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 06/24/2025

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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S 000	Initial Comments Complaint Investigation 2595709/IL195168	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3 300.3210t) 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.

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:

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.

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 requirments are not met as evidenced by:

Based on interviews and record reviews, the facility failed to prevent a resident injury, and failed to determine the origin of the injury. This affected one of three residents (R1) reviewed for injury of unknown origin. This failure resulted in R1 sustaining left eye swelling and discoloration, discolorations to chest and right leg, scratches to face and chest area, and complaints of chest pain which were identified by the emergency room staff when R1 presented to the hospital for agitation.

Findings include:

On 6/24/25 at 2:30 PM, V7 (Complainant) stated

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that R1 presented to the emergency room on 6/22/25 at 1:02 AM with bruising and swelling to left eye, bruising to mid chest area, bruising to right leg, and scratches to face and chest area. V7 stated that the bruising on R1's chest appeared to be a heel print from being kicked in the chest. V7 stated that R1 stated V3 (Nurse) beat him up because R1 would not give V3 the bottle of rubbing alcohol which was his. V7 stated that R1's injuries were consistent with a person being assaulted. V7 stated that R1 also complained of chest pain.

On 6/22/25 at 12:30 PM, V4 CNA (Certified Nurse Aide) stated that the incident happened after dinner on 6/21/25. V4 denied R1 exhibiting any behaviors prior to 6/21. V4 stated that V4 was rounding on his assigned residents when V4 observed R1 pouring rubbing alcohol into a cup. V4 stated that V4 immediately informed V3 (Nurse). V4 stated that V3 went to R1's room to speak with R1. V4 stated that R1 was verbally aggressive and threw the cup of rubbing alcohol at V3. V4 stated that V4 went to R1 and R2's room two hours later to provide resident care to R2. V4 stated that R1 pulled the privacy curtain open to see who the person was that told on R1. V4 stated that R1 walked towards V4, R1's gait was unsteady, wobbly. V4 stated that as V4 was opening the door to get staff assistance, R1 hit him on his left side of neck/shoulder area. V4 stated that V4 informed V3 that R1 was being verbally and physically aggressive. V4 stated that V3 informed him she was going to handle the situation with V5 (Assistant Administrator). V4 stated that R2's family member brought in the bottle of rubbing alcohol earlier on 6/21 and R1 took the bottle of rubbing alcohol from R2's belongings.

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S9999	Continued From page 3 On 6/23/25 at 10:00 AM, V6 CNA stated that V6 heard V4 CNA asking for help, he was having difficulty with R1. V6 stated that she was walking down hallway and heard V4 say don't hit me, V6 entered room to try to calm R1 down. V6 stated that V6 went on other side of the privacy curtain to speak with R1. V6 stated that R1 told her to get out and head butted her on her lower lip. V6 stated that V6 ran out of R1's room due to her lip bleeding. V6 stated that V3 and V5 were approaching R1's room as she was exiting room. V6 stated that R1 is cranky, he can be verbally inappropriate at times. V6 denied R1 ever being physically aggressive prior to that evening. V6 stated that she did not see R1 anymore that evening. On 6/23/25 at 10:15 AM, V3 (Nurse) stated that she was at nurses' station when V4 CNA informed her that R1 was pouring rubbing alcohol into cup. V3 stated that she went to R1's room, saw cup 1/2 full of rubbing alcohol. V3 stated that V3 asked R1 what he was going to do with it, R1 did not respond. V3 stated that V3 asked R1 to give her the cup. V3 stated that R1 held the cup and threw the liquid at her, V3 pulled the curtain to block liquid. V3 stated that most of the liquid hit curtain, only a little got on her clothes. V3 stated that R1 was verbally aggressive with her, but she was able to take the bottle of rubbing alcohol with her out of room and placed it at the nurses' station. V3 stated that V3 then heard a scream, V3 rushed to R1's room with V5 (Assistant Administrator) to find V6 CNA screaming. V3 stated that V3 observed V6's lip bleeding; V6 stated that R1 head butted her. V3 stated that V3 and V5 walked with R1 to the social services' office. V3 stated that afterwards V3 called the physician and obtained orders for medication injection and to send R1 to the	S9999		

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hospital for evaluation. V3 stated that R1 stayed in the office with V5 on 1:1 monitoring until the ambulance crew transported R1 to the hospital. V3 stated that V3 is not sure how R1 got the bruises. V3 did not report an injury of unknown origin to the Administrator. V3 stated that R1 is alert and oriented x 3, his baseline.

On 6/23/25 at 12:10 PM, V5 (Assistant Administrator) stated that V5 was working in his office on Saturday, 6/21, completing needed work. V5 stated that V3 (Nurse) informed V5 that they found a bottle rubbing alcohol in R1's possession. V5 stated that this bottle belonged to resident's roommate, R2. V5 stated that later R1 was becoming verbally and physically aggressive with staff and V5 saw V6 (CNA) was bleeding from her lower lip. V5 stated that V5 went to R1's room to de-escalate the situation. V5 stated that with re-direction V5 was able to get R1 to exit his room and agree to go to the social services office. V5 stated that while V5 was walking to the office with R1, R1 attempted to exit a back door at the facility. V5 stated that V5 was able to get R1 into the office to monitor R1 1:1. V5 stated that V5 sat with R1 until the ambulance crew arrived to transport R1 to the hospital for behaviors. V5 stated that R1 left the facility around 6:00 PM. V5 stated that V5 left the facility between 7:00 PM and 7:30 PM. V5 denied any staff member hitting R1. V5 denied R1 having any injuries prior to transporting to the hospital.

On 6/23/25 at 3:00 PM, V1 (Administrator) stated that V1 was informed that R1 was being aggressive with staff on 6/21. V1 stated that staff are CPI (Crisis Prevention Institute) trained. V1 stated that this is not used very much at this facility. V1 stated that it is possible R1 could have sustained bruising when staff were trying to

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de-escalate the situation with R1.

R1 has diagnoses including but not limited to stroke with hemiplegia affecting left non-dominant side, unsteadiness on feet, abnormalities of gait and mobility, major depressive disorder, bipolar disorder, delirium, anxiety disorder, suicidal ideations, and schizoaffective disorder.

R1's outside ambulance report, dated 6/21/25, noted staff called for transport to hospital at 6:11 PM for a resident being aggressive with staff. The outside ambulance crew were dispatched to the facility at 11:29 PM and arrived at R1 at 00:05 AM. R1 noted with contusion to left eye, complaints of chest pain, and injury to right leg. R1 is claiming that staff struck him in the face and kicked him in the chest.

R1's hospital record, dated 6/22/25 notes R1 presented to the emergency room at 1:21 AM for aggressive behavior/uncooperative behavior. R1 noted with hematoma (localized collection of blood) of left upper eye with swelling to affected orbit. R1 with noted bruising to chest area and right leg. R1 complained of chest pain, 10 out of 10. Per report, R1 found consuming rubbing alcohol in room to which altercation ensued with staff and R1.

R1's medical record, dated 1/7/25, notes R1 exhibited physical aggression. R1's medical record does not note the details of this physical aggression. R1's medical record does not note any other incident of physical aggression until 6/21/25.

On 4/25/25, Psychiatric Nurse Practitioner noted R1 is being seen for follow up visit: R1 is adherent with medication with encouragement

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S9999	Continued From page 6 from staff; fair hygiene and states " I am doing well". Objective: R1 is AO x 2-3, fair grooming with good hygiene has no overt indication of depressive signs/symptoms. Fair insight/judgment; normal speech, apathetic fair concentration but denies suicidal/homicidal ideation. Assessment: He presents cooperative; fairly guarded endorses normal sleeping habit. Nursing staff reports R1 is adherent with medication and without exacerbation. R1's screening assessments for indicators of aggressive and/or harmful behaviors, dated 10/29/24, 1/3/25, 1/7/25, 2/3/25, and 5/5/25, note R1 is at minimal risk for aggression. The facility's abuse policy, revised 1/31/25, notes the nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. (A)	S9999		