscious, uncooperative, unable to swallow, or is NPO: administer 50 mL of D50W (1 amp) slow push and start IV D5W at 100 mL/hour. If no IV access: Glucagon 1 mg subcutaneously or IM, then establish an IV access and start IV D5W at 100 mL/hour. Repeat glucose, check and treatment every 15 minutes until greater than 70 mg/dL.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34069 Based on observation, interview, and record review, the facility failed to follow R44's Fall care plan by not placing the call light within reach. This failure affected 1 resident (R44) of 2 reviewed for falls in a total sample of 20. Findings include: On 4-16-24 at 11:05 AM, R44 was resting comfortably in bed. Surveyor noted R44's call light clipped on the privacy curtain which was approximately 3 feet away from R44. Surveyor noted R44 was unable to reach for the call light. On 4-16-24 at 11:05 AM, R44 said she has a history of falls. R44 said her legs gave out the last time she fell . R44 said she got up by herself and did not notify staff for assistance. R44 said as a result of her fall, the staff told her to call for assistance when getting up. Surveyor asked R44 to activate her call light and R44 said she cannot reach her call light when it is clipped to the curtain. On 4-16-24 at 11:10 AM, V7 (Certified Nurse Aide) observed R44's call light clipped to the curtain and verified R44's call light was out of R44's reach. V7 said call lights should be in reach of the residents. On 4-16-24 at 11:14 AM, V8 (Licensed Practical Nurse) said it is staff's responsibility to ensure call light is in reach for all residents. V8 said if R44's call light is clipped to the curtain, R44's call light was not in R44's reach. Fall Report dated 2-2-24 documents: Incident description: Pt was observed lying on her back in front of her bed by CNA. Writer was called. Pt was assessed- able to move her hands asking for help to get up while laughing. Resident was assisted back to her wheelchair with 2- assist. No injury, no s/s of concussion. Pt A&O 2-3, no change in mental status/ within normal baseline parameters. Resident Description: Resident stated that she was trying to transfer to her wheelchair when she stumbled and fell . I fell on my buttocks and my buttocks hurt, she added laughing. Asked if she hits her head, resident denies hitting her head. Rated pain to her buttocks as 4/10. Fall Investigation dated 2-2-24 documents: RCA: resident attempted to transfer to wheelchair without staff assistance. R44's Fall Care Plan initiated 5-17-23 documents: Interventions: Promote placement of call light within reach and assess residents' ability to use (initiated 1-25-24). Fall Prevention and Management dated 1-22 documents: General: This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While programming all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50382 Based on observation, interview, and record review, the facility failed to label multi-dose medication for one of two medication rooms observed for medication storage and labeling. This failure has the potential to affect all 93 residents currently residing in the facility. The facility also failed to discard expired glucagon from their emergency medication box. This deficient practice has the potential to affect all 13 diabetic residents in the facility. Findings include: 1. On [DATE] at 9:49AM during Medication Storage and Labeling observation with V2 (Director of Nursing), the first-floor medication storage room was observed with two vials of opened, undated Tuberculin, Purified Protein (Mantoux) 5TU/0.1ml, 10 dose vial. During an interview on [DATE] at 10:05AM with V2, V2 stated that she confirmed with pharmacy that the multi-dose vials should be labeled with an open or accessed, and discard date 28 days unless manufacturer specifies a different (shorter or longer date) as stated in the facility policy. Facility policy titled: 5.21: Vials and Ampules and Guideline Storage of Medications. All vials and ampoules of injectable medications are used in accordance with the manufacture's recommendations. 6. Expiration of multi-dose vials. a. If a multi-dose vial has been opened or accessed, the vial should be dated and discarded within 28 days unless manufacturer specifies a different (shorter or longer) date. b. If a multi-dose vial has not been opened or accessed, it should be discarded according to the manufacturer's expiration date. 40102 2. On [DATE] at 2:55PM, this surveyor asked V2 (DON) to open the pyxis to show the surveyor the glucagon. V2 stated the emergency medication box is located in the cabinet in the medication room. At 3:07PM, V2 opened the cabinet that housed the emergency medication box and showed the surveyor two glucagon syringes. The expiration date of both glucagon syringes was documented as ,d+[DATE]. V2 stated that medication should have been discarded at the end of ,d+[DATE] and should've been replaced with glucagon that is not expired. V2 reported no residents should be given expired medication even in an emergency situation. There are currently 13 residents in the facility that get their blood sugar checked and are prescribed insulin. This expired medication can affect all 13 residents. On [DATE] at 9:49AM, V2 stated the emergency box is pharmacy's responsibility to remove expired medication. V2 reported the facility is responsible for checking the med carts and the med room while the pharmacy is responsible for the pyxis and medication cabinet. V2 said the emergency medication box should be checked every month. V2 was unaware if pharmacy checked the emergency medication box last month. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:03PM, V15 (Pharmacy Consultant) stated the pharmacy contracted with the facility is responsible for coming to pick up the expired medication. V15 reported V15 runs a report in the pyxis each month to see what medications need to be removed and then a list is compiled and sent to the pharmacy. V15 stated the pharmacy is then responsible for coming to pick up the expired medication and replace it with new medication. V15 reported last running the report on [DATE] and did not see glucagon on the report of expired or soon to be expired medication. V15 denied checking the emergency medication box to see if any medication was expired. V15 was unable to answer why the expired medication was not picked up by the pharmacy. The expired glucagon was photocopied. Both syringes are labeled glucagon emergency kit for low blood sugar. Both syringes expired on ,d+[DATE]. The policy titled, Storage of Medications, dated ,d+[DATE] documents, Purpose: To provide the staff with guidance on proper storage of medications . 11. Outdated, contaminated, or deteriorated medications - and those in containers that are cracked, soiled or without secure closures should be immediately removed from stock and disposed of according to medication disposal procedure. If necessary, medications should be reordered from the pharmacy.