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 03/24/2025

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

(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 2/17/25: IL188299	S 000		
S9999	Final Observations Statement of Licensure violations: 300.610a) 300.1210b)4) 300.1210c) 300.1210d)4)A) 300.1210d)5) 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	S9999		

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 03/24/2025

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S9999	Continued From page 1	S9999		

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. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:

A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin

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 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 2	S9999		

breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These Requirements were not met evidenced by:

Based on the interview and record review, the facility failed to assess and identify the underlying cause of a resident's (R1) new onset of pain in the left leg and failed to inform the primary care provider of continued pain after being administered tramadol 50mg, also to conduct a comprehensive assessment for a resident with a new onset of left leg pain. This affected one out of three residents (R1) reviewed for nursing assessments and pain management in a total sample of seven. This failure resulted in R1 being delayed treatment and in R1 having increased pain levels for four days before R1 was sent to the hospital for treatment of a left hip fracture.

Findings Include:

R1 is a 56-year-old with the following diagnoses: epilepsy, Todd's paralysis, dementia, and chronic kidney disease.

The Hospital Records dated 2/22/25 document R1 was admitted to the hospital for left hip fracture post fall. R1 reported falling while trying to get in the wheelchair two days ago. R1 is unable to move the left lower extremity and reported achy and tenderness. R1 is guarded,

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 03/24/2025

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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S9999	Continued From page 3	S9999		

and the pain is rated ten out of ten. R1 reported taking pain medication with minimal relief. R1 was admitted for further evaluation. Upon exam, R1 had extremity pain, limited range of motion, and joint swelling to the left hip. The admitting diagnosis was a closed intertrochanteric fracture of the left hip. An x-ray of the left hip dated 2/22/25 documents there is an intertrochanteric fracture to the left hip. The exam was extremely limited due to difficulty in positioning.

The Facility Investigation Report dated 2/27/25 documents R1 suffered a fracture to the left hip. R1 reported falling when transferring to the wheelchair but did not report the fall to any staff. No roommates were able to give a statement. All staff interviewed denied witnessing a fall. On 2/17/25, R1 complained of left pain. Pain medication was given, and an x-ray of the left knee was negative. The nurse practitioner ordered to continue tramadol, which was an order from the most recent hospitalization. Another nurse practitioner assessed R1 on 2/18/25 and had no new orders. On 2/19/25, pain medication was given for generalized pain. R1 complained of pain on 2/21/25. The nurse practitioner assessed R1 and ordered a left hip x-ray, which showed a fracture of the left femur. R1 was sent to the hospital and had hip surgery to repair the left femur fracture.

On 3/22/25 at 1:23PM, V1 (Nurse) stated V1 first worked with R1 on 2/21/25 and R1 was refusing to eat breakfast so V1 went to assess R1. V1 reported R1 told V1 that R1's left leg hurt very badly and when V1 went to touch the leg R1 screamed out to not touch R1's leg. V1 stated that V1 had notified the nurse practitioner (V8) and that V8 had come to the room to assess R1. V1 reported that V8 attempted to move R1's left

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 03/24/2025

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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S9999	Continued From page 4	S9999		

leg, but R1 could not move the leg at all on R1's. V1 stated that R1 is a resident who is frequently in a wheelchair, self-propelling around the facility, so it is abnormal for R1 to stay in bed all day. V1 reported that an assessment is completed if a resident complains of pain. V1 stated that the staff asked where the pain was, when it started, what it felt like, and how the resident rated it if they were alert. V1 reported if a resident isn't alert, V1 will look back in the progress notes to see if there is anything new. V1 denied R1 was able to point or say where the pain was or rate the pain. V1 stated that a physical assessment would be completed to touch areas to see where the resident was hurt. V1 reported wherever V1 touches and a resident screams, V1 knows will be the area of most pain. V1 stated that V1 will look for any physical differences that are new onsets for a resident to determine what is causing the pain.

V1 reported that staff have to reassess the resident 30-60 minutes after a pain medication is given to see how they are doing. V1 stated that if the pain comes back, staff has to contact the doctor to let them know and get additional orders to address the pain.

On 3/22/25 at 1:50PM, V3 (Nurse) stated V3 took care of R1 on 2/17/25 and 2/18/25. V3 reported R1 first complaint of pain on 2/17/25 so V3 called the nurse practitioner and an x-ray of the left knee was ordered. V3 stated R1 told V3 the pain was in R1's left leg. V3 denied R1 ever having pain in that area before. V3 reported that R1 could not say why the leg was painful. V3 said, "I know he has osteoarthritis, so I assumed it was that." V3 stated R1 did not get out of bed that day. V3 reported the following day R1 complained of left leg pain and was given pain medication. V3 denied R1 was able to describe the pain. V3 stated when a resident has new onset pain, the

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 03/24/2025

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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S9999	Continued From page 5	S9999		

nurse is responsible to find out where the pain is at and what the resident rates their pain. V3 reported V3 did not think to ask what caused the pain because the previous hospital stay reported R1 had osteoarthritis. V3 stated R1 never left the bed on either of those days. V3 denied assessing anything other than R1's left knee. V3 reported V3 did not notice R1 not moving the left leg. V3 stated R1 was in pain, so V3 thought R1 didn't want to move the leg while it hurt.

V3 stated that R1 rated the pain a four or five out of ten. V1 reported that nurses must check on a resident after pain medication is given to see if it lowers the pain. V3 stated that R1 is alert and oriented times two.

On 3/22/25 at 3:04PM, R1 was lying in bed. R1 stated R1 broke R1's left hip after falling out of a wheelchair. R1 was not able to give a date, time frame, or any other details about the fall due to confusion. R1 was not able to give any other details regarding when x-rays of the leg were taken and what the time frame was from when R1 fell to when R1 was sent to the hospital. R1's mental status was assessed. R1 is alert and oriented times two. R1 reported the date as March 25, 2003, and the location as Chicago, IL. R1 was also able to accurately state R1's name and birth date. R1 stated he went to the hospital and had surgery to have the left hip repaired. R1 reported R1 was taking medicine for R1's pain but did not know the name of the medication or how often R1 was taking the medication. R1 stated R1's pain was a ten out of ten. R1 reported moving or touching the left leg made the pain worse. R1 reported that the pain felt like electricity in R1's whole leg, but the worse pain was near the hip. R1 was not able to answer any questions about the nurses or nurse practitioner's

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 03/24/2025

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

(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 6	S9999		

assessment of R1's pain. R1 stated R1's pain level is now a three or five after having the surgery. R1 reported R1 is still being given pain medication. R1 denied knowing why R1 was not sent to the hospital sooner. R1 reported R1 uses a wheelchair to go smoke and move around the facility. R1 stated that R1 was not getting out of bed when R1 had a pain level of ten out of ten. R1 said, "It was the worst pain in my life." R1 reported that the pain medication would lower the pain from ten to eight when it was at its worst. R1 stated R1 yelled out more than once when staff tried to touch R1.

On 3/23/25 at 1:45PM, V7 (CNA) stated R1 is an active resident who first reported pain on 2/17 during V7's shift. V7 reported telling the nurse about R1's pain but was not aware of any other actions the nurse took for R1's pain. V7 stated R1 is a resident that enjoys being up in the wheelchair to go to smoke break but on this day R1 did not get out of bed. V7 reported R1 did not want staff to touch R1 because R1 was in so much pain so staff tried to avoid touching R1 to not make the pain worse.

On 3/23/25 at 2:29PM, V8 (Nurse Practitioner) stated R1 kept pointing to the knee area when V8 was first notified of R1's pain on 2/17/25, so V8 put in an order for a left knee x-ray. V8 reported that when R1's knee was touched, R1 had increased pain, so V8 thought the pain was coming from the knee or could be a pain from frequent episodes of pancreatitis. V8 stated the left knee x-ray was negative but a couple days later staff notified V8 of R1's leg pain again. V8 reported V8 touched R1's hip and groin area during the second assessment and R1 moved away in pain. V8 denied being made aware of an additional times R1 reported pain other than on

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	IL6001283	A. BUILDING: _____ B. WING _____	C 03/24/2025

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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S9999	Continued From page 7	S9999		

2/17/25 and 2/21/25. V8 stated V8 would have come to assess R1 sooner if V8 was aware R2 was still in pain.
V8 reported V8 continued the tramadol order from the hospital for pain but V8 was not aware that the medication had only a little affect in lower R1's pain.
On 3/24/25 at 9:45 AM, V9 (Rehab Nurse Practitioner) stated when assessing pain, a nurse should ask questions about where the pain is at and what the level of pain is. V9 reported if a resident can't tell you where the pain is at or what happened then when an assessment is being done, then range of motion should be tested and any imaging should be ordered based off of the assessment. V9 stated if a resident is showing signs of facial grimacing or yelling out, then they are in pain. V9 was unable to remember assessing R1 on 2/18/25 and was not able to answer why no further imaging was ordered on 2/18/25 when V9 assessed R1. V9 reported the left knee imaging was negative and staff assumed that is where the pain was coming from.

On 3/24/25 at 12:54PM, V10 (DON) stated R1 began complaining of pain to the left knee so an x-ray was taken that was negative. V10 reported two or three days later R1 still complained of pain so an x-ray of the hip was completed and showed a fracture to the femur. V10 stated staff should do a complete assessment for a resident to rule out as many causes as possible when there are complaints of new pain. V10 reported staff need to check the pain level and where the pain is at and what the pain feels like during the assessment. V10 stated if pain keeps returning then the physician or nurse practitioner needs to be notified again.
V10 reported a hip x-ray was not done at the same time as the knee x-ray because "the nurse

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 03/24/2025

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

(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 8	S9999		

practitioner said they had to work their way up the leg before they order all the images."
V10 reported pain scores need to be documented in the MAR every shift and every time a pain medication is administered. V10 reported documenting the pain scores allows staff to see if the current plan of treatment is working.

On 3/24/25 at 1:49PM, V11 (Primary Physician) stated if a resident is complaining of pain in the leg then V10's concern is an injury to the hip so V11 always orders an x-ray to the hip. V11 reported pain is subjective so staff must go off what the resident is reporting and treat it that way. V11 said, "I have seen people who stub their toe and rate the pain a 10 and other people who have a fracture who say the pain is not that bad. You have to get to an answer of what is cause a new onset of pain if possible." V11 stated if the resident can't tell staff where the pain is but there are signs of pain then a full assessment must be done to identify as best as possible where the pain is and what caused the pain.

The Hospital Records dated 2/7/25 document R1 admitted to the hospital for increased confusion and was complaining of left hip pain. R1 was unable to state a reason for the pain. On physical exam, R1 had normal extremities. An x-ray of the pelvis was taken to rule out any injuries. The hospital x-ray report dated 2/8/25 documents the left hip had no evidence of fracture but had mild osteoarthritis in both hips. R1 was discharged back to the facility on 2/11/25.

A Nursing note dated 2/16/25 documents R1 is in stable condition and denied any pain or discomfort this shift.

A Nursing note dated 2/17/25 at 1:26PM

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 03/24/2025

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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S9999	Continued From page 9	S9999		

documents R1 complained of an increase of pain. The nurse practitioner ordered ibuprofen as needed and an x-ray of the left knee.

A Nursing note dated 2/17/25 at 7:23PM documents R1 is alert and oriented time two and able to make needs known. One view of the left knee was unable to be completed because the left knee could not straighten out all the way.

A Nursing note dated 2/17/25 at 8:49PM documents R1 is alert but confused. The left knee x-ray results indicate the left knee has moderate osteoarthritis with joint space narrowing from chrondromalacia. Knee bones with osteopenia suggest early demineralization of bone mass. There is no evidence of osseous destruction or acute pathological fracture. The physician was notified of the results.

The X-ray Report of the left knee dated 2/17/25 documents the left knee has moderate osteoarthritis with osteopenia. There is no evidence of osseous destruction or acute pathological fracture.

A Nurse Practitioner note dated 2/18/25 documents R1 recently returned from the hospital for altered mental status. R1 reported pain to the left leg which appeared to have left knee flexion and contracture present. The x-ray to the left knee showed moderate arthritis present. The nurse practitioner attempted to gently stretch the left lower extremity, but R1 yelled out when the nurse practitioner touched R1's left lower limb. Three different pain medications are ordered as needed.

A Nursing note dated 2/19/25 documents R1 complained of generalized body pain. Pain

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 03/24/2025

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

(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 10	S9999		

medication was administered. Continue plan of care.

A Nursing note dated 2/21/25 at 12:17PM documents R1 complained of pain to the left leg and difficulty moving the left leg. R1 was unable to state the level of pain on a pain scale or the exact onset of the pain at this time. R1 only said, "It hurts. Don't touch it." Pain medication was administered and the in house nurse practitioner was notified. The nurse practitioner examined R1 and ordered for an x-ray of the left trochanter.

A Nursing note dated 2/21/25 at 5:35PM documents R1 complained of pain to the left and right leg and both feet.

The X-ray Report of the left hip dated 2/21/25 documents a fracture at the neck of the left femur is seen with displaced distal fragments. Mild osteoarthritis of the hip is also present.

A Nursing note dated 2/21/25 at 6:39PM documents the left trochanter x-ray was positive for a fracture to the neck of the left femur and displaced distal fragments. The physician was notified and ordered to send R1 to the hospital. An ambulance was called and was scheduled to arrive in 90 minutes.

A Nursing note dated 2/22/25 documents R1's admitting diagnosis as left intertrochanter fracture with displacement.

A Nursing note dated 2/26/25 documents R1 readmitted to the facility post left hip surgery.

The Medication Administration Record dated 02/2025 documents R1 was given scheduled tramadol 50 mg at 9AM and 5PM as ordered.

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 03/24/2025

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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S9999	Continued From page 11	S9999		

A pain score is documented with each administration of tramadol. The documented pain scores range from zero to eight out of ten. The first documentation of a score higher than zero was on 2/14/25 at the 5PM dose when R1 rated the pain a five out of ten. There is an order to monitor and record pain score every shift. The order was discontinued on 2/8/25 when R1 went to the hospital and was not reordered again until 2/26/25. From 2/11/25 through 2/21/25, pain scores were not being assessed and recorded every shift for R1. An order for 600mg of ibuprofen every six hours as needed was placed on 2/17/25. The documentation shows R1 only received ibuprofen on 2/21/25 at 9:37AM. No pain score was documented with the administration of this medication.

The Comprehensive Pain Assessment dated 2/11/24 documents R1 denied any reports of pain. R1 did not verbally admit to having any pain and did not show any nonverbal signs of pain, such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.

The Comprehensive Pain Assessment dated 2/17/25 documents R1 reported pain to the left knee. R1 has generalized osteoarthritis, which could be a reason for the pain. R1 has also had a decrease in physical activity. Pain is relieved by position change and mediation. R1 shows facial grimacing and vocalizes reports of pain. R1 described the pain as aching. The facial pain scale documents the pain hurts even more (four out of ten on the numerical pain scale). An x-ray of the knee was ordered, and an order for ibuprofen 600 mg every six hours as needed was put in by the nurse practitioner.

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 03/24/2025

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

(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 12	S9999		

The Comprehensive Pain Assessment dated 2/18/25 documents that R1 did not report any pain. R1 did not verbally admit to having any pain and does not show any nonverbal signs of pain, such as facial grimacing, restlessness, rubbing, or bracing. The facial pain scale documents the pain score at a zero out of ten.

There is no documentation that a Comprehensive Pain Assessment was completed on 2/19/25 or 2/20/25.

The Comprehensive Pain Assessment dated 2/17/25 documents R1 reported pain to the left hip. R1 has generalized osteoarthritis, which could be a reason for the pain. R1 was withdrawn from activities on this day and pain was increased with repositioning. Pain is relieved with medication. R1 shows facial grimacing, bracing, and vocal complaints to not touch the area that is panful. R1 described the area as aching and discomfort. The facial pain scale documents the pain hurts a whole lot. The numerical pain scale rate the pain a ten out of ten.

The Minimum Data Set (MDS) dated 12/12/24 documents a Brief Interview for Mental Status score as 11 (moderate cognitive impairment). Section GG of the MDS documents R1 uses a wheelchair for a mobility device. R1 needs partial to moderate assistance with bed mobility and substantial to maximal assistance with transfers. R1 is able to self-propel in the wheelchair with supervision or touching assistance. Section J of the MDS documents R1 has not received any scheduled or as-needed pain medication in the last five days and denied having any pain within the last five days.

The Care Plan revised on 2/27/25 documents R1

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 03/24/2025

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

(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 13	S9999		

is at risk for an alteration in comfort related to fracture of femur, arthritis, history of falls, and seizures. Interventions include: assess pain characteristics by duration, location, and quality; and monitor for non-verbal indicators of pain (moaning, crying, grimacing, wincing).

The policy titled, "Pain Management," dated 10/2024 documents, "General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Guideline: the pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever. The experiencing person says it is and exists whenever he or she says it does. "Pain Management" is defined as the process of alleviating the residence pain to a level that is acceptable to the resident is based on his or her clinical condition and establish treatment goal. Pain management is a multidisciplinary care process that includes the following: observing for the potential for pain, effectively, recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the residence pain, developing in implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions; and modifying approaches as necessary. It is important to recognize cognitive, cultural, familial, or gender specific influences on the resident's ability or willingness to verbalize pain ...Policy: 1. Pain is assessed using the

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S9999	Continued From page 14 comprehensive pain assessment form: upon admission, quarterly, with significant change, following a fall, when new pain is identified, and when existing pain worsens. 2. Pain will be assessed at least once a every shift and documented in the EMAR using the pain scale appropriate for the patient. The following pain scales are available for use: numerical scale and PAINAND scale for the cognitively impaired ...6. If pain has not been managed, consistent with the residence goals and needs, the interdisciplinary team may need to reconsider current interventions and revise those interventions as needed; or if pain has been maintained and/or resolved, the nursing staff will work with the physician to taper or discontinue analgesics." (A)	S9999		