STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145898	A. Building B. Wing	07/18/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedures for protecting residents from abuse by not ensuring staff were monitoring residents in the dining area who were at risk for abuse and with a history of aggression and by not ensuring adequate staff supervision was provided for residents involved in a physical altercation. This failure applied to two of five residents (R4 and R5) reviewed for abuse. Findings include: R4 is a [AGE] year-old male with a diagnosis's history of Schizophrenia, Delusional Disorders, Bipolar Disorder, Dementia, and Legal Blindness who was admitted to the facility 05/24/2024. R4's most current care plan documents he has a history of mood swings, impulsive behavior, related to a diagnosis of Bipolar Disorder and is at risk for abuse related to severe mental illness. R4's progress notes dated 6/19/2024 document he was involved in an argument with another resident in the Dining Hall while waiting for breakfast. The argument, as per eyewitness report, escalated within minutes and R4 was hit in the face. R4 was hit below his right eye and left forehead & sustained redness and swellings. The physician was notified and gave orders to send R4 to local hospital for evaluation. R4 was given pain medication for complaint of pain to the right eye. R4's Hospital Report dated 06/19/2024 documents he was evaluated at the emergency room by a physician at 11:25 AM due to being the victim of an assault by another resident at the facility, he reported he was punched multiple times in the face, head, and lower neck just before arriving to the emergency room and was observed with a headache, facial strain, contusion, and minor head injury, R4 was discharged back to the facility with diagnoses including being a victim of assault batter, minor head injury, contusion (bruise) to the face, and myofascial cervical strain (pain around a certain area of the face that is sensitive to pressure) with instructions to apply a cool compress to the area and use over the counter acetaminophen for symptom relief. R5 is a [AGE] year-old male with a diagnosis's history of Schizoaffective Disorder who was admitted to the facility 04/25/2024. R5's current care plan initiated 04/26/2024 documents he has a history of aggressive, inappropriate, and/or maladaptive behavior. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress note dated 6/19/2024 documents R5 was involved in an argument with another resident in the Dining Hall while waiting for breakfast. The argument, as per eyewitness report, escalated within minutes and R5 slapped the other resident in his face. Facility Reported Incident Investigation Report for incident of 06/19/2024 documents R4 reported R5 became verbally abusive to him and asked R5 to leave him alone, R5 refused which resulted in a verbal altercation, R5 then hit him, R4 was then observed with a swollen right eyebrow; V22 (Social Services) reported that R5 exhibits delusional behaviors sometimes; R5 has been observed with delusional behaviors since admission and his admission paperwork shows a history of aggressive behaviors, delusions, erratic behaviors, and poor impulse control. Witness statement from V18 documents on 06/19/2024 she entered the dining room in response to a commotion and observed chairs knocked over and a resident on the floor, observed R5 screaming and yelling at R4, observed R4 run towards R5 and threaten to hit him, observed R4 's right eye swollen, observed R5 become verbally abusive to R4 which resulted in a verbal altercation, observed R5 then physically attack R4 and knocking things down, she was the only Certified Nursing Assistant in the room while attempting to stop R5, she could not stop R5 and began screaming to the top of her lungs for over a minute before other staff entered the dining area, it took two staff to stop R5, she observed R4 leaned over a chair being hit in the head and back of his neck. On 07/16/2024 at 10:36 AM V11 (Certified Nursing Assistants) stated she was present on the day of the physical altercation with R5 and R4. V11 stated she heard a commotion coming from the dining room while taking care of a resident she was preparing for breakfast. V11 stated when she arrived to the dining room R5 was yelling at R4 and R4 was agitated but R4 is blind and couldn't see. V11 stated she believes they were arguing before she came in the dining room because she heard R5 yelling which made her go in the dining room. V11 stated this incident occurred just prior to breakfast and there were more than ten residents in the dining room at the time. On 07/16/2024 at 11:11 AM V15 (Housekeeping Assistant Manager) stated on 06/19/2024 he was buffing the floors in the hallway on the east side of the building and heard a lot of arguing in the dining area and responded to see what was going on. V15 stated he went into the dining room and saw R5 and R4 were continuously arguing. V15 stated V11 (Certified Nursing Assistant) and another newer Certified Nursing Assistant whose name he could not recall were already in the dining room with R5 and R4. V15 stated they were both trying to de-escalate the situation and calm the residents down. V15 stated at this time V11 had to leave the dining area to return to a resident she was assisting, and he told her it was fine to leave, and he and the Certified Nursing Assistant will take care of the situation. V15 stated he and the female Certified Nursing Assistant were redirecting R5 and R4 and attempting to calm them down. V15 stated the situation then de-escalated for a few minutes and both residents were quiet, so he went to report the incident to V14 (Nurse Supervisor). V15 stated while reporting the incident to V14 they heard really loud arguing coming from the dining room so they both returned to the dining room quickly. V15 stated when he and V14 arrived to the dining room R5 and R4 were grabbing each other. V15 stated the female certified nursing assistant was still in the dining area with R5 and R4 and she was trying to push R5 and R4 apart but couldn't get them apart. V15 stated he and V14 were able to physically separate R5 and R4. V15 stated he believes the certified nursing assistant didn't want to get hurt during the altercation. V15 stated if an activities aide is not present with the residents in the dining area, then a certified nursing aide is present because the residents have to be monitored at all times. V15 stated he didn't hear any staff calling out for help during this incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 12:03 PM V18 (Certified Nursing Assistant) stated on 06/19/2024 while in a resident's room she heard commotion, she headed to the dining area and she and another coworker V15 (Housekeeping Assistant Manager) arrived there at the same time. V18 stated when she arrived to the dining room, she could tell that there had been an altercation and that R4 was yelling and said to R5 why did you hit me. V18 stated while R4 was saying this he was moving towards R5 as if he wanted to hit him back. V18 stated she did observe R4 with a red bruise near his right eye when he made the statement about R5 hitting him. V18 stated there were no other staff present before she and V15 arrived to the dining room, there were more than five residents present and more were coming in and out of the dining area as well. V18 stated she and V15 diffused the situation, V15 helped R4 back to his chair, R5 was walking towards the door to leave out and she picked up the knocked over chairs. V18 stated while V15 went to go get the nurse she remained in the dining room. V18 stated R5 then returned to the dining area, began cursing at R4 and threatening to hit him again. V18 stated R4 told R5 to do it and R5 ran over to where R4 was sitting. V18 stated she tried to stop R5, but he rushed through her and began punching R4 who had stood up when he heard R5 approaching. V18 stated R4 also struck back at R5. V18 stated R4 then tried to run away, she screamed for help, and R5 began striking R4 again from the back while he was running away. V18 stated she called for help again and then multiple staff came into the dining room and separated R5 and R4. V18 confirmed she screamed for over a minute before any staff came into the room during the incident. V18 stated there should always be more than one staff present with residents when they are in the dining room because you never know when situations like this could happen. V18 stated it was challenging to attempt to separate R5 and R4 during a physical altercation and protect another female resident who was present from being hurt from the fall out. V18 stated there is supposed to be at least one staff in the dining room monitoring the residents, but it was so early in the morning, we were changing shifts, and we were getting people up to go to the dining room and it was a lot. V18 stated she was in the middle of preparing a resident to come in the dining room whose room was directly next to the dining room and that is how she was able to hear the commotion. On 07/16/2024 at 1:03 PM V4 (Assistant Administrator) stated there are usually two activity aides in the dining area and they are always there except during their breaks. V3 (Director of Nursing) stated there is usually a CNA (Certified Nursing Assistant) in the dining room in the morning while other aides bring residents to the dining area for breakfast. V4 stated if an altercation occurs and there is a commotion a code is called, and staff respond quickly to assist. V4 stated the facility is small and the kitchen is also close by the dining area therefore staff should be able to respond immediately for any commotion or disruptions. V4 stated there should always be at least one staff in the dining area for supervision of the residents. V4 stated if there is only one staff present during an altercation, the staff should attempt to separate the residents while calling for help. V4 and V3 agreed that if there is only one staff present during a physical altercation it could be challenging for the staff present to separate the residents in the altercation. On 07/16/2024 at 2:11 PM V17 (Licensed Practical Nurse) stated at about 8 AM on 06/19/2024 while preparing to pass medication at the nurse's station she heard commotion coming from the dining room and as she approached the dining area V15 (Housekeeping Assistant Manager) and V14 (Registered Nurse) were with R5 and R4 who were already separated after an altercation. V17 stated she took R4 to his room and assessed him and asked what was going on and he responded that he didn't know what was going on, why it happened, or what the argument was about but wanted to call his family and the police. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 2:21 PM V23 (Resident Representative) stated R4 expressed that his back was hurting after the physical altercation he had at the facility. V23 stated R4 said he was going to file a complaint about the person that attacked him. The facility's Abuse Policy received 07/16/2024 states: It is the policy of this facility to prevent abuse of our residents. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to adequately monitor and supervise a newly admitted resident with a known history of falls, confusion, and assessed to be at risk for falls. This failure applied to one (R3) of three residents reviewed for falls and resulted in R3 sustaining a laceration to her left eyebrow that required transfer to local hospital and treatment with sutures after a fall in the facility hallway. Findings include: R3 is a [AGE] year-old female admitted to the facility on [DATE]. R3's past medical history includes, but not limited to: unspecified dementia without psychotic disturbance, mood disturbance and anxiety, essential primary hypertension, hypothyroidism, etc. Fall risk assessment dated [DATE] scores resident as 21, indicatind a high risk for fall due to impaired memory or judgement, unsteady gait, and history of falls in the past 1 -6 months, status post fall and/or fracture in the past 6 months. Minimum data set assessment (MDS) dated [DATE] section C (cognitive pattern) documented that R3 has a memory problem, and R3's cognitive skills for daily decision making are moderately impaired. R3 was also assessed as having inattention with disorganized thinking. Section GG (Functional status) of the same assessment documented that R3 required partial to moderate assist for all Activities of daily Living (ADL) care and requires supervision for walking 10 to 50 feet. Interim fall care plan dated 6/14/2024 documented that R3 is at risk for falls, interventions include call light within reach, provide clutter free environment, provide proper well-maintained footwear. There was no provision for any type of assistive device for the resident. Progress note dated 6/16/2024 at 1:03AM states the following: Staff reported to the writer that the resident was observed on the floor of the hallway sitting with a laceration to her left eyebrow with moderate bleeding. Pressure applied to area. PROM performed to bilateral upper and lower extremities without limitation. Resident transferred to wheelchair with standby assist. Resident unable to give statement of incident, 911 called for transportation to the hospital. Ambulance run sheet dated 6/16/2024 states in part: dispatched to location for fall victim, crew found patient at the nursing station in wheelchair, nurse stated that patient was walking in the hallway when she fell and one of the residents came and told the nurse, staff did not witness the fall, patient had a 2 inch laceration above her left eyebrow. Hospital record dated 6/16/2024 documented in part: chief complaint fall, diagnosis laceration to left eyebrow, bleeding controlled. Under history, the document states in part: [AGE] year-old female brought by ambulance for evaluation of facial laceration. Patient was found on the floor in the hallway at her facility. She has a history of frequent falls, and she has known dementia. R3 underwent a laceration repair, length was documented as 4 inches, requiring some sutures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/16/2024 at 2:30PM, V3 (DON) said that she is not very familiar with R3, she came to the facility on a Friday and fell a day or two later, the family stated that resident sustained some injuries requiring sutures, facility was unable to obtain the hospital records because resident was not returning to the facility. V3 stated that she spoke to the nurse that was assigned to the resident and she said that resident was very confused, she was ambulatory with an unsteady gait, she was alerted by the CNA that the resident fell in the hallway, the fall was not witnessed. On 7/16/2024 at 4:32PM, V20 (LPN) said that she recalls R3, she was alert with some confusion, ambulatory with an unsteady gait. Resident will be considered a fall risk due to her unsteadiness, her fall incident occurred on the night shift between 12:00 and 1:00AM, R3 was not yielding to redirection and was continuously walking up and down the hallway. V20 said that she was notified by another nurse that the resident was on the floor, when V20 arrived at the scene, she noted moderate amount of blood coming from a laceration to the resident's left eyebrow, V20 applied pressure to the site and assessed the resident, no other injuries were noted. V20 said that the bleeding continued, she called the doctor and received an order to send the resident to the hospital, V20 called 911 and notified the daughter/POA. On 7/17/2024 at 1:55PM, V24 (RN) stated that she is the fall coordinator for the facility. When residents are newly admitted , the admitting nurse evaluates the resident and initiates a baseline care plan and any required interventions, the entire care plan will then be completed according to facility policy. V24 said that R3 was admitted to the facility on a Friday evening and had a fall incident on Sunday. Residents should be monitored during the night shift, the CNAs are supposed to stay close to resident's rooms for monitoring and to see the call lights. Nurses and CNAs are also supposed to round every 1 to 2 hours on residents, resident interventions should be individualized and for a new resident that is confused, and being a fall risk, staff could have tried putting her on a one-to-one supervision or have her sit in a wheelchair and put her in the nursing station. On 7/17/2024 at 11:18AM, V27 (CNA) said that he works the 11:00 PM to 7:00 AM shift and was assigned to R3 the day she had a fall, he did not witness the fall incident because he was in another room with another resident, he was informed that the resident fell by another staff. V27 added that the CNAs are supposed to monitor the hallway, but they usually do that after rounds, while they are rounding, he does not think that anyone monitors the hallway because all the CNAs are rounding at the same time. Fall prevention and management policy revised 07/2022 stated in part that the facility is committed to maximizing each resident's physical, mental and psychological well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies and facilitate as safe an environment as possible. Under guidelines, the policy states: a fall risk evaluation will be completed upon admission, readmission and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified in the interim plan of care and the ISP with interventions implemented to minimize fall risk.