

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010086	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/25/2022
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

BRIA OF PALOS HILLS **10426 SOUTH ROBERTS**
PALOS HILLS, IL 60465

(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 Facility Reported Incident of July 11, 2022-IL149364	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.2210b)5) 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 and assistance to prevent accidents. Section 300.2210 Maintenance	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>b) Each facility shall:</p> <p>5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition.</p> <p>These Requirements were not met evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure one resident's bed was in safe condition to prevent an avoidable accident. This affected 1 of 3 resident (R1) reviewed safety. This failure resulted in (R1) sustaining a laceration requiring 23 sutures during a transfer.</p> <p>Findings include:</p> <p>R1 was admitted to the facility on 6/22/22 with a diagnosis of type 2 diabetes, repeated falls, chronic pain, congestive heart failure, respiratory failure, end stage renal disease, unsteadiness on feet and lack of coordination. R1's brief interview for mental status score dated 6/29/22 documents a score of 12/15 which indicated cognitively intact.</p> <p>R1's facility final reportable dated 7/18/22 documents under occurrence resolution: Upon investigation it was concluded that while doing a transferring back to bed resident leg made contact with the bed frame causing laceration.</p> <p>R1's ambulance run report dated 7/11/22 documents: RN reports that patient was being transported from her dialysis chair to her bed, when metal part of the bed made a 8 inch laceration on the patient's outside left calf. She stated pain was 9/10 and pointed to her leg.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's hospital record dated 7/11/22 documents: Patient was in nursing home being transferred to the bed and her leg got cut on bed frame. Under skin documents 14 (cm) centimeter irregular laceration to the left lateral shin. Under treatment: 23 sutures placed.</p> <p>On 8/19/22 3:40 pm, V3 Director of Nursing (DON) said they determined that R1 leg was cut on the side of bed where an end cap should have been placed on the bed. Surveyor observed R1's hospital bed that had metal rod noted in the middle of the bed frame. The end of metal rod had a small square plastic insert to cover the edges of the rod. V3 said the small square insert was not present in R1's bed at time of the incident and sharp edges caused the laceration. (B)</p>	S9999		