STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051136	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF PALOS HILLS	**10426 SOUTH ROBERTS , PALOS HILLS, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Survey Complaint Investigations: 2594058/IL192053 2594094/IL192034 2593931/IL191553	S0000		
S9999	Final Observations Statement of Licensure Violations (1 of 4): 300.610a) 300.1210b) 300.1210c) 300.1210d)4)A) 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 this Part. The written policies shall be followed in operating the facility. 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. 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. 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 as evidenced by: Based on interview and record review, the facility neglected to follow their policy and procedure to	S9999		

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S9999	Continued from page 2 ensure staff provided incontinence care at least every two hours for a resident identified as dependent on staff for toileting. This affected one of three (R131) residents reviewed for neglectful care and services. This failure resulted in R131 being exposed, soiled with feces, crying, verbally distraught, begging for help and feeling uncomfortable. Findings Include: R131 was diagnosis with mixed/urinary incontinence, rash and other nonspecific skin eruption, malignant neoplasm of vulva and obesity. Minimal Data Set (MDS) section C (cognitive patterns) dated 5/8/25 brief interview for mental status documents a score of thirteen which indicates cognitively intact. Section GG (functional abilities) documents R131 was dependent with toilet hygiene (helper does all of the effort). Resident does none of the effort to complete the activity or the assistance of two (2) or more helpers is required for the resident to complete the activity. Care Plan initiated on 1/31/25 and 5/8/25 documents: R131 has a self-care deficit in bed mobility related to decrease ability to position or reposition self in bed and turn from side to side without staff assist. At risk for abuse and neglect. On 5/13/25 at 4:53pm, R131 who was assessed to be alert to person, place and time said, she was left in her feces from 2am until the police arrived. R131 said, she called V37 to report staff was not answering her call light and she needed to be cleaned up after a bowel movement. R131 said, her vaginal area was exposed and there was so much diarrhea. R131 said, she felt bad and just wanted some help while starting to tear up. R131 said, she was falling in and out of sleep due to her nightly medication and was not provided incontinence care until the police arrived. Facility provide statement for R131 dated 5/14/25 documents: "I woke up. I had a mess on my hands because I was in diarrhea. I pressed the call light to be changed. No one was coming so I called my son and V37. I just remember being uncomfortable and needing to be changed." On 5/15/25 at 10:03am, V37 (family) said, R131 called him crying, upset, verbally distraught begging for help early Monday morning at 2am complaining of staff not	S9999		

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S9999	Continued from page 3 answering her call light on the night shift. Not changing her after she had a bowel movement. R131 has a wound from radiation in her groin. V37 said, R131 called him back multiple time between 3am -5am to report staff still hadn't come to her change/provide incontinence care. V37 said, he called the facility with no answer. V37 said, after the multiple calls from R131 due to her not receiving care, he called the police for a well check. R131 was left soiled and saturated in urine and feces for four hours. The facility tried to say R131 tore of her adult brief. R131 does not have any behaviors. Facility provided concern form dated 5/12/25 (9:37am) documents: V37 stated he had concerns regarding care. Wasn't able to reach anyone. Stated he called police. All parties notified. Facility provide statement for V37 dated 5/14/25 (2:41pm and 4:08pm): V37 said, that he received a phone call from R131 early Monday morning and that she mentioned she was waiting for someone to come and change her. V37 also mentioned that he called the police because he said he felts like R131 was being mistreated. Police Report dated/time report 5/12/25 at 6:31am documents: Last known secure 5/12/25 at 3:00am. On 5/12/25 at 6:52am, police responded to nursing home in reference to a citizen assist complaint. V37 informed them that he was requesting a well-being check on his wife, R131. V37 stated that he tried calling the facility several times and no one was answering. Additionally, V37 informed Southwest Central Dispatch (S.W.C.D) that he spoke with R131 who stated she was sitting in her own feces and had open wound. V37 explained that he was unhappy with the care R131 was getting. Upon police arrival, police observed a female subject standing behind a nurse's cart, dressed in scrubs. In the hallway for two hundred rooms. Police inquired, if she was the nurse for the wing, at which point she informed police she was and assisted police with the location of R131's room. Upon entering R131's room, police could smell the strong odor of feces. Police then observed a female subject, later identified as R131, lying on the bed closest to the entry door of the room. R131 did not have any undergarments on, was lying on her back, and her vaginal area and groin area appeared to have a large amount of feces on it. R131 was holding a bed sheet that also appeared to have feces on it. Police spoke with R131, who explained the	S9999		

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S9999	Continued from page 4 following in summary but not verbatim: She/R131 had been lying in that condition since May 12 2025 between the hours of 2:00am -3:00am. R131 further advised that she called her husband to report the condition and also her son. Police asked, R131 if she had a call button located near her, to contact staff. R131 informed police there was call button beside her bed, but no one had come to assist her. Police relocated back into the hallway and spoke with the female subject standing behind the nurse cart, dressed in scrubs. Police informed her of R131's condition, at which time the female subject standing behind a nursing cart, dressed in scrubs advised that she was not a CNA (certified nurse's assistant). Police relocated to the administrative area and knocked on the doors. Police was met by a male subject, dressed in what appears to be a doctor coat. Police informed him of R131 condition and what the female subject standing behind a nurse cart, dressed in scrubs explained to police. The male subject dressed in what appears to be a doctor's coat immediately relocated to R131 room and then contacted another individual. Upon the arrival of a second female staff member, she did not enter R131's room and began working on her schedule paperwork. Police inquired with the female staff member if she needed police assistance getting another staff member to assist her, due to R131 sitting in her feces since 2:00am. After some time had passed a third female staff member arrived at the location where the second female staff member was. The third female staff member explained that she was gathering an undergarment "adult brief" for R131. Police inquired with the third female staff why R131 did not have an undergarment on at this moment. The second female staff member answered and advised that it was due to R131 having behavioral problems. Upon the second/third female staff entering R131's room, the second female staff member began question R131 about her notifying the police and who she contacted about her condition. Police advised R131 that she did not have to answer the questions, at which time the second female staff member became agitated and informed police that R131 was obligated to answer her questions, due to the second female staff member being in charge of the floor. Police advised the second staff member that R131 had been lying in her feces for some time and that assisting R131, prior to question R131, would be her best interest. On 5/15/2025 at 11:27am, V28 (social service) said R131 did not have any behaviors related to refusing incontinence care nor is any charted in the care plan with seventeen pages. V28 said, she would assume R131 would want to be changed after a bowel movement like	S9999		

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S9999	Continued from page 5 anyone else. On 5/15/2025 at 3:15pm V35 (nurse) said, she was assigned to R131's unit on the night shift (11pm -7am) for 5/11/25. V35 said, she was an agency nurse and had never worked with R131 before. V35 said, there wasn't an evening (3pm -11pm) nurse on R131's unit to get report from. V35 said, when she started her shift at 11pm, there were two certified nursing aides that introduced themselves to her. V35 said, she thought those two aids were assigned to her unit. V35 said, two hours into her shift she realized a lot of call light were going off. V35 assumed the aides were in other resident's room providing care. V35 said, R131's family called to complaint that R131 was soiled. V35 said, she went into R131's room at 1:00am. V35 said, R131 was soiled with feces and needed to be changed. V35 said, she needs another staff member to assist with R131 due to her size. V35 said, she did not have any staff to assist her with R131 incontinence care. V35 said, there wasn't any aides on her unit. V35 said, she started to check all of her assigned resident to make sure they were alive. V35 said, she called V10 (manager on duty/nurse) and informed her that there was no CNAs on her shift and only one nurse on the opposite unit. V35 said, residents were soiled and neglected. V35 said, the facility put her licensed and the residents at risk. On 5/15/25 at 5:06pm, V10 (IP Nurse) said, she worked upstairs on the second floor on the 3-11 shift. V10 said, she was the manager on call from Sunday night (5/11/25). V10 said, she was short staff on the night shift of 5/11/25 going into the early morning of 5/12/25 on R131's unit. V10 said, on R131's unit there was only one nurse and one certified nursing assistant working on the 11-7am for the long term care unit/R131's unit. V10 said, two (2) nurse and (4) four CNA are needed for the long term care unit. One nurse and two CNA should have been on R131's unit. On 5/16/25 at 1:16pm, V48 (CNA) said, she was short staffed on the night shift on (5/11/25) Sunday night. V48 said, she worked with V47 (CNA), and they provided incontinence care for R131 two to three times that night with the last time being around 4:30am- 5:00am. V48 said, she did not see the police. V48 said, she did not chart the care provide to R131. Facility provided witness statement from V47 dated	S9999		

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S9999	Continued from page 6 5/14/25 documents: V47 was a CNA on the night 5/11/25. V47 was not assigned to R131. V47 did not take care of R131 on 5/11 night shift. Statement given by V47 via phone on 5/15/25 at 11:20am. On 5/16/25 at 4:20pm, V9 (nurse) said, she was the nurse on the south unit. V9 said she worked the day and evening shift on 5/11/25. V9 said, she was in the facility charting until 1:30am -1:45am because she sent a resident to the hospital. V9 said, at the end of her double shift she was not providing any patient care. On 5/16/25 at 12:13pm, V2 (Administrator) said, if staff was aware that R131 needed incontinence care and failed to provide it, that failure is neglect. V2 said, residents should be changed every two hours and as needed. V2 said, she did not view the camera to determine if staff responded to R131's call light. Surveyor requested to view the video footage of staff entering and exiting R131's room. V2 did not present any video footage for review during the survey. On 5/16/25 at 1:47pm, V4 (ADON) said, she came into the facility on 5/12/25 at 2:00am, that morning. V4 said she was informed around 11:45pm that a nurse was needed on the south unit on long term care side. V4 said, she spoke agency nurse, who informed her that the south unit nurse had just left. The nurses are not supposed to leave without being relived or giving report to another nurse. The long term care unit had two nurses when she reported for work, ideally it should be three nurses assigned to the long term care unit. V4 said, she did not interact with the police. Abuse policy dated 9/2017 documents: This facility affirms the right of our resident to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. Neglect means the failure of the facility, it employees or service providers to provide goods and service to a resident that are necessary to avoid physical harm, pain or mental anguish or emotional distress. Further, neglect means a facility's failure to provide or willful withholding of adequate medical care, mental health treatment, psychiatric rehabilitation, personal care or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident. (B)	S9999		

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S9999	Continued from page 7 Statement of Licensure Violations (2 of 4): 300.610a) 300.1210b) 300.1210c) 300.1210d)5) 300.1220b)3) 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. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued from page 8 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin 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. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to prevent one resident with a tracheostomy, who was identified as high risk for skin breakdown and dependent on staff for care, from acquiring a wound, and failed to follow their policy to develop and implement interventions individualized based on the resident's condition for one resident at high risk for skin breakdown with 18 impaired skin areas. This affected two of three residents (R111, R122) reviewed for pressure sores. This failure resulted in R122 sustaining an open wound to the left side of the neck measuring 7 cm x 1cm x 0.5 cm at the tracheostomy collar and R111 obtaining multiple pressure wounds at the facility.	S9999		

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S9999	Continued from page 9 Findings include: 1. R122 was admitted to the facility on 1/28/25 with a diagnosis of respiratory failure, type II diabetes, abnormal posture and tracheostomy status. R122's minimum data set dated 2/4/25 documents R122 is dependent on staff for rolling left to right and for all activities of daily living. R122's Braden scale for predicting pressure sore risk documents score of 8. A score of 9 or below indicates very high risk for skin breakdown. On 5/15/25 and 5/16/25 at 10:46 AM, R122 was observed in bed with head leaning to left side. R122 had tracheostomy collar in place. A tracheostomy collar is a soft, clear mask that fits over the tracheostomy tube to deliver oxygen that has a green thin strap that goes around the neck. R122's skin and wound evaluation dated 5/4/25 documents in house acquired laceration to left side of neck measuring length 6.5 (centimeters, CM) x 0.7 CM). R122's wound assessment report dated 5/6/25 documents: Resident was in bed for wound evaluation. Resident has Respiratory Failure, and Cerebral Infarction. Resident is status trach/vent, incontinent, and poor bed mobility. Resident has laceration injury to the neck due to trach collar. Injury was picked up and is being treated. Primary Etiology: Skin Tear/Laceration. Stage/Severity: Stage 3. Size: 7 cm x 1 cm x 0.5 cm R122's wound note dated 5/13/25 documents: Resident has laceration injury to the neck due to trach collar. Injury was picked up and is being treated. Primary Etiology: Skin Tear/Laceration Stage/Severity: chronic On 5/16/25 at 12:27PM, V43(Wound NP) said R122's wound was classified as a laceration due to the shape of wound being straight and linear. The opening was caused from resident moisture causing the skin to became softer and easier for foreign force to cause breakdown. R122 trach collar was determined to be the cause of opening along with moisture. V43 said it was classified	S9999		

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S9999	Continued from page 10 as laceration and skin tear which are the one in the same and can be used interchangeable. V43 said the wound stage three on initial note was done in error. On 5/16/25 at 10:59AM, V3 8(Respiratory Manager) said R122's had a wound to left neck which could have been caused by friction from the trach collar. V38 said staff are supposed to ensure the strap is placed on pad the to ensure it does not irritate the skin. On 5/15/25 at 2:20 PM, V30 (wound nurse) said R122's wound is a laceration from the tracheostomy collar. Laceration is a cut in the skin from trauma like friction from the tracheostomy collar. Facility policy reviewed 9/23 Pressure injuries documents: to prevent or reduce the incidence of pressure injuries, standards of practice should be implemented. A pressure injury may be defined as any lesion caused by unrelieved pressure that results in damage to the underlying tissue, although friction and shear are not primary causes of pressure injuries, friction and shear are important contributing injuries to pressure Injuries. A pressure injury is localized damage to the skin and or underlying tissue usually over a bony prominence or related to a medical or other device. The injury occurs as a result of intense and or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Medica l device related pressure injury. Use staging system to stage. This describes the etiology of the injury. Medical device related pressure injuries result from the sue of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system. -- 2. R111 diagnoses include but are not limited to fracture of lumbar vertebra, diabetes, protein calorie malnutrition, and attention to gastrostomy. R111 is not verbally or physically responsive when spoken to or while staff providing care.	S9999		

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S9999	Continued from page 11 On 05/14/25 at 10:35 AM V15, CNA, said, "I check and change R111 every 2 hours. We check and change everyone every 2 hours." On 05/14/25 at 12:53 PM V30, wound nurse, accompanied surveyor to see R111. R111 in his bed laying mostly on his right side. R111's right ear was resting on his shoulder and pillow. A visible 4x4 foam dressing was over his left ear. V30 said R111 has deep tissue injuries to his left ear, elbows, sacrum, ischium, feet, and left lateral neck/head areas, skin tears and lacerations over his right hand. V30 said interventions for pressure relief include a horse shoe shaped neck pillow, heel boots, and an air mattress set to his weight. The neck pillow was not on R111 neck and was at the top of the mattress. V30 said interventions include turn every 2 hours for all residents who can't reposition themselves. V30 did not make any movement or response during observations and conversations at this time. On 5/15/25 at 1:55PM V30, Wound care, said R111's right ear wound was identified on 5/1/25 and present on readmission. V30 said the wound was unstageable. On 5/12/25 the right ear measured 0.7 x 1.0 x 0.1 deep, and at stage 3. V30 was asked specifically what intervention were put in place for V30's ear pressure ulcer. V30 said interventions include turn and reposition, every 2 hours, wedges in his room help him be elevated off his sides and bottom, and an air mattress, protein supplements were added. V30 said these wounds were present since before his readmission. V30 said R111 has always had an air mattress originally delivered on 12/26/24. V30 said interventions are appropriate for R111. V30 said they are repositioning R111 enough. The surveyor asked if the facility completed a tissue tolerance test for R111. V30 said a tissue tolerance test has not been done to V30's knowledge. The surveyor asked V30 if R111's care plan includes the use of his neck pillow. V30 said it's not on there. V30 was asked if bolsters are on the care plan and V30 said they are not on there. V30 said they have heel boots and turn and reposition every 2 hours on the care plan. V30 said R111 has about 18 skin impairments (without counting). V30 said we complete "unavoidable" documents we fill them out and the nurse practitioner reviews and signs them. V30 said R111 has unavoidable documentation for his sacrum and left ear but not the right ear because it did not develop in the facility.	S9999		

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S9999	Continued from page 12 On 5/16/25 at 11:42 AM V32, MDS Nurse, said the purpose of the care plan is how they know what care and services to provide to the residents. V32 said the action part of the care plan is the interventions, "what we are doing". V32 said the care plan is individualized based on resident needs and preferences. V32 said anyone providing care to the resident has access to the care plan. On 5/16/25 at 11:52AM V44, Doctor, said R111's prognosis is poor. R111 is a bedbound patient. R111 said interventions for pressure relief should be followed. The surveyor discussed the unavoidable assessment completed by the facility for R111's ear with the intervention for heel protectors. R111 said, "I don't see that applying to an ear wound." V30 provided a list with R111 skin impairments including left ear unstageable pressure ulcer acquired in house and right ear stage 3 pressure ulcer. There are 18 impairments on the list for R111. On 5/16/25 at 11:46AM V30 said we use Braden scale for everyone. V30 said R111 is at high risk for pressure ulcers. Review of R111 wound progress notes date 5/12/25 identify sacrum pressure ulcer, right knee, right hand, right lateral foot, and left leg vary from pressure to venous. Wounds on bilateral ears and left side of head and breakdown on various sites of body. Right ear pressure ulcer stage 3 size 0.7 x 1 x0.1, peri wound skin is fragile. Left ear pressure unstageable size 2.8 x 1.9 x 0.1 granulation and eschar present. Peri wound fragile. Pictures include in document of left ear. Care plan provided to the surveyor by the facility for R111 reviewed and does not include use of wedge/bolster, neck pillow. There is no intervention for turning or repositioning or frequency. There is no intervention specific to R111 left and right ear to relieve pressures, except for treatment. An Unavoidability/Avoidability Determination for R111 ulcer site left ear, unstageable onset 4/21/25. Diagnosis identified Severe PVD, Urinary and Bowel incontinence, and history of pressure ulcers. Interventions include moisture barrier after each	S9999		

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S9999	Continued from page 13 incontinent episode, pressure relief mattress, low air loss, turn and reposition every 2 hours, supplements, and tube feeding. The policy for Skin Management: Treatment/General Wound Treatment dated 4/2024 states, in part, treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. The facility recognizes that the selection of treatment protocol is individualized based on the resident condition and practice patterns ...implement prevention protocol according to resident needs. Mobility: turn and reposition as needed using a person centered approach. (B) Statement of Licensure Violations (3 of 4): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999		

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S9999	Continued from page 14 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. 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: 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide effective supervision for a resident with a diagnosis of right-side hemiplegia, lack of coordination, abnormal posture, displaying agitation while in dining room, and failed to ensure effective interventions to include supervision and monitoring were implemented to prevent a resident from falling out of bed. This affected two of three residents (R59, R65) reviewed for safety, supervision, and falls. This resulted in R65 falling from the wheelchair, R65 was sent to the local hospital for treatment of a clavicle fracture, and resulted in R59 sustaining a closed head injury, abrasion to the top of the scalp and left upper extremity (arm) with diffuse swelling. Findings include: 1. R65 face sheet shows diagnosis of hemiplegia and hemiparesis following non traumatic subarachnoid, type 2 diabetes, aphasia, lack of coordination, abnormal posture, unspecified dementia. R65 incident report dated 3/13/2025 denotes in-part	S9999		

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S9999	Continued from page 15 fall, date of incident 3/13/25, location dining room, during lunch resident was in the dining room while his room was being cleaned. Resident became agitated and he reached for the door and fell. Resident unable to give description. Was this incident with incident witnessed, "N" documented. Description took vital signs, informed Doctor, and family. Neuro check initiated with normal findings. The resident initially denied pain, but after 30 minutes c/o (complain of) pain to left arm. MD was updated and ordered Xray of left shoulder, arm, and elbow. Pain level -one. Mental status- confused/ fearful, orientated to person. Non complaint to safety guidance. Resident had a misunderstanding with his sister who was visiting and was agitated and hard to redirect. On 5/14/25 at 2:17pm V21 (LPN) said she was the Nurse for R65 on 3/13/25 when R65 fell in the dining room. V21 said on this day, R65 room was being deep cleaned and R65 had to get up from bed and come to the dining room until the room was finished being cleaned. V21 said R65 was in a manual wheelchair. V21 said R65 usually stays in his room and watch his movies. V21 said R65's sister did visit that day, and during that visit R65 was agitated because he wanted to go back to his room. V21 said R65 sister was upset that R65 was agitated. V21 said R65 sister was not in the dining room when R65 fell, she was lingering in the hallway. V21 said she asked several times if she could put R65 back in his bed because of the agitation. V21 said R65 reached for the door in the dining room, to open the door and that's when he fell from the wheelchair. V21 said the Director of Nursing at that time allowed her to watch the video and she observed what happened on the video. V21 said she watched the video, but she can't recall if someone was in the dining room when R65 fell. V21 said she does recall that she observed two aides in the hallway. V21 said staff are supposed to monitor the dining room. Facility presented assignment sheet for 3/13/25 (day of R65's fall). V52 (CNA) was identified as one of the aides that was standing in the hallway. On 5/14/25 V52 said herself and V54 were in the hallway, and the other aides were setting up for lunch services. V52 said she thinks a nurse was in the dining room when R65 fell, but she doesn't recall. V52 said R65 was having behaviors because he wanted to go back to his room. V52 said you could hear R65 banging on the door. V52 said herself	S9999		

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S9999	Continued from page 16 and the other aide were planning to put R65 back to the bed, but he had the fall prior to them putting back to bed. V52 said R65 does not usually get out of bed, he prefers to be in his room and watch his movies. V52 said staff are supposed to monitor the dining room when residents are in there. 5/16/25 at 1:42pm V53 (CNA) said she was not in the dining room when R65 fell, she was taking her 15 minute break. V53 said the dining room supposed to be monitored, she thought it was. V53 said she doesn't know who was monitoring the dining room. 5/16/25 at 2:14pm V9 (LPN) said she was not in the dining room when R65 fell, she was passing medications. R65's emergency room after visit summary dated 3/14/25 denotes you was seen diagnosis clavicle fracture. Upon exit of this survey the facility failed to identify who was monitoring the dining room when R65 fell from the wheelchair. Facility fall policy prevention management policy with last review date 8/2024 denotes in-part this facility is committed to maximizing each resident physical. Mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for prevention strategies, and facilitate as safe an environment as possible. All falls shall be reviewed, and the residents existing plan of care shall be modified as needed. -- 2. R59 has diagnoses with Dementia, history of falling and unspecified fracture of left humerus shaft with routine healing. Brief interview for mental status dated 3/6/25 documents a score of eight which indicates moderate cognitive impairment. Fall risk evaluation 2/27/25 documents score of twelve. Scoring a ten of higher makes resident "high risk" for falls. Minimal data set dated 3/8/25 documents: roll to left and right; R59 requires substantial/maximal assistance (helper does more than half the effort), lying to sitting on side of bed: R59 is dependent.	S9999		

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S9999	Continued from page 17 On 5/14/25 at 3:15pm, R59 who was alert to self only said, she fell out of bed but could not elaborate on the events prior to the fall. On 5/14/25 at 3:22pm, V22 (nurse) said R59 had two unwitnessed falls from the bed. R59 was observed on the floor face down both times. V22 said she was not sure how R59 fell. V22 said she got report that R59 did not move. V22 said R59 did not have any injuries the first fall. The second fall R59 complained of arm pain. V22 said R59 was sent to the hospital both times. On 5-15-25 at 1:54pm, V46 (restorative directive) said R59 was high risk for falls. R59 was dependent on staff for repositioning in bed. R59 was unable to turn and reposition herself. V46 said she is not sure how R59 fell since she was unable to reposition self without staff assistance. V46 said R59's fall intervention was ineffective to prevent her from falling out of the bed. R59 was given a fall mat after the first fall which was an ineffective because R59 had a second fall from the bed. Fall mats do not prevent falls from the bed. Fall mats decrease the chance for injuries if the resident falls onto the floor. V46 said R59 sustained abrasion to the scalp and left toe with the second fall. V46 said she does not know what R59 hit to obtain the abrasions nor is it documented. Nursing note dated 4/8/25 document: "Resident (R59) observed laying in a prone position (flat on their stomach, with their face downward or turned to one side), on the floor next to the bed. Resident states, "I fell out the bed". Left upper extremity edema, no visible injures, bed was at the lowest position and call light still attached to the resident." Fall incident dated 4/8/25 documents: R59 has poor bed mobility, positioning and requires assistance from staff. R59 has old left arm fracture with routine healing. Will maintain be in the lowest position. Floor mat given. Round at a minimum of every two hours and prompt or assist for change in position, toilet, offer fluids and ensure resident is warm and dry. Hospital after visit summary dated 4/8/25 documents: fall from bed. Nursing Note dated 5/5/2025 documents: Resident (R59) observed laying prone position on the floor near bed. R59 states, "I rolled out bed. Left upper extremity	S9999		

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S9999	Continued from page 18 edema, abrasion to left top of head. Complains of pain 8/10. Fall event dated 5/5/25 documents: During rounds, the nurse on duty observed the resident laying prone position on the floor on the floor mat. Injury: Abrasion top of scalp and left third toe. Hospital paperwork dated 5/25 documents: Resident presented to the emergency department at this time for evaluation after experiencing a fall out of her bed. According to the patient, the patient was sitting on the edge of the bed and fell off of the bed. R59 has a history of dementia. Physical Exam Finding: Left upper extremity with diffuse swelling, contracted, sling. Closed head injury, Abrasion of scalp. Fall Prevention and Management Policy dated 5/2015 documents: The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. (B) Statement of Licensure Violations (4 of 4): 300.610a) 300.1010h) 300.1210b)4) 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. Section 300.1010 Medical Care Policies	S9999		

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S9999	Continued from page 19 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor and implement effective interventions for one resident at risk for malnutrition. This affected one of three residents (R113) reviewed for weight loss. This failure resulted in R113 sustaining a 34.8 percent unplanned weight loss in less than 6 months.	S9999		

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S9999	Continued from page 20 Findings include: R113 was admitted to the facility on 12/19/24 with a diagnosis of diabetes, muscle wasting, dysphagia, seizures and gastrostomy status. R113 's minimum data set dated 3/24/25 documents substantial/maximal assistance with eating. On 5/15/25 at 2:00PM, R113 weight was taken via mechanical weight lift by staff. Weight scale was set to 0 prior to weighing. Resident weight was 133 pounds. R113's weight on 12 /25/24 documents 201 pounds; 2/5/25 documents weight of 199 pounds, 2/19/25 documents 132.2 pounds; 3/5/25 documents 132.8 pounds, 3/7/25 document 132.8 pounds; 4/1/25 documents 131.6 pounds; 5/6/25 document 129 pounds, 5/14/25 documents 129 pounds R113's 12/20/24 dietary note documents: R113 receiving continuous feeding with nothing by mouth status. R113's eternal feed order dated 1/16/25 documents eternal feeding 1.2 bolus 250 ml two times a day. (900 calories, 40 grams of protein) R113's dietary note dated 2/23/25 documents: enteral feeding 250 ml bid bolus (nutrient content 900 calories, 40.5 gm protein, 363 ml free water and water flush 250 ml four times a day. (total water 1363 ml) excluding oral intake. has puree 1:1 pleasure feeding order intake 50-75%. Weight history: 2.5.25 199, 12.9.24 201, 11.6.24= 199, 10.9.24 = 200 Height 59" Body Max Index 40.2 estimated Kcals needs: 1420-1704 adjusted BW (25-30); estimated protein needs: 54-65 (1.0-1.2); estimated fluid needs: 1420-1704 (25-30 ml); Skin: intact; Plan: Continue Enteral Nutrition and water flush as ordered. Monitor tolerance to Tube Feeding and follow up as needed. R113 dietary evaluation documents high risk for malnutrition. Question accuracy of 199 weight on 2/5/25. Estimated caloric needs 1510-1812 calories. Under intake variable intake 50- 75 % is fed by staff. Under comments: significant change continues, artificial nutrition with no new orders or interventions documented.	S9999		

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S9999	Continued from page 21 R113's dietary note dated 4/26/25 documents: EN: feeding 250 ml bid bolus (nutrient content 900 calories, 40.5 gm protein, 363 ml free water and water flush 250 ml Four times a day. (total water 1363 ml) excluding oral intake. has puree 1:1 pleasure feeding order intake 50-75%. Weight t history: 4.1.25= 131.6, 2.7.25= 132.8, 2.5.25 199, 12.9.24 201, 11.6.24= 199, 10.9.24 = 200 Height 59 inches Body Max Index 29.6. Weight loss 34% in 180 days discussed in Nutrition at Risk meeting 4.9.25 and 3.12.25 and secondary to acute kidney failure estimated. Kcals needs: 1495-1794 kcal; estimated protein needs: 54-65 gm (1.0-1.2); estimated fluid needs: 1495-1794 cc; Skin: intact; Plan: Continue Enteral Nutrition and water flush as ordered. monitor tolerance to Tube Feeding and follow up as needed. On 5/16/25 at 10:09 AM, V45 (dietician) said R113 had a significant weight loss of 34 percent based on weight of 199 pounds to 131 pounds. V45 said R113 was on continuous artificial feeding and orders was changed in January to receive feeding twice a day which is about half of her caloric intake due to R113 eating by mouth. V45 said in February she questioned the weight and asked for reweight which indicate same weight. V45 said she begin to question the accuracy of all R113 weight from august 2024 through January 2025 saying she was unsure if R113 ever weighed 200 pounds and was always around 130. After a significant weight change depending on resident, we will monitor weights weekly, implement supplements or caloric counts. V45 was unable to provide any additional information related to any interventions or monitoring down for R113 weight and requesting to review her notes. At 11:29AM, V45 was not able to present any new information related to R113, except that she reviewed her hospital weights which did not match but said they do not use hospital weights calculate weight changes. V45 said R113's weight was stable at 130 pounds and no further interventions were placed. On 5/16/25 at 1:09PM, V50 (Nurse Practitioner) said he was not able to recall any concerns related to R113 having a significant weight loss. V50 recalls receiving reports of R113 not eating good possible to mood. V50 was shown R113 weights and was unable to explain the change or any interventions put in place.	S9999		

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

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S9999	Continued from page 22 Facility weight management policy reviewed 6/24 documents: to establish a policy for the consistent, timely monitoring and reporting of resident's weights. Weekly weights will also be done with a significant change of condition, food intake decline or with physician order. The director of nursing will forward dietary recommendations to the physician or nurse practitioner will follow up with recommendations within 24- 48 hours. (B)	S9999		