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 05/09/2022

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 2292715/IL145502	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240e) 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	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirments are not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure one (R6) of 3 residents reviewed for abuse was free from assault and serious injury. Findings include: Initial Incident Report dated 05/05/22 documents, "It was reported that R5 and R6 were involved in a physical altercation. Both residents were immediately separated, emergency contact notified and investigation initiated per facility protocol. R5 was noted with a laceration to the left side of the forehead above the eye area and first aid was immediately administered. R6 was noted with a laceration to the back of his head and first aid was immediately administered." Nurses' notes dated 5/07/22 documents, "resident (R6) was involved in an altercation with another resident (R5). Both parties were separated and taken to different locations for	S9999		

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S9999	Continued From page 2 safety. The resident (R6) was observed with blood on the back of his head. The area was cleansed. Also attempted to take the resident's vital signs and offered pain medication however he (R6) refused both. Stated that he (R6) was okay and wanted to be left alone." Nurses' notes dated 5/05/22 documents R6 transported by ambulance to community hospital. Hospital Emergency Discharge dated 5/06/22 documents, R6 with history of blunt head injury, scalp laceration. Nurses' notes dated 5/06/22 documents, R6 noted with 3 sutures intact to posterior region of head upon arrival to nursing home. Nurse Practitioner notes dated 5/05/22 documents, R5 laceration site cleansed with saline; no active bleeding noted; steri-strips applied to approximated edges left forehead laceration site. Current Face Sheet documents, R5 admitted on 6/17/2021. R5 with diagnoses to include: CHRONIC KIDNEY DISEASE, MUSCLE ATROPHY, MUTLIPLE SITES, HEMIPLEGIA AND HEMIPARESIS, TYPE ii DIABETES, HTN, MAJOR DEPRESSION, PSYCHOSIS-UNSPECIFIED, CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS, BIPOLAR DISORDER. Current Face Sheet documents, R6 admitted on 12/31/2021. R6 with diagnoses to include: SCHIZOPHRENIA, REDUCED MOBILITY, ACQUIRED ABSENCE OF RIGHT LEG BELOW KNEE, ACQUIRED ABSENCE OF LEFT LEG BELOW KNEE, LEGAL BLINDNESS, ESSENTIAL HYPERTENSION, INSOMINIA	S9999		

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S9999	Continued From page 3 At this time of this investigation on 5/07/22 at 9:00am, R5 and R6 continue to reside in rooms adjacent to each. On 5/07/22 at approximately 11:05AM, R5 requested to speak with writer. R5 was sitting in a wheelchair in the dayroom. R5 is a double below the knee amputee. R5 observed with reddened eye and steri-strip stiches to the left eyebrow. At this time, R5 stated that nurses and CNAs were very nice and provided good care to him. R5 was asked about the injury to his left eyebrow. R5 stated he got into a fight with another resident (R6) a few days ago. R5 stated R6 had been very verbally abusive to him and staff. R5 stated that his own mother was a "crack head" and had abused drugs for years until she died. R5 said, "R6 called my mother names and talked about her. I became very angry, had argument in the dayroom with R6." R6 hit me, I don't know with what, but I was bleeding. When asked R5 who hit who first, R5 said, "I hit him first because I was angry when he said something about my mother, and he is always cursing at the female staff." R5 stated he took the armrest off of his wheelchair and hit R6 in the head. R5 said, "when R6 came to R6 hit me in the eye. We were separated by staff, and I was sent to the hospital. I'm still in the room next door to his room. We apologized to each other; we get along now, just don't say anything to each other." R5 stated that R6 and he did not get along since he's been at the facility and argue a lot. R5 stated he was tired of R6 being verbally abusive to female staff and staff did not deserve that, but R6 would continue on with being mean, cursing at everyone, staff and other residents. On 5/07/22 at approximately 1:30pm, V1(Administrator) stated, R5 and R6 had a	S9999		

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S9999	Continued From page 4 physical altercation on the evening of 5/05/22 in the dayroom and she has begun and submitted an initial investigation report to IDPH on 5/05/22. V1 stated the investigation is ongoing. V1 provided the initial report of the investigation to survey team. On 5/07/22 at 2:30pm, V8 (Social Worker) stated that the incident between R5 and R6 happened on the evening shift on 5/05/22. V8 commented that R5 and R6 had a physical altercation, R6 was sent to the hospital and came back to the facility the next day. V8 stated that R6 reported that R5 was aggressive towards him, and he (R5) retaliated. V8 said, "R5 and R6 both have Schizophrenia. R6 hallucinates a lot, responds to auditory hallucinations, responds to internal stimuli." V8 stated R5 apologized to R6. V8 commented that before the incident R5 would react to R6. V8 further comment that she would explain to R5 that R6 was not talking to him but talking out loud to himself. V8 stated that she would also talk with R6 because he could get loud. Behavior Care Plan dated 2/18/2022 documents, R5 expresses maladaptive behavioral symptoms related to attention seeking and making false allegations, also repetitive complaints not regarding care. R5 makes false allegations when seeking attention. Interventions: Behavioral expectations: respectful conduct, no profanity or yelling. R5 with history of aggressive, inappropriate, maladaptive behavior. The history includes: Physical Aggression, Verbal Aggression, Socially inappropriate. R5 has a diagnoses of Serious Mental Illness(SMI). Abuse: R5 is at risk for abuse and neglect related to SMI and medical complexities. Staff will intervene when any inappropriate behavior is observed.	S9999		

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S9999	Continued From page 5 Behavior Care Plan dated 5/07/22 documents, R5 with history of aggressive, inappropriate, maladaptive behavior. Goal: R5 will behave in a manner consistent with resident conduct policies through the next review. Staff will monitor well-being of others. R5 will have zero episodes of abuse and neglect throughout next review. Current Behavior Care Plan for R6 documents, R6 with history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior. Resident has a diagnosis of Schizophrenia. Resident has a history of verbal and physical aggressive behaviors. While at the nursing station during interviews on 5/07/22 at approximately 2:50pm, with V9(CNA), V10(CNA) and V11(LPN) and V12(CNA) stated they were not at work when the physical altercation happened between R5 and R6. They stated the incident happened on the evening shift and they heard about what happened. At this time, V12 said, "R5 flirts and is grabby with the women; know them (R5 and R6) to be aggressive." V9 said, "I've not known them to argue before. They said the incident happened in the dining room. Their (R5 and R6) rooms are next to each other. R6 is legally blind." V10 said, "R6 is 'in and out'. R6 can be verbally aggressive, R6 may curse somebody out. R6 don't like people bumping him. He, (R6) will spazz out. R6 is a below the knee amputee." V11 said, "V6 is always aggressive, try to help him. R6 makes noise yelling, using profanity, is verbally abusive towards women." V11 stated, "both R5 and R6 are aggressive. R5 will remove hand rest on his wheelchair, uses it as a weapon, threatens you with it. Told me he may hit people with it."	S9999		

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S9999	Continued From page 6 On 5/7/22 at approximately 4:00pm, R6 was resting in bed. R6 said, "I'm doing ok." When asked about the incident involving a physical altercation with R5, R6 showed writer metal stitches on back of his head. R6 said, they (staff) gave him (R5) a weapon. What he (R5) did was done badly. He (R5) him me with it. I punched him (R5) with my fist." When asked if R5 felt safe at the facility, R5 said, "I feel safe a little bit, not all the way because of what happened. He (R5) hit me before and staff was around, didn't do anything before. The don't do their job all the way." On 5/7/22 at 4:10pm, V1 (Administrator) and V13 (Social Worker) stated R5 is not in his room at this time. R5 is being moved to another room. On 5/7/22 at approximately 4:15pm with V1, V13 and V14 (Restorative Nurse), observed R5 demonstrate how he removes armrest from his wheelchair. R5 easily removed armrest from his wheelchair. The armrest was not locked in place. R5 placed armrest back on to his wheelchair. R5 was escorted back to the dayroom. At this time, V14 stated that they do not have any wheelchairs with unremovable or lockable armrest. V14 stated all our wheelchairs are the same. V14 stated the armrest is removable so that a resident can transfer between surfaces. At this time, V1 said, "We will find a way to make sure R5 cannot remove the armrest to ensure he cannot use it as a weapon again. V14 will order R5 a new wheelchair that does not have the removable armrest." On 5/8/22 at 8:50am, V1 said, "We secured R5 will chair armrests with a zip lock to make sure he cannot remove it. We're ordering R5 another wheelchair."	S9999		

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S9999	Continued From page 7 Abuse Policy revision date 2/2021 documents impart: This facility affirms the right of our residents to be free from abuse, mistreatment. This facility therefore prohibits abuse, neglect and mistreatment of residents; In order to do so, the facility has attempted to establish a resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse and mistreatment of residents. This will be done by: orienting and training employees on how to deal with stress and difficult situations, and how to recognize occurrences of abuse, neglect; establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect. (B)	S9999		