STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001283	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF RIVER OAKS	14500 SOUTH MANISTEE BURNHAM, IL 60633

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S 000	Initial Comments Facility Reported Incidents: January 8, 2024 IL170375 February 3, 2024 IL170376 February 28, 2024 IL170907	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) 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	S9999		

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resident to meet the total nursing and personal care needs of the resident.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure residents were free from physical abuse. This applies to 3 of 15 residents (R6, R3 and R1) reviewed for abuse in the sample of 15. This failure resulted in R5 hitting R6 in the face. R6 was sent out to the local hospital and sustained a displaced right maxillary sinus fracture and displaced fracture of the right zygomatic arch.

The findings include:

1. The facility's Abuse Final Report, dated 2/9/24, documents on 2/3/24, R6's interview statement: he was in the hallway when R5 approached him saying things that were not making sense ...the next thing, he got hit in the face by R5. R5's interview statement he thought R6 hit him in the foot and got mad and hit R6. Interviews of witness: two staff members verbalized they were present with residents, as they observed them having a verbal disagreement ...R5 abruptly swung at R6 .... R6 was sent out to the local hospital for further medical evaluation. CT scan conducted there was a mildly displaced fracture of the right zygomatic arch and displaced fracture of the right maxillary sinus.

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R5's face sheet shows he is 34-year-old male, with diagnoses including bipolar disorder, current episode depressed, severe with psychotic features, paranoid schizophrenia, unspecified psychosis not due to a substance, and violent behavior.

R5's current care plan shows he has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior ...this history includes violent behavior.

R6's face sheet shows he is a 62-year-old male, with diagnoses including paranoid schizophrenia, anxiety, psychotic disorder with delusions, schizoaffective disorders, bipolar, and major depressive disorder.

R6's Hospital Records, dated 2/3/24, documents R6 hit by another patient right side of the face, abrasion and bruising to right side of face.

R6's CT (Computed Tomography) scan, dated 2/3/24, documents there is a mildly displaced fracture of the right zygomatic arch, comminuted displaced fracture of the right maxillary sinus and blowout fracture of the floor of the right orbit with herniation of the intraorbital fat.

On 5/31/24 at 10:16 AM, R6 was observed standing in the hallway outside of his room located on the annex unit. He said he got beat up a long time ago.

On 5/31/24 at 9:36 AM, V8 (Resident Services) said he was here when R5 struck R6 in the face. R5 was aggravated about something, and R6 was pacing the halls back and forth. R5 said R6 was walking back and forth and that seemed to

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S9999	Continued From page 3 bother him. On 5/31/24 at 12:21 PM, V5 (Assistant SSD) said R5 has a history of aggressive behaviors, but said this was the first incident he had with another resident at the facility. R6 is very calm, compliant, and reports no aggressive behaviors. R5 said R6 was coming to him and R5 had an altercation with R6. "If a resident hits another resident that is physical abuse." On 5/31/24 at 1:09 PM, V10 (Registered Nurse/RN) said he was R6's nurse on 2/3/24. He was alerted two residents were fighting. He saw R6 on the floor he was bleeding and had a laceration to his right eye. "(R5) admitted to hitting (R6) because he had thought (R6) called him a name. (R5) gets agitated at times and acts out." On 5/31/24 at 1:52 PM, V3 (Assistant Director of Nursing/ADON) confirmed R5 hit R6 in the face. R6 sustained facial fractures. 2. The Facility Reported Incident (FRI) sent to the State Agency, dated 2/28/24, shows: "(R3), 54 year old, alert and oriented x 3 with diagnoses that include end stage renal disease, schizoaffective disorder and depression. (R4), 81 year old, alert and oriented x2-3 with diagnoses of asthma, schizophrenia and bipolar. Allegation type-Physical Abuse. It was reported that (R4) allegedly exhibited physical aggressive behavior towards (R3). (R3) said as she was coming in from the smoking patio, she was trying to get herself through the door when (R4) came around and was also trying to get through the door. (R4) was fussing and then smacked (R3) in the face. (R4) said (R3) was in the way and took too long. (R4) stated he did not intend to hit (R3)	S9999		

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but realized only when it had already happened. Staff attempted to redirect (R4) when he abruptly smacked (R3) then he said sorry as he realized what had happened."

On 5/31/24 at 11:37 AM, R3 was in the dialysis unit receiving dialysis. R3 said R4 hit her in the face. R3 stated, "That hurts! Why? that was unnecessary! I was trying to get out of his way and he just hit me!" R3 said V4 (Activity Aide) was there during the incident.

On 5/31/24 at 1PM, R4 was lying in bed alert. R4 said he does not recall any incident between him and R3.

On 5/31/24 at 11 AM, V4 (Activity Aide) said she was with the residents in the smoking area. V4 said she did not witness the incident, but heard R3 all of a sudden became hysterical. R4 was by R3. R3 pointed to R4 and said. "He smacked me!" V4 said she separated R4 and R3 and reported the incident to the nurse.

On 5/31/24 at 1:20 PM, V7 (License Practical Nurse-LPN) said it was reported to her that R4 hit R3 in the face. V7 said the facility procedure was to place the perpetrator (R4) on 1:1 then notify physician and family. R4 was monitored for further behaviors.

3. The FRI sent to the State Agency, dated 1/8/24, shows: (R1), 81 year old, alert and oriented x3 with diagnoses that include weakness and schizoaffective disorder. (R2), 41 year old alert and oriented x 3 with diagnoses of weakness, schizophrenia and major depressive disorder.
Allegation type-Physical Abuse. "It was reported that (R2) allegedly exhibited physical aggressive

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behavior towards (R1). (R1) stated she sat on her bed when (R2) came into her room and swung at her, hitting her face and walking out her room without saying anything. She stated she did not do anything nor has she interacted with him at anytime".

On 5/31/24 at 9:50 AM, R1 was in bed. R1 said she got hit in the face, but does not want to discuss the issue any further. V24 (Licensed Practical Nurse/LPN), who was R1's nurse, said R1 was transferred from another unit due to an incident, but she does not know the details of the incident.

On 5/31/24 at 12:35 PM, V5 (Assistant Social Service Director) said R1 was moved to another floor for her safety and R2 was sent to the hospital for psychiatry evaluation. R2 has not been back to the facility at this time.

On 5/31/24 at 1:20 PM, V7 (LPN) said R2 was placed on 1:1 supervision after it was reported to her R2 hit R1 without provocation. V7 said R2 was sent to a psych unit per physician order, and had not been back to the facility.

On 5/31/24 at 1:20 PM, V7 (LPN) and V5 (Assistant SSD) both said when a resident hits another resident, that is abuse. Abuse was not tolerated in this facility.

The facility Policy on Abuse and Neglect, with revised date of 1/40/24, shows, Policy- This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatments of residents. In order to do so, the

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S9999	Continued From page 6 facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than accidental means. Abuse is the willful infliction of injury unreasonable confinement intimidation or punishment with resulting in physical harm, pain, or mental anguish to a resident. This also includes deprivation by an individual, including caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Physical Abuse- is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching. Kicking and controlling behavior through corporal punishment. (B)	S9999		