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	IL6007991	A. BUILDING: _____ B. WING _____	05/30/2025

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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.3210t) 3240b) 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	S9999		

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care and personal care shall be provided to each 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.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to prevent a resident to resident physical assault. This affected two of four (R48, R70) residents reviewed for physical abuse. This failure resulted in R48 assaulting R70 in the face with a shoe on 4/8/25. R70 sustained purple discoloration to the right eye lid and petechia above the eyebrow.

Findings include:

On 5/28/25 at 1:15pm R70 observed alert to person, place, time and situation. R70 stopped surveyor and stated the facility has mixed residents with mental illness with residents that have medical problems. R70 said R48 hit her in the face with a shoe and she sustained a bruise to the eye. R70 said this was last month. R70 showed surveyor a picture on her cellular phone.

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The image was of R70's face, there was a dark purple discoloration to the right eye lid and petechia above the eyebrow. R70 said V1 (Assistant Administrator) was aware, and she told her son about it. R70 said this happened the day the rooms were changed.

Review of R70's progress notes noted that R70 and R48 had a verbal altercation and R48 was relocated to another room.

On 5/28/25, R48 is not interview-able.

The data information on R70 phone denotes that image was taken on 4/14/2025 at 9:33am.

On 5/28/25 at 2:59pm V26 (R70's son) said that R70 did report to him that a resident hit her in the face with a shoe. V26 said that matter should be investigated.

On 5/28/25 at 3:30pm V1 (Assistant Administrator) said R70 did inform him that R48 hit her in the face with a shoe. V1 said how does a bruise come a week later. V1 said he did see the bruise to R70's right eye, and when he asked R70 about it, R70 replied "I told you what happened". V1 restated that R70 said R48 hit her with a shoe. V1 said he is not a medical professional. V1 said R70 also fabricates stories. V1 said he does not know how R70 sustained the bruise to the right eye and petechia to forehead. V1 said he did not report the injury of unknown origin to the State Department. V1 said he did not reach out to the Administrator for guidance regarding the bruise to R70's eye and reported injuries. V1 said he thought the matter was resolved with he separated R70 and R48's room. V1 said the injury of unknown origin should have been reported to the State Department. V1 said

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he did not investigate R70's allegation of physical assault when alleged. V1 said the allegation was not investigated.

On 5/28/25 at 4:20pm V2 (Administrator) said she was not aware of the bruise to R70's right eye. V2 said there is nothing documented in R70's medical records about the bruise to the right eye. V2 agreed that V1 should have reported the injury to the State Department.

Facility policy for abuse with last review date 9/2024 denotes in-part the facility affirms the right of our residents to be free from abuse, neglect, mistreatment or misappropriation of resident property or mistreatment.

(B)

2 of 2

300.610a)
300.1210b)
300.1210d)2)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 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

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S9999	Continued From page 4 Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. These requirements are not met as evidenced by: A. Based on interviews and records reviewed the facility failed to prevent one dependent resident receiving narcotic medication known to the cause side effect of constipation from developing a "large stool burden." This affected one of one resident (R41) reviewed for quality of care and hospitalizations. This failure resulted in R41 being transferred to the hospital and admitted for a diagnosis of Sterocoral Colitis secondary to severe constipation.	S9999		

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B. Based on interview and record review, the facility failed to follow physician' s orders for obtaining monthly laboratory draws for seizure medications levels for residents identified with seizure disorders. This affected two residents (R94 and R6) reviewed for following physician orders.

Findings include:

On 2/23/25 hospital History and Physical identifies R41's chief complaint constipation. R41 is being admitted for Sterocoral Colitis, Urinary Retention, and UTI. According to National Institutes of Health, they define Sterocoral as a rare inflammatory form of colitis that occurs when impacted fecal material leads to distention of the colon. R41 returned to the facility on 2/24/25. R41's diagnosis include but are not limited to malignant neoplasm of right breast and constipation.

On 05/28/25 at 1:06 PM R41 in bed observed twice, both times R41 was non-responsive.

On 5/29/25 at 11:31AM V12, LPN, said R41 called 911, it happened before for bowels. V12 said R41 was on a narcotic that she took everyday, she took 2 a day. V12 said R41 was educated that a side effect of the narcotic was constipation. V12 said R41 was on a stool softener. V12 said R41 gets agitated when she can't go, it was not her first time not being able to go. V12 said R41 "panics" about not being able to have a bowel movement. V12 said R41 has a prescription for bowel care daily. V12 said in the past I have given her lactulose one time to go. V12 said R41 has a cancer diagnosis. V12 said if residents complain of not having a bowel

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movement we assess for distended abdomen or blood in the stool. V12 said I would ask R41 when she pooped last, and I would encourage fluids. V12 said we try to avoid using an enema on R41 because she might bleed. V12 said we discuss the care for R41 bowels with the Nurse Practitioner. V12 said we would document in the progress notes the assessment we did. (The facility provided V12 as an assigned nurse to R41 during 2/20/25-2/23/25.)

On 5/29/25 at 9:59AM V22, LPN said R41 didn't tell me she needed anything on 2/23/25. V22 said R41 just called 911. I saw the ambulance came in; I was surprised. We went to her room and R41 transferred to the hospital. She never told me anything was wrong in the beginning. There was nothing told to me in report and no pain reported. V22 said R41 left, I didn't get an assessment.

On 5/29/25 at 12:36PM V19, Nurse Practitioner, said R41 had breast cancer, and she had pain to the breast. V19 said R41 was on norco for pain management. V19 said constipation can be a side effect of the norco. V19 said constipation can be related to norco, immobility being in a wheelchair and age. V19 said R41 had bowel concerns for at least 1 year that I have been coming to the facility. V19 said R41 was on a bowel regimen with medications and providing adequate hydration. V19 said to monitor R41 she was verbal and could report her bowel concerns. V19 said the CNAs will report if a resident is not going. V19 said R41 was obsessive about her bowels. V19 said I would expect nurses to confirm with CNAs and give PRNs if needed if R41 was reporting the need to have a bowel movement. V19 said they should document symptoms and give the PRN if needed. V19 said R21 would probably present with pain or

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discomfort in the abdomen and possibly some tenderness. V19 said R21 would have been able to report that to us. V19 said the ER visits could have been avoided if treated in the facility for bowel care.

On 5/30/25 at 9:49AM V3, Director of Nursing, reviewing R41's Documentation Survey Report for Bowel Continence with the surveyor and said the report shows R41 had small bowel movements on 2/21/25 and 2/22/25 day shifts and evening shifts. V3 said monitoring for constipation includes monitoring the stool output and how much she is going. V3 said the interventions were not effective in preventing constipation. At 10:30AM V3 said the only documentation with an assessment for R41 I have is the SBAR that was provided already, there was no progress notes documented. The only bowel related policy we have is for Retraining and 3 day assessments for new admissions. While reviewing the Medication Administration Record (MAR) for R41 with the surveyor, 2/1/25-2/23/25, V3 said R41 was not given as needed (PRN) Dulcolax suppository, enema or lactulose. R41 has Dulcolax suppository, enema, and lactulose available for administration on her MAR. V3 said the PRN constipation medication would be given based on assessment. At 10:43AM V3 said R41 had no inhouse labs for 2/1/25-2/23/25.

R41's care plan states she has a bowel elimination problem (constipation) related to decreased GI motility. Interventions include assess and monitor bowel routine. Assess and monitor medication which may cause diarrhea. Give medication as ordered. Monitor for signs and symptoms of GI distress. Monitor medications which may contribute to constipation.

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S9999	Continued From page 8 Observe for decreased bowel sounds. R41's cognitive pattern assessment for 1/1/25 identifies a score of 13 and on 4/2/25 14, both are cognitively intact scores. R41's MDS 1/1/25 identify she uses a wheelchair. R41's requires substantial to maximum assist for toileting hygiene and is dependent for toilet transfers. R41 is always incontinent of stool. R94 was admitted to the facility on 9/23/24 with a diagnosis of major depressive disorder, anxiety and conversion disorder with seizures or convulsions. R94's physician orders document monthly Tegretol(Carbamazepine) level dated 2/14/25. Carbamazepine extended release 100 mg. Give one tablet two times a day for conversion disorder with seizures. R94 carbamazepine level dated 2/19/25 was 5.3 normal. There was no level drawn for March. R94 carbamazepine level dated 4/11/25 documents 2.6 low. Reference range for carbamazepine is (4.0 -12). There were no carbamazepine levels for May. R94's Nurse Practitioner (NP) note dated 4/11/25 documents: Tegretol level 2.6. Conversion disorder with seizures or convulsions Give additional dose of Carbamazepine ER 100 mg x 1 Continue Zonisamide and current dose of Carbamazepine Seizure precautions. On 5/29/25 at 12:04PM, V19 (NP) said she ordered monthly Carbamazepine levels to ensure R94's medication is at a therapeutic level. V19 said it is recommended to check monthly. If levels are low medication level would be rechecked in a	S9999		

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month and if still low medication change would be initiated. V19 said she did order one time dose of Carbamazepine after April results. V19 said she was unable to find any other lab results for R94's Carbamazepine level after April. V19 said she would expect her orders to be followed, and another lab draw to have occurred for May to follow up. V19 said if the therapeutic level is low, it can put the resident at higher risk for seizures.

On 5/30/25 at 10:18AM, V24 (Pharmacist) said if the carbamazepine level is low it is recommended to adjust the dose and recheck the level within a week to see if there are any changes. If only a one-time dose of carbamazepine was given it would not have any long term effect on therapeutic levels and it would be expected to recheck the level within a week.

R6's medical record notes R6's primary diagnosis is unspecified convulsions.

R6's POS (physician order sheet), dated 2/14/25, notes an order for monthly lacosamide, Keppra, phenobarbital, and valproic levels.

R6's medical record, dated 10/23/24, notes R6's lacosamide level was 5.7 (normal range 5-10); Keppra level was 5.51 (normal range 10-40); phenobarbital level was 30.3 (normal range 15-40); and valproic acid level was 49.1 (normal range 50-100).

There is no documentation found in R6's medical record noting these laboratory tests were completed and reported monthly or that the physician was notified laboratory testing was not done.

Facility policy titled physician orders revised

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S9999	Continued From page 10 1/2023 document: Physician orders are followed as written. Follow through with orders by making appropriate contact or notification (lab or pharmacy). (A)	S9999		