IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 27, 2019

Avrum Weinfeld, Registered Agent
MST Health Properties, LLC
5151 Church Street
Skokie, Illinois 60077

RE:	Complaint #:	IL 107210, IL 107578
	Survey Date:	January 2, 2019
	Docket #:	19-C0073
	Violation Type:	A Violation w/Fine, 2-B Violations w/Fines

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Bria of Chicago Heights.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Bria of Chicago Heights/January 2, 2019/19-C0073/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: BRIA OF CHICAGO HEIGHTS COMPLAINT #: 0107210
LIC. ID #: 0043406
DATE COMPLAINT RECEIVED: 11/09/18 09:29:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
133	PHYSICAL ASSAULT RES TO RES	1
199	OTHER	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: BRIA OF CHICAGO HEIGHTS COMPLAINT #: 0107578
LIC. ID #: 0043406
DATE COMPLAINT RECEIVED: 11/28/18 08:56:00

IDPH Code	Allegation Summary	Determination
131	RESIDENT INJURY	1
206	HOUSEKEEPING	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

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3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. MST HEALTH PROPERTIES, LLC, D/B/A, BRIA OF CHICAGO HEIGHTS Respondent.	)))))))))	Docket No. NH 19-C0073

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on January 2, 2019 at Bria of Chicago Heights, 120 West 26th Street, S. Chicago Heights, Illinois 60411. On February 27, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Bria of Chicago Heights, 120 West 26th Street, S. Chicago Heights, Illinois 60411 on August 20, 2017. The Facility's current license number is 0043406. The term of the conditional license shall be from March 27, 2019 to September 26, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 27, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

- **Type A violation** of an occurrence for violating one or more of the following sections of the Code: 300.1210b), 300.1210d)6), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 27th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. MST HEALTH PROPERTIES, LLC, D/B/A, BRIA OF CHICAGO HEIGHTS Respondent.	))))))))))	Docket No. NH 19-C0073

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Required; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Avrum Weinfeld
Licensee Info:	MST Health Properties, LLC
Address:	5151 Church Street Skokie, Illinois 60077

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 27th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. MST HEALTH PROPERTIES, LLC, D/B/A, BRIA OF CHICAGO HEIGHTS, Respondent.	)))))))))	Docket No. NH19-C0073

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on January 2, 2019, at Bria of Chicago Heights, 120 West 26th Street, S. Chicago Heights, Illinois 60411. On February 27, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$4,400.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.1210b), 300.1210d)3), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).
  Fine = $2,200

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b) and 300.3240a).
  Fine = $2,200

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 27th day of February ,2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. MST HEALTH PROPERTIES, LLC, D/B/A, BRIA OF CHICAGO HEIGHTS , Respondent.	)	Docket No. NH 19-C0073

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Avrum Weinfeld
Licensee Info:	MST Health Properties, LLC
Address:	5151 Church Street Skokie, Illinois 60077

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 27th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

BF300/19-C0073/Bria of Chicago Heights/January 2, 2019/kk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING: _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 1897681/ IL00107578 1897336/ IL00107210	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 3) 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

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S9999	Continued From page 1 and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met evidencded by: Based on interview, and record review, the facility failed to follow their fall care plan intervention that included frequent rounds, staff assistance, and failed to develop effective interventions to include undefined safety cues to meet the impaired cognitive status to prevent the incidents of falls	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING: _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 2 for 1 of 3 (R2) resident reviewed for fall prevention. This failure resulted in R2 having 3 falls in 8 days, and the third fall R2 was sent to the local hospital where she was assessed to have a brain bleed, and bilateral acute subdural hematoma. Findings include: A review of R2's clinical record indicates that R2 is 77 years old with a diagnosis of dementia, and Alzheimer disease. R2's fall risk evaluation dated 1/16/18 score shows 8, fall risk evaluation dated 4/16/18 shows score of 8. According to fall risk evaluation a score of 10 or greater indicates high risk for fall. A review of R2 progress notes dated 7/7/18 at 10:45pm documents received resident alert at start of shift, alert but confused, laying on floor "voluntary" R2 added I just want to lay here-indication of her confused state. On 1/2/18 at 3:08pm V16 (Nurse) said he found R2 on the floor and R2 stated she just want to lay here therefore he did not consider R2 to have fallen. V16 said R2 was confused. V16 said he did not see R2 lay herself on the floor. V16 said he did not initiate the facility's fall policy. V16 said he did not report the occurrence to the physician. A review of R2's clinical record there was no fall risk assessment completed, nor was the current plan of care reviewed, or revised with fall prevention interventions the last documented fall revision was dated 7/26/2017 and last intervention promote call light placement documented was dated 10/4/2016. A review of R2's fall incident report dated 7/9/18	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING: _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

with revision date of 8/28/18 show incident description shows resident observed on her right side on the floor by the side of her bed. Resident appeared to be resting. Resident assessed, no pain observed, and noted to have redden area to right cheek. Injury type: bruise, injury location: face. R4 (roommate/witness) stated that R2 rolled out of bed onto the floor and appeared to have been sleeping. The incident report notes documented R4 stated that the resident rolled out of the bed onto the floor while she was sleeping. Resident laying on her right side and noted to have a redden area to right cheek. No complaints of pain/discomfort. Will continue to monitor.

A review of the nursing notes dated 7/9/2018 9:01am documents that R2 is exhibiting weakness, and only able to walk a few steps and requires rest breaks, the note documents R2 is given a wheelchair and requires staff assistance for safe locomotion. Nursing note 12:15pm documents R2 still exhibits decreased activity tolerance, and endurance. Staff to provide assistance as needed. 12:20pm nursing notes documents R2 has had a fall. Please see post fall evaluation for details. A review of the post fall evaluation with an effective date of 7/9/2018, has documented date of 7/6/2018 that vital signs and body assessment was conducted on 7/6/2018, the post fall evaluation also indicates that R2 had a bruise on the right side of face. The post fall evaluation documents that R2 physician was notified on 7/6/2018 at 0600am and the emergency contact was notified on 7/6/2018 at 0700am.

On 12/14/18 3:35pm R4 said that R2 didn't fall out of the bed, R4 said that I didn't tell anyone that R2 fell out of the bed. R4 said that she never saw R2 just lay on the floor. R4 was assessed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007991	A. BUILDING _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET SOUTH CHICAGO HEIGHT, IL 60411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

be alert and oriented x 3 during this interview.

A review of the care plan dated 7/10/2018 documents that R2 is at risk for falls, with new interventions to include regular rounds, staff assistance, safety cues, promote placement of call lights.

On 12/12/18 1:30pm V12 (restorative nurse) said she would not describe specific in regards to safety cues noted on the care plan. V12 said that she would be that specific.

A review of the physical therapy evaluation dated 7/11/2018 documents R2 with dementia, Alzheimer's, muscle weakness, abnormalities of gait and mobility, and unsteadiness on feet. The therapy evaluation documents that R2 requires assistive device related to worsening gait and unsteadiness. The evaluation also documents that R2 requires contact guarded assistance and is more confined to a wheelchair.

On 12/12/18 at 9:29am V35 (physical therapy) said that R2 was confused had impaired visual perception, posture deficits, head leaning forward, balance deficits, and able follow single step commands. V35 also said that R2 was referred due to being unsafe and unsteady gait, and unsteadiness promoting R2 for use of wheelchair.

12/12/18 2:20pm V16 said he don't remember all the details about R2's falls it's been awhile. I remember the roommate saying she stumbled coming back from the toilet. I found her on the floor when I was doing my rounds, I did my assessment and put her back to bed. Resident was able to talk but confused. I noticed the bruise on her face but it was old. I called the doctor,

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monitor her for change in condition, I believe I did neuro checks.

A review of R2's fall incident report dated 7/15/18 at 7:45am with revision date of 8/13/18 shows incident description: resident observed on the floor when summoned by staff, resident on right side position on the floor. Resident unable to tell what happened to her. Three staff put resident back in bed, assessment done from head to toe. No visible injury noted. Denies pain, Nurse Practitioner on call for V19 (medical doctor) made aware. Resident will be sent out to hospital for evaluation.

A review of R2's progress notes 7/15/18 at 8:45am R2 had a fall. See post fall evaluation. A review of the post fall evaluation with an effective date of 7/15/2018, has documented date of 7/6/2018 that vital signs and body assessment was conducted on 7/6/2018. The post fall evaluation documents that R2 physician was notified on 7/15/2018 at 08:45am and the emergency contact was notified on 7/15/2018 at 08:47am. There is no note or document reviewed with a description of why R2 was initially sent to the hospital. The progress notes dated 2:55pm documents local Ambulance Company called for transport to local hospital, the note documents R2 was being sent to the local hospital for a change in mental status. The progress notes documents that R2 left the facility in stable condition at 3:09pm

A review of R2's hospital record dated 7/15/18 shows arrival time 3:43pm, at 3:48pm is documented that patient admits from the facility with complaints of fall. Patient was found at 8:00am lying on her right side on the ground. Patient is poor historian with a history of

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S9999	Continued From page 6 dementia. The hospital notes also documents that R2 is non-verbal, with a history of dementia and psychiatric disease. R2' fall is noted to be unwitnessed and downtime unknown, the local hospital documents they will obtain a CT imaging of the brain and cervical spine. The hospital records documents that R2 is assessed to have brain bleed, bilateral acute subdural hematoma, and a 10mm right to left midline shift, and recommends emergent transfer to another acute hospital. (A) (2 of 3) 300.1210)b) 300.1210d)3)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	S9999		

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and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

Based on interview, and record review, the facility failed to conduct a comprehensive assessment after a report of change in ability to walk and stand for 1 of 3 residents (R1) reviewed for comprehensive assessments. This failure resulted in R1 having difficulties with weight bearing, and walking for 2 days, before being assessed with lower extremity pain, and having a X-ray taken.

Findings include:

A review of the incident report dated 11/22/2018 R1 was found on the floor in (R4's) room seated

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with legs straight. Full body assessment performed LOC (level of Consciousness) within normal limits ROM (range of motion) performed x 4 extremities no limitation, or signs or symptoms of injuries noted at this time. R1 assisted to standing position with staff assistance, and ambulated throughout the hallways. The incident report is written by V9 (nurse).

A review of the progress note of R1 dated 11/22/2018 documents that R1 had behavior episode. See behavior evaluation for details.

On 12/27/18 at 11:33am V9 (Licensed Practical Nurse-LPN) said she was informed by R5 that R1 was sitting on the floor in his room, V9 said she did not get R1 up, R1 was assisted off the floor by V37 (activity aide). V9 said V37 brought R1 to her and she assessed him, and V9 said R1's (ROM)range of motion was within normal limits. V9 said R1 did not fall, he sat himself on the floor, V9 said she did not see him sit himself on the floor. Surveyor attempt to clarify the discrepancies in incident report documentation and verbal statement of what happened, V9 said whatever the report said then that's what happened.

On 12/27/18 at 3:40pm V39 (Certified Nursing Assiatant- CNA) said 11/22/2018 after dinner R1 had difficulties walking when trying to assist him back to his room to bed. I had to stand behind him and guide him with force, R1 was holding on to wall, having trouble bearing weight on the left side and placing his weight to his right side. V39 said that R1 is usually independent with walking and doesn't require the assistance of the walls or the rails. V39 said that he reported to V9 (nurse) that R1 had difficulties with walking, and required assistance to get him back to his room. V39 said

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once R1 was placed in bed he remained there the remainder of the shift, V39 said that staying in bed was not R1's normal behavior because R1 likes to walk around the nursing unit.

On 12/28/18 at 10:59am V9 said that V39 reported that he was having a difficult time assisting R1 back to his room, V9 also said she saw when V39 had to use force to assist R1 with walking to his room after dinner V9 said she thought R1 was resisting care, V9 said she did not assess R1 at that time when she noticed V39 using force to assist R1 with walking.

On 12/27/18 at 7:50am V33 (CNA) said R1 did not fall when he worked with him on 11/22/18 (11p-7am shift). R1 did not get up and ask for snack on 11/22/18. I was not aware of any behavior R1 had that day. I did not know that he was on behavior monitoring. R1 walked a lot, he wandered. R1 slept the entire night when I worked with him, I didn't noticed anything abnormal. R1 did not complain of pain when I worked with him. R1 did not use a wheelchair when I worked with him.

On 12/18/18 at 9:28am V28 (CNA) said she worked with R1 on 11/23/18 on 7am-3pm shift. V28 said upon starting her shift R1 was in the bed and she requested that V6 assist help getting R1 out of bed since she worked with him the night prior. V28 said she helped to put R1 in a wheel chair. Resident was in his room all day sitting in wheelchair. V28 said she thought R1 was different because he usually walks around the nursing unit, but, that day he was sitting in a wheelchair and falling asleep the entire shift, he only ate 50% of his lunch and R1 usually eats 100% of meals, V28 again said R1 didn't seem right. V28 said she reported it to V22 (nurse) and

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V22 said she would check on R1 and keep an eye on him. A review of V28's documentation on 11/23/2018 indicated a NA, V28 said when she documented on 11/23/18 NA-(not applicable) it means resident did not walk. V28 said she changed his brief he didn't seem to be in discomfort. I did my rounds on R1, I changed him after breakfast, before and after lunch, R1 was noted mumbling a lot, and I could not understand his mumbling. The only thing I noticed was R1 was not walking as he normally does.

According to V1 (Administrator) she said that V22 (Nurse) no longer works for the facility, several phone attempts were made to contact V22, unsuccessfully. A review of the progress notes during V22's shift on 11/23/2108 documented no entries/assessments in regards to V28 reporting R1's change in condition with walking.

On 12/14/18 at V7 (CNA) said he worked with R1 on 11/23/18 (3-11pm shift), R1 did not fall when he worked with him, V7 said R1 was in the bedroom for the entire shift sitting in a chair and that wasn't like R1. R1 did not walk around that shift, it was unlike R1 because R1 walked continuously. V7 said he did not inform anyone that he thought R1 was not his usual self he thought it was his medicine. V7 said R1 had behavior of sitting his self on the floor. V7 said R1 was not displaying signs of pain. Review of V7 point of care documentation shows R1 was independent for walking in room. V7 said that's was an error, R1 did not walk on 11/23/18 during 3-11pm shift. V7 said he should have reported to the nurse that R1 was not up ambulating as he usually does.
On 12/14/18 at 9:50am V6 (CNA) said she worked with R1 on 11/23/18 11pm-7am shift. V6 said R1 was in the bed when she arrived on for

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her shift. V6 said R1 usually gets up at night and ask for something to eat, and he did not get up on 11/23/18 (11-7a shift), V6 said that was unusual for R1. V6 said she changed R1's brief around 1:00 am and she didn't notice anything wrong with R1. V6 said she checked on R1 several times that night and he was ok laying in the bed in a fetal position. V6 said in the morning around 6:45am when it was time to get R1 up he didn't want to be bothered, saying leave me alone and not wanting to get dressed, pulling the covers over his head. V6 said as she tried to stand R1 up, R1 kept leaning/falling back to the bed. V6 said she struggled to put R1's pants on because of this. V6 said someone helped her pull R1 pants up but she don't know who. V6 said once R1 was dressed she helped R1 back into bed. V6 said she did not inform anyone of what happened because she thought he was tired and didn't want to be bothered and it was time for her to go home. V6 said R1 did not have a fall on her shift. V6 said she did not get any report that R1 was on behavior monitoring.

On 12/14/18 at 12:40pm V8 Certified Nursing Assistant-(CNA) said she worked with R1 on 11/24/18 (7am-3pm shift), V8 said when she was providing care and tried to stand R1 up he did not want to stand, she notice he was in pain and she informed the nurse (V5). V8 said V5 said "I have to order an x-ray because R1 fell".

(B)

(3 of 3)

300.610)a)
300.1210)b)6)

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S9999	Continued From page 12 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999		

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Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

Based on interview, and record review, the facility failed to follow the abuse policy, current plan of care and protect a resident assessed to be at risk for abuse from being physically attacked by another resident for one of three residents (R2) reviewed for physical abuse. This failure resulted in R2 being pushed to the ground and punched by R7, R2 was sent to the local hospital, and treated for a laceration above the right eye.

Findings include:

A review of the facility incident report dated 5/18/2018 indicates that R2 was struck by R7 in the hallway. R2 was assessed to have a small laceration to the right eyebrow. The incident report indicated that V27 (housekeeper) witnessed the incident. The report indicated that V27 said that R2 was walking closely behind R7, R7 then turned around and struck R2 in the lower body, causing R2 to go to the floor, R7 was noted to have struck R2 in the right side of her face.

A review of R2's clinical record indicates that R2 is 77 years old with a diagnosis of dementia, and Alzheimer disease. R2's current plan of care dated 5/11/2018 indicates that R2 has a behavior of wandering. A review of the abuse/neglect

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screening dated 5/10/2018 indicated that R2 was identified to be vulnerable for abuse due to dementia, increased safety risk, impaired insight and judgement, verbally aggressive behaviors, and mental cognitive impairment related to making delusional statements, walking into peer personal space.

A review of the R2's current plan of care origination date of 3/20/15 and revised on 5/18/2018, R2 is identified to be at risk for abuse/neglect. The goal is indicated that R2 will remain safe and will be free from abuse/neglect through the next reporting period. The noted intervention includes "Assure resident that he/she is in a safe and secure environment with caring professionals.

A review of R2's clinical record social service notes dated 5/18/2018 at 12:49pm documents that R2 was approached by a resident peer in a hostile manner; the resident peer was physically aggressive toward R2. The note then documents that R2 was sent to the hospital for evaluation. The nursing notes dated 5/18/2018 1:00pm documents R2 was struck and pushed down by roommate. R2 sustained a skin tear to the right brow. The wound was noted to be cleaned, steri-strip applied, and ice pack was applied. R2 was assisted to her feet and seated and transported to the hospital by ambulance team.

On 12/11/18 at 5:10pm V27 (housekeeping staff) said she saw on 5/18/2018 that R2 was walking behind R7 and R7 turned and pushed R2 down and then punched R2 in the body. V27 said R2 hit her head on a metal ramp leading out to the patio area. V27 said that she noted R2 bleeding from the right side of her forehead. V27 said R2 was not verbally aggressive or noted to be provoking

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S9999	Continued From page 15 R7 prior to the attack. A review of R2's hospital records dated 5/18/18 shows clinical impression: laceration to face without complication, the hospital record indicated that EMS driver stated that "R2 was hit in the face by another resident at the facility, R2 is noted to be irritable, and does not want the CT-Scan, R2 is noted to be pacing back and forth in the hallway". A review of the Facility's policy title "Abuse Prevention Program" documents that the facility affirms the right for their residents to be free from abuse/neglect and misappropriation of property. The policy also document(s) the purpose of the policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse. (B)	S9999		