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 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF PALOS HILLS	10426 SOUTH ROBERTS , PALOS HILLS, Illinois, 60465

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S0000	Initial Comments Complaint Investigations 2598799/2598046, 2600903/2598180	S0000		09/03/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.1210b) 300.1210c) 300.1210d)2)6) 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 this Part. The written policies shall be followed in operating the facility. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes	S9999		09/03/2025

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

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S9999	Continued from page 1 or nurse's notes of that resident. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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. 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: Findings Include: Based on interview and record review, the facility failed to implement respiratory care interventions	S9999		

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S9999	Continued from page 2 including ensuring the application of hand mitten restraint as ordered, and to maintain patency of trach tubes due to resident history of chronic pulling of tracheostomy tube according to the plan of care for 1 of 3 (R4) residents reviewed for tracheostomy care. As a result of the facility's noncompliance with mittens not being applied and monitored by staff, R4 was able to reach her tracheostomy tubing and self-decannulated which led to her expiring. R4 is a 51-year-old with the following diagnosis: aphasia following cerebral infarction, acute respiratory failure with hypercapnia, tracheostomy status, dependence on supplemental oxygen. R4 admitted on 8/1/2025 and expired in the facility on 8/24/2025. On 8/24/25, R4 was found unresponsive with the tracheostomy pulled out and later pronounced expired in facility by paramedics. On 8/26/2025 at 9:44 AM, V1 (Administrator) and V2 (Assistant Director of Nursing) informed surveyor that their electronic medical records (EMR) were down from 8/18/2025 until the morning of 8/25/2025. All clinical documents were produced manually during this time. However, a completed progress note was not provided because it was not done as confirmed by V2. There was also no documented incident report of 8/24/2025 provided to the surveyor. A police report from Palos Hills Police Department was obtained pertaining to the death incident of R4 on 8/24/2025. Report indicate V17 (Agency Nurse) informed V3 (Palos Hills Police) that she was the nurse for R4. According to report on 8/24/25, between the times of 5:55AM and 6:05AM, V17 was in the room assisting another resident when V17 observed R4's trach tube not in place and R4 was unresponsive. Police interview of V11 (Respiratory Therapist/RT) indicated that he was the respiratory therapist of R4 and approximately at 4:45 AM of 8/24/2025, V11 was in the room of R4 assisting with trach care. V11 stated R4 is supposed to wear glove restraints (identified as mittens) to prevent her from removing her trach tube as she has history of removing her trach tube. Report indicated that V11 stated he did not observe R4 wearing glove restraints while in the room. Report indicated an interview with V16 (Nursing Supervisor) was also completed. V16 stated R4 was supposed to always wear the glove restraints according care plan. V17 stated that it was her first time working with R4 and was unaware that glove restraints were to be in place. Additionally, V17 reported that the facility online medical records database of R4 for physician orders and	S9999		

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S9999	Continued from page 3 plan of care were inaccessible and V17 was not provided with updates, information or paperwork pertaining to R4 by the prior shift nurse. V16 informed V3 that there should be a binder at nurse station with R4's plan of care information. Report indicated V3 checked the binder and did not appear to be properly filled out. On 8/26/2025 at 10:25AM, V3 (Palos Hills Police Department) stated he arrived at facility with R4 unresponsive and 911 paramedics working on her. Staff were interviewed and nurse on duty/ Agency nurse told V3 at approximately 5:55A - 6:05A R4 was observed with trach not in place (pulled out). V3 said while in the facility he did not observe R4's mittens in placed. V3 said employee informed him that electronic access to chart was down from a week to a week and half. V17 stated she did not get report from outgoing nurse regarding R4's mitten needs to be in placed at all times and V17 has no knowledge of facility restraint policy. V3 stated he believed there was neglect on facility as staff do not know their restraint policy and there was no hand off report from nurse to nurse according to his interview with agency nurse who was on duty. On 8/26/2025 at 11AM, in separate interviews, V2 and V4 (Restorative Nurse) both stated R4 should have mittens on at all times to maintain trach patency because R4 has a history of pulling on trach tubes. On 8/27/2025 at 10:28AM, V7 (Attending Physician/AP), stated he is the AP in facility only and not R4's community doctor. V7 said the last time R4 was seen was Friday, 8/22/2025. R4 was stable. He was aware that R4 has history of pulling on trach tube and the plan was to apply restraint (mitten) to prevent R4 from pulling trach. There was an order for mittens to be on at all times, staff to monitor, and may remove only when there is staff present and working with resident. V7 signed off on the Death certificate with cause of death, Respiratory Failure (not complete list). V7 stated the immediate cause of death was possibly R4's trach being pulled out since there was no oxygen being received by R4. On 8/27/2025 at 11:34 AM, V8 (Certified Nursing Assistant/CNA) stated she work 11-7 shift on 8/23 thru 8/24 and was assigned to R4. V8 said she rounded on R4 every 2 hours and at 5:00AM she provided incontinence care. V8 said she did not visibly saw the mittens being on during her entire shift. V8 said no one communicated to her about R4's need of mittens. V8 stated she do not know the facility restraint policy and only received education today in the morning. V8 further state that	S9999		

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S9999	Continued from page 4 during police investigation and interview with staff she was present and heard the nurse did not know anything about R4 needing mittens. V8 said there is no CNA to CNA shift to shift report or endorsement. On 8/27/2025 at 1:42 PM, V11 (Respiratory Therapist/RT) stated he was the RT working with R4 on 8/23 -8/24/2025. V11's shift is 7p - 7a. On 8/24/25 at 6:15AM nurse called stated R4 trach was out. When he went to the room V11 said R4 did not look like she was breathing and there was no pulse. V11 stated he do not re-call seeing R4's mittens on. V11 said there was an order for mittens as R4 have the history of self-decannulating behavior. V11 rounded 6X on R4 during his shift and at one point he reported to the nurse that mitten needs to be applied, however, V11 said he was unsure if nurse went to the room to check after acknowledging he was heard. On 8/28/2025 at 10:25 AM, V14 (R14's Daughter) stated the incident of her mother pulling on tracheostomy tube occurred 3x since admission to facility. Stated facility was aware before admission that her mother was on restraints from another facility because of behavior. Requested for restraint but was told initially by V13 (Regional Nurse Consultant/ Interim DON) that facility is restraint free and that they do not use restraint in the building, but later it was decided that R4 needed it after the 2nd attempt and upon return from hospital. During this investigation, multiple call attempts to V17 (Agency Nurse) for an interview was done with no success of a call back. Review of R4's medical records indicate an admission date of 8/1/2025 with diagnosis information of aphasia following cerebral infarction, tracheostomy status and dependence on supplemental oxygen (not a complete list). Comprehensive assessment of MDS Section O, dated 8/8/2025, indicated R4 with tracheostomy care, Section C, 8/8/2025, indicated Brief Interview for Mental Status (BIMS) was not conducted. Order Summary Report, start date 8/13/2025, read: Monitor left hand mitt for circulation, motion, sensation, PAIN, ROM. Every 2 hours for monitoring remove mitt for 10-15 period, CMS/ADL/ROM. Care Plan Report, date initiated 8/13/2025 read: Focus- Physical Restraints: Requires physical restraint r/t pulling on mechanical equipment. Interventions include Check and remove restraints as per policy. Keep resident close to areas that are supervised. Provide hazard free environment. Special Instructions read: Apply MITT to LEFT hand to maintain patency of trach tubes due to patient chronic pulling	S9999		

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S9999	Continued from page 5 of tubing. Ventilator/Aerosol Flowsheet indicated Trach care was done by V11 on 8/23/2025 at 8:30 PM where trach inner cannula was changed. Consent for Use of Restraint/Device, effective date 8/13/2025 read: 2. Benefits, a. Based on the resident's individual needs, restraints may be beneficial for the following. 2. Prevention of injury to self or other. Progress Notes, Effective Date: 8/8/2025 15:39 Type: Nurses Notes: Note Text: @ 0910 Pt., was observed by this nurse with her trach out, immediately RT was called to pt's room by CNA. 2 RT put the trach back in and SPO2 97 HR 66. Progress Notes, Effective Date: 8/10/2025 23:59 Type: Nurses Notes: Note Text: A Shiley 5XLTD decannulation occurred. Nurse notified the RT. Despite multiple attempts, the trach wouldn't reinsert. DON was notified. RT applied a 4x4 gauze over the stoma and a non-rebreather mask. R4 was stable at 95% oxygen saturation and 82 b/m HR. Ambulance left with her not in distress. Progress Note, Effective date 8/13/2025 20:08 Type: Nurses Notes: Note Text: Writer called resident daughter to inquire / inform of the use of hand restrain, daughter verbalized that she is aware of such order from the hospital and gave verbal Consent for the use of the hand mitten to restrain resident from pulling out her trach again. Nurse on Duty made aware. Facility did not provide progress note or completed incident report for 8/24/2025 self-decannulation incident. Review of Illinois Certificate of Death read Cause of Death, Immediate Cause a. Nontraumatic Intracerebral Hemorrhage, b. Acute Respiratory Failure, c. Type 2 Diabetes. Certificate was signed and certified by the Attending Physician/Physician in Charge on 8/25/2025. Policy and Procedure Guideline: Physical Restraint/Device, Review date 10/2021 General: To provide guidance on the assessment for the use and documentation of physical devices including, but not limited to, position change alarms, bed rails, furniture positioning, concave mattress, reclining chairs, cushions such as wedge shaped, hand mitts, abdominal binders, etc. A physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff. Guideline: 2. If is determined that the physical device is a restraint:	S9999		

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S9999	Continued from page 6 a. A physician order will be obtained. b. Education will be provided to the resident/resident representative regarding the risks and benefits of the physical device. c. Informed consent will obtain from the resident/resident representative using the Consent for use of Restraint/Device Form 3. If a resident or resident representative request the use of a restraint, then the facility will evaluate the appropriateness of the request and consult with the physician/NP to determine if resident has a medically necessary reason for the restraint. 6. the effectiveness of physical device in treating the medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical device is being used and documented in the progress note. 7. The behavior incident that prompted the use of the physical device will be documented in the progress note. 8. The date and time the physical device was applied and released will be documented in the progress note. 9. the name and title of the person responsible for the application and supervision of the physical device will be documented in the progress note. (AA)	S9999		