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	11/18/2025

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 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** Based upon interview and record review the facility failed to follow policy procedures, failed to ensure that fall risk assessments were accurate, failed to utilize the falling star program for identified high risk residents, failed to ensure that staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, failed to provide supervision, and/or failed to ensure that responsible staff are aware of root cause of fall - to prevent additional falls for three of three residents (R1, R3, R4) reviewed for falls. These failures resulted in R1 sustaining an unwitnessed fall on 11/10/25 which resulted in facial injuries and anterior wedge compression fracture of L1 vertebral body. Findings include:The falling star program guidelines state residents will automatically be placed on the Falling Star Program if: at the discretion of the IDT (Interdepartmental Team) based on risk factors (BIMS score 0-7, unsteady gait, >2 antipsychotic medications, poor safety awareness, 10 or higher score on fall evaluation form). 1.R1's diagnoses include frontotemporal neurocognitive disorder, Alzheimer's disease, unsteadiness on feet, and abnormalities of gait/mobility.R1's (8/1/25) BIMS (Brief Interview Mental Status) determined a score of 5 (severe impairment) and inattention is present/fluctuates. R1's (8/1/25) functional assessment affirms resident requires supervision or touching assistance for walking. R1's (6/18/25) fall risk assessment determined a score of 10 (high risk). R1's (7/16/25) fall risk assessment (1 month later) determined a score of 8 (at risk) however confused not selected as warranted. R1's (9/3/25) care plan states resident is at high risk for falls related to recent fall, cognitive deficits, and use of psychotropic medication. Interventions: encourage resident to keep room free of obstacles/clutter, keep frequently used items within reach, promote placement of call light within reach, rounding at a minimum of every 2 hours [Falling star program was excluded].R1's (11/10/25) 3:00pm incident report states resident was seen 15 minutes before incident, writer took him to the room and sat him on the bed. Resident was observed by CNA (Certified Nursing Assistant) standing behind the room door, holding onto door handle. On examination noted abrasion on bridge of nose, below left eyelid and hematoma on left side of his head. Writer Nurse was notified. Nurse Practitioner notified and together assessed resident. Resident is alert x1 and unable to verbalize. Roommate is alert oriented x2-3 later stated that resident fell in the room. Medical doctor notified and order received to transfer resident to hospital for further evaluation. Statements: Unwitnessed fall. R1's (11/10/25) post fall risk assessment (documented at 8:17pm) determined a score of 8 however History of falls in the past 1- 6 months was not selected. On 11/12/25 at 1:15pm, surveyor inquired about R1's (11/10/25) incident. V2 (DON/Director of Nursing) stated, He (R1) had a fall in his room. He has frontal lobe dementia and ambulates; he had one slipper on and one off when the aide found him. The roommate said that he fell and got his self up in the doorway. He's supposed to come back from the hospital later today. We (staff) sent him out because his eye looked red and there was a bruise on his forehead. On 11/12/25 at 2:58pm, surveyor inquired about R1's (11/10/25) incident. V4 (Registered Nurse) stated, On the 10th around 2:50pm or thereabout I (V4) saw him (R1) moving toward the exit door, so I said don't go there. He (R1) walked hurriedly towards his room, I was closely following him and held his hand because the way he walks is a shuffled gait and such a (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 0689 Level of Harm - Actual harm Residents Affected - Few	speed as if he was falling. He (R1) himself opened the door and entered. I watched him move towards his bed and he sat on the bed. At that time, his roommate (R2) was in bed covered and resting. I came out and closed the door then I went to my station [R1 was left sitting on the bed and the door was closed - therefore supervision was not provided]. After I attended to other nursing issues around 3 or a little after, one of the CNAs (V6) called and said she saw (R1) has a bruise on the bridge of his nose and some drainage from the right eye. I said what happened, she (V6) said the call light was on and (R1) was standing behind the door holding the handle and she saw drainage coming from his eye. I tried to dab it, and he say it hurts. I further examined him and saw a hematoma on the forehead right side. It was like an abrasion here (bridge of nose) and underneath the right eye you could see like tears running but it was mixed with blood so there must have been some lacerations somewhere that was mixed with the tears. I went looking for the roommate (R2) and said what happened to (R1) he (R2) said I (R2) didn't push him or anything he fell to the ground in his room. On 11/17/25 at 11:21am, R1 was observed lying in bed asleep (alone) in the room. Only one (1) floor mat was adjacent R1's bed however the other side of R1's bed was roughly 1.5 feet away from the wall. V9 (Family) subsequently entered R1's room. Surveyor inquired about R1's (11/10/25) incident. V9 responded, He's (R1) nonverbal and doesn't talk. Before he fell, he would be in the dining room to keep an eye on him. I got a call that he fell around 3:00pm, 3:30pm. They (staff) said that he got up and saw his face was red and swollen. They called the ambulance. The right side of his lip was swollen, and he had a little broken skin on the right eyelid. He likes to walk around but has a shuffled gait and is bent over when he walks. I try to tell him to hold the rail when he walks, he doesn't listen. He gets up and he's gone but I slow him down. There is a definite progression with his walking, a significant decline. I was upset that he fell but he's a sundowner, he's quick. They (staff) sit out there (hallway) and watch him because he's a real go [NAME] you almost need a sitter. On 11/17/25 at 11:17am, V7 (CNA) was assigned to R1. Surveyor inquired how R1 ambulates. V7 stated, I (V7) been here for 2 weeks. The report I got was to feed him and change him, restorative would assist him with getting out the bed and walking and affirmed she was unsure. On 11/17/25 at 12:15pm, V8 (Licensed Practical Nurse) was assigned to R1. Surveyor inquired about R1's fall prevention interventions. V8 stated, He (R1) walks around, and we (staff) monitor him because we don't like him to stay by himself. We redirect him to the dining room when he's up so people can see him. On 11/17/25 at 12:20pm, surveyor inquired about R1's fall prevention interventions. V7 (CNA) stated, He's a 2 person assist to get up and make sure his pad is on the floor. Surveyor inquired if R1 has any other fall preventions interventions. V7 responded, No ma am, it's a strongly with a 2 person assist.On 11/17/25 at 1:57pm, surveyor inquired about R1's risk for falls (prior to 11/10/25). V11 (Restorative Director) reviewed R1's EMR (Electronic Medical Records) and stated, His (R1) fall risk assessment was an 8 on 7/16 (2025), it was a 10 on 6/18/25 (one month prior). The one on 7/16 for his mentation they have impaired judgment marked and for the one on 6/18 they have confused and impaired judgment which can kinda fall into the same thing. The score is based off of what they (staff) have clicked. Surveyor inquired if R1 is confused with impaired judgment. V11 responded, He's alert to his self, he's nonverbal so it's kinda hard to necessarily say. He definitely has impaired judgment and he's dementia but is really tricky with him. Surveyor inquired about R1's functional status. V11 replied, He (R1) has a steady gait [R1 has a shuffled gait per V4 and V9] but needs 2-person care because he's resistant. He's ambulatory without assist [R1's functional assessment affirms supervision, or touching assistance is required for walking] but his safety awareness is poor. Surveyor inquired if R1 has a shuffled gait. V11 stated, No [incongruent with V4 and V9's statements]. Surveyor inquired if R1 is bent over while walking. V11 responded, No, not necessarily he walks up and down the hallway fine [incongruent with V4's statement]. Surveyor inquired about R1's fall prevention interventions prior to (11/10/25). V11 replied, Prior to him falling we had encouraged and offered rest periods when walking long distances, keep the room free from obstacles and clutter, monitor resident for tolerance and endurance [falling star program was excluded]. Surveyor inquired about the root cause of R1's (11/10/25) fall. V11 stated, From my (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	understanding the roommate said he tripped and fell when he was in the room and got his self-up. I didn't talk to the roommate, collectively we (DON, ADON/Assistant Director of Nursing) get together and discuss the falls. It was unknown how he fell. The roommate reported that he fell. Surveyor inquired if leaving R1 in the room with the door closed would be appropriate if he's a high risk for falls. V11 replied, He wasn't necessarily a high risk for falls prior to the fall, he does have poor safety awareness. To be left alone with the room closed; if he was resting that would be ok but for a long period of time, I don't think that would be okay. I wouldn't necessarily close the door. Surveyor inquired what care plan interventions were added (post 11/10/25 fall). V11 responded, We put him on the falling star program which means if no ones in the room with him and he's not resting he shouldn't be in the room by himself. It's a certain protocol we have for the falling star, when we see a star on the door, he's a high fall risk, they get hourly rounding or every 30 minutes, so we know when they last saw him and what he was doing. Surveyor inquired if R1 was on the falling star program prior to 11/10/25 fall. V11 replied, No, he got added after he fell. Surveyor inquired why R1 was not on the falling star program prior to 11/10/25. V1 stated, There was no indications that he would fall or a need to be on the program. Like I said he has poor safety awareness when he walks around, and he was at risk for falls but not a high fall risk. Surveyor inquired what fall risk score is considered high risk. V11 responded, 10 or higher [R1's 6/18/25 fall risk assessment determined a score of 10 - therefore high risk]. R1's (11/10/25) History & Physical states facility staff found the patient on the floor with swelling to the right side of his face. He is nonverbal at baseline and unable to provide further history. X-ray impression: anterior wedge compression fracture of L1 vertebral body is new compared to 7/14/25 and favored to be acute. On 11/17/25 at 4:21pm, surveyor inquired what fall prevention interventions should be implemented for a resident identified at high risk for falls. V12 (Medical Director) stated, Physical therapy to determine if they are high risk or low risk and help make them walk. Surveyor inquired about potential harm to a resident that sustains an unwitnessed fall. V12 responded, It could be anything of course; head injury is the worst especially if they have a bleed or something like that. 2.R3's diagnoses include altered mental status, muscle weakness, reduced mobility, hemiplegia and hemiparesis following cerebral infarction. R3's (10/16/25) BIMS determined a score of 8 (moderate impairment) with disorganized thinking.R3's (10/16/25) functional assessment affirms resident is dependent on staff for tub/shower transfer. Toilet transfer and walking were not attempted due to medical condition or safety concerns. R3's (10/17/25) fall risk assessment determined a score of 12 (high risk).R3's (1/28/23) care plan states resident is at high risk for falls secondary to hemiplegia and hemiparesis, interventions: keep bed in lowest position.On 11/17/25 at 11:17am, V7 (CNA) was seated in the hallway directly across from R3's room however she (V7) provided no redirection or assistance to lower R3's bed - which was noted to be in high position - while he (R3) was lying in bed.On 11/17/25 at 11:57am, (40 minutes later) R3 was lying in bed however the bed remained elevated (waist high) therefore not in lowest position per care plan intervention. R3 stated I'm (R3) in bed most of the time because I had a stroke. Surveyor inquired if R3 can walk R3 responded, No. 3.R4's diagnoses include morbid obesity, muscle weakness, reduced mobility, abnormal posture, hypertension, and altered mental status. R4's (10/2/25) BIMS determined a score of 13 (cognition intact).R4's (10/2/25) functional status affirms resident is dependent on staff for chair/bed to chair transfers. Toilet transfer and walking were not attempted due to medical condition or safety concerns. R4's (7/14/21) care plan states resident is at high risk for falls due to gait/balance problems, muscle weakness, and psychoactive drug use that may potentiate falls.On 11/17/25 at 12:07pm, R4 was lying in bed. R4 stated I'm (R4) here (in bed) all the time. I'm supposed to get up every Monday, Wednesday, and Friday but I'm not doing it. R4 also affirmed that she's incontinent, doesn't walk, and requires 2 persons assist with transfers.R4's (7/29/25) fall risk assessment determined a score of 9 (at risk) however elimination status was not marked (2 points) and predisposing factors none was selected however R4 is diagnosed with Hypertension (2 points) - therefore the assessment was scored incorrectly.On 11/17/25 at 3:00pm surveyor relayed concerns (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	with R4's (7/29/25) fall risk assessment score. V2 (DON) affirmed R4 is likely high risk for falls due to diagnoses and inability to walk. The fall prevention and management policy (revised 10/2018) states the facility will identify and evaluate residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. Facility guideline following a fall incident: A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at high risk for falls; a score of less than 10 indicates at risk for fall. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.