

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Bria of Geneva		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 East State Street Geneva, IL 60134	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35267 Based on interview and record review, the facility failed to report an allegation of abuse to the abuse coordinator and Illinois Department of Public Health per facility policy. This applies to 2 of 3 residents (R1, R2) reviewed for abuse in a sample of 3. The findings include: Face sheet, printed 8/22/24, shows R1 was admitted to the facility on [DATE] and his diagnoses included acute kidney failure, adjustment disorder, vascular dementia, congestive heart failure, history of falls, depression, transient ischemic attack, and weakness. MDS (Minimum Data Set), dated 7/25/24, shows R1's cognition was moderately compromised. Face sheet, printed 8/22/24, shows R2 was admitted to the facility on [DATE] and his diagnoses included dementia, unspecified psychosis, depression, anxiety, psychoactive substance abuse, and insomnia. MDS, dated [DATE], shows R2's cognition was severely impaired. On 8/21/24 at 11:40 PM, R1 stated R2 was very confused and continuously wandered. R1 stated R2 continuously entered R1's room because the room used to be R2's room prior to R2 moving to another room. R1 stated on 8/18/24, R2 came into his room and tried to move his roommate while in bed. R1 stated he yelled at R2 to stop coming into R1's room and R2 placed his hands on R1's right and left side of R1's upper torso and shoved R1 backward while he was sitting in his wheelchair. R1 stated his wheelchair rolled back, hit his dresser in the back of the room, and R1 fell out of his wheelchair on to the floor. R1 stated staff came to assist him back into the wheelchair. R1 stated he experienced pain in his knee, hip and upper torso and R1 received an X-ray the evening of 8/18/24 to examine his knee. On 8/21/24 at 3:00 PM, V1 (Administrator) stated he was informed by the police that R1 called the police and reported that R2 hit/shoved R1 during their altercation earlier in the day. V1 stated he did not report the allegation to IDPH because he did not think the allegation was credible since the allegation did not surface from R1's nurse at the time of the incident. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 10:30 AM, V1 stated on 8/18/24 R1 alleged R2 wandered into R1's room and R2 shoved R1 causing R1 to go backward in his wheelchair. V1 stated there were no witnesses and no injuries and V1 did not believe the incident happened so V1 did not report/investigate the allegation. V1 stated R1 was alert and oriented and desired to go home, so R1 made up the story to convince R1's family to take him out of an unsafe facility. V1 stated he could not be sure the incident actually occurred. Facility document provided by V1, signed 8/21/24, shows, Initially [R1] told the nurse that he was trying to sit in his chair and slid out, but later, when I spoke to [R1] about 8:00 PM [R1] said he was pushed. That [R2] was in the room and had pushed him into his chair as he was trying to stand. I asked why he hadn't said that initially to the nurse and he stated that he just remembered it. There were no injuries and [R2] left the room immediately. On 8/21/24 at 3:00 PM, V1 stated he had not yet reported R1's allegation of abuse to IDPH. On 8/21/24, V7 (Agency LPN - Licensed Practical Nurse) stated she was first to respond to R1 on the floor on 8/18/24. V7 stated she asked R1 what happened and R1 reported that R2 shoved him while sitting in his wheelchair in his room and R1 fell out of his wheelchair as a result of the push. V7 stated when V5 came into the room to assess R1, V7 told V5 that R1 reported R2 shoved R1 and then left the room because R1 was not assigned to her that day. Progress note, written by V7 on 8/18/24, shows R1 was observed in a sitting position in front of his wheelchair as R2 was walking out of R1's room. The progress note fails to show R1 reported R2 physically touched R1. On 8/21/24 at 1:45 PM, V5 (LPN - Licensed Practical Nurse) stated at the time of the 8/18/24 incident, he located R1 on the floor in his room and stated R1 did not report that he was shoved or touched by R2 during the incident. V5 stated a nurse coworker responded to R1 first at the time of the incident. Progress note written by V5 (LPN - Licensed Practical Nurse), shows no report that R1 was physically touched by R2. The note shows R2 stated R1's chair rolled back and he slid off the chair while yelling at R2. Physician note, dated 8/19/24, shows, R1 received an X-ray of his left knee due to a fall the day prior. The note shows no acute findings were shown. Progress notes, dated 8/18/24, show the facility performed a fall risk evaluation, skin condition form related to R1's fall, and a pain evaluation assessment related to R1's reports of pain in his left front knee. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Abuse Policy and Prevention Program 2022 document, dated 10/2022, shows, Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or the compliance officer. In the absence of the administrator, reporting can be made to and individual who has been designated to act in the administrator's absence Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an incident investigation Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately but not more than two hours after the allegation of abuse.		