STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0043406	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CHICAGO HEIGHTS	120 WEST 26TH STREET , SOUTH CHICAGO HEIGHT, Illinois, 60411

(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 Complaint Investigation 25911029/2666036	S0000		11/19/2025
S9999	Final Observations Statement of Licensure Violations: 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 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 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be	S9999		11/19/2025

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

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S9999	Continued from page 1 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 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 are not met as evidenced by: Based upon interview and record review the facility failed to follow policy procedures, failed to ensure that fall risk assessments were accurate, failed to utilize the falling star program for identified high risk residents, failed to ensure that staff are aware of resident fall prevention interventions, failed to implement fall prevention interventions, failed to provide supervision, and/or failed to ensure that responsible staff are aware of root cause of fall - to prevent additional falls for three of three residents (R1, R3, R4) reviewed for falls. These failures resulted in R1 sustaining an unwitnessed fall on 11/10/25 which resulted in facial injuries and anterior wedge compression fracture of L1 vertebral body. Findings include: The falling star program guidelines state residents will automatically be placed on the Falling Star Program if: at the discretion of the IDT (Interdepartmental Team) based on risk factors (BIMS score 0-7, unsteady gait, >2 antipsychotic medications, poor safety awareness, 10 or higher score on fall evaluation form). 1.R1's diagnoses include frontotemporal neurocognitive disorder, Alzheimer's disease, unsteadiness on feet, and abnormalities of gait/mobility. R1's (8/1/25) BIMS (Brief Interview Mental Status) determined a score of 5 (severe impairment) and inattention is present/fluctuates. R1's (8/1/25) functional assessment affirms resident requires supervision or touching assistance for walking.	S9999		

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S9999	Continued from page 2 R1's (6/18/25) fall risk assessment determined a score of 10 (high risk). R1's (7/16/25) fall risk assessment (1 month later) determined a score of 8 (at risk) however "confused" not selected as warranted. R1's (9/3/25) care plan states resident is at high risk for falls related to recent fall, cognitive deficits, and use of psychotropic medication. Interventions: encourage resident to keep room free of obstacles/clutter, keep frequently used items within reach, promote placement of call light within reach, rounding at a minimum of every 2 hours [Falling star program was excluded]. R1's (11/10/25) 3:00pm incident report states resident was seen 15 minutes before incident, writer took him to the room and sat him on the bed. Resident was observed by CNA (Certified Nursing Assistant) standing behind the room door, holding onto door handle. On examination noted abrasion on bridge of nose, below left eyelid and hematoma on left side of his head. Writer Nurse was notified. Nurse Practitioner notified and together assessed resident. Resident is alert x1 and unable to verbalize. Roommate is alert oriented x2-3 later stated that resident fell in the room. Medical doctor notified and order received to transfer resident to hospital for further evaluation. Statements: "Unwitnessed fall." R1's (11/10/25) post fall risk assessment (documented at 8:17pm) determined a score of 8 however "History of falls in the past 1- 6 months" was not selected. On 11/12/25 at 1:15pm, surveyor inquired about R1's (11/10/25) incident. V2 (DON/Director of Nursing) stated, "He (R1) had a fall in his room. He has frontal lobe dementia and ambulates; he had one slipper on and one off when the aide found him. The roommate said that he fell and got his self up in the doorway. He's supposed to come back from the hospital later today. We (staff) sent him out because his eye looked red and there was a bruise on his forehead." On 11/12/25 at 2:58pm, surveyor inquired about R1's (11/10/25) incident. V4 (Registered Nurse) stated, "On the 10th around 2:50pm or thereabout I (V4) saw him (R1) moving toward the exit door, so I said don't go there. He (R1) walked hurriedly towards his room, I was	S9999		

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S9999	Continued from page 3 closely following him and held his hand because the way he walks is a shuffled gait and such a speed as if he was falling. He (R1) himself opened the door and entered. I watched him move towards his bed and he sat on the bed. At that time, his roommate (R2) was in bed covered and resting. I came out and closed the door then I went to my station [R1 was left sitting on the bed and the door was closed - therefore supervision was not provided]. After I attended to other nursing issues around 3 or a little after, one of the CNAs (V6) called and said she saw (R1) has a bruise on the bridge of his nose and some drainage from the right eye. I said what happened, she (V6) said the call light was on and (R1) was standing behind the door holding the handle and she saw drainage coming from his eye. I tried to dab it, and he say it hurts. I further examined him and saw a hematoma on the forehead right side. It was like an abrasion here (bridge of nose) and underneath the right eye you could see like tears running but it was mixed with blood so there must have been some lacerations somewhere that was mixed with the tears. I went looking for the roommate (R2) and said what happened to (R1) he (R2) said I (R2) didn't push him or anything he fell to the ground in his room." On 11/17/25 at 11:21am, R1 was observed lying in bed asleep (alone) in the room. Only one (1) floor mat was adjacent R1's bed however the other side of R1's bed was roughly 1.5 feet away from the wall. V9 (Family) subsequently entered R1's room. Surveyor inquired about R1's (11/10/25) incident. V9 responded, "He's (R1) nonverbal and doesn't talk. Before he fell, he would be in the dining room to keep an eye on him. I got a call that he fell around 3:00pm, 3:30pm. They (staff) said that he got up and saw his face was red and swollen. They called the ambulance. The right side of his lip was swollen, and he had a little broken skin on the right eyelid. He likes to walk around but has a shuffled gait and is bent over when he walks. I try to tell him to hold the rail when he walks, he doesn't listen. He gets up and he's gone but I slow him down. There is a definite progression with his walking, a significant decline. I was upset that he fell but he's a sundowner, he's quick. They (staff) sit out there (hallway) and watch him because he's a real go getter you almost need a sitter." On 11/17/25 at 11:17am, V7 (CNA) was assigned to R1. Surveyor inquired how R1 ambulates. V7 stated, "I (V7) been here for 2 weeks. The report I got was to feed him and change him, restorative would assist him with getting out the bed and walking" and affirmed she was	S9999		

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S9999	Continued from page 4 unsure. On 11/17/25 at 12:15pm, V8 (Licensed Practical Nurse) was assigned to R1. Surveyor inquired about R1's fall prevention interventions. V8 stated, "He (R1) walks around, and we (staff) monitor him because we don't like him to stay by himself. We redirect him to the dining room when he's up so people can see him." On 11/17/25 at 12:20pm, surveyor inquired about R1's fall prevention interventions. V7 (CNA) stated, "He's a 2 person assist to get up and make sure his pad is on the floor." Surveyor inquired if R1 has any other fall preventions interventions. V7 responded, "No ma am, it's a strongly with a 2 person assist." On 11/17/25 at 1:57pm, surveyor inquired about R1's risk for falls (prior to 11/10/25). V11 (Restorative Director) reviewed R1's EMR (Electronic Medical Records) and stated, "His (R1) fall risk assessment was an 8 on 7/16 (2025), it was a 10 on 6/18/25 (one month prior). The one on 7/16 for his mentation they have impaired judgment marked and for the one on 6/18 they have confused and impaired judgment which can kinda fall into the same thing. The score is based off of what they (staff) have clicked." Surveyor inquired if R1 is confused with impaired judgment. V11 responded, "He's alert to his self, he's nonverbal so it's kinda hard to necessarily say. He definitely has impaired judgment and he's dementia but is really tricky with him." Surveyor inquired about R1's functional status. V11 replied, "He (R1) has a steady gait [R1 has a "shuffled gait" per V4 and V9] but needs 2-person care because he's resistant. He's ambulatory without assist [R1's functional assessment affirms supervision, or touching assistance is required for walking] but his safety awareness is poor." Surveyor inquired if R1 has a shuffled gait. V11 stated, "No" [incongruent with V4 and V9's statements]. Surveyor inquired if R1 is bent over while walking. V11 responded, "No, not necessarily he walks up and down the hallway fine" [incongruent with V4's statement]. Surveyor inquired about R1's fall prevention interventions prior to (11/10/25). V11 replied, "Prior to him falling we had encouraged and offered rest periods when walking long distances, keep the room free from obstacles and clutter, monitor resident for tolerance and endurance" [falling star program was excluded]. Surveyor inquired about the root cause of R1's (11/10/25) fall. V11 stated, "From my understanding the roommate said he tripped and fell when he was in the room and got his self-up. I didn't talk to the roommate, collectively we (DON,	S9999		

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S9999	Continued from page 5 ADON/Assistant Director of Nursing) get together and discuss the falls. It was unknown how he fell. The roommate reported that he fell." Surveyor inquired if leaving R1 in the room with the door closed would be appropriate if he's a high risk for falls. V11 replied, "He wasn't necessarily a high risk for falls prior to the fall, he does have poor safety awareness. To be left alone with the room closed; if he was resting that would be ok but for a long period of time, I don't think that would be okay. I wouldn't necessarily close the door." Surveyor inquired what care plan interventions were added (post 11/10/25 fall). V11 responded, "We put him on the falling star program which means if no ones in the room with him and he's not resting he shouldn't be in the room by himself. It's a certain protocol we have for the falling star, when we see a star on the door, he's a high fall risk, they get hourly rounding or every 30 minutes, so we know when they last saw him and what he was doing." Surveyor inquired if R1 was on the falling star program prior to 11/10/25 fall. V11 replied, "No, he got added after he fell." Surveyor inquired why R1 was not on the falling star program prior to 11/10/25. V1 stated, "There was no indications that he would fall or a need to be on the program. Like I said he has poor safety awareness when he walks around, and he was at risk for falls but not a high fall risk." Surveyor inquired what fall risk score is considered "high" risk. V11 responded, "10 or higher" [R1's 6/18/25 fall risk assessment determined a score of 10 – therefore high risk]. R1's (11/10/25) History & Physical states facility staff found the patient on the floor with swelling to the right side of his face. He is nonverbal at baseline and unable to provide further history. X-ray impression: anterior wedge compression fracture of L1 vertebral body is new compared to 7/14/25 and favored to be acute. On 11/17/25 at 4:21pm, surveyor inquired what fall prevention interventions should be implemented for a resident identified at high risk for falls. V12 (Medical Director) stated, "Physical therapy to determine if they are high risk or low risk and help make them walk." Surveyor inquired about potential harm to a resident that sustains an unwitnessed fall. V12 responded, "It could be anything of course; head injury is the worst especially if they have a bleed or something like that." 2.R3's diagnoses include altered mental status, muscle	S9999		

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S9999	Continued from page 6 weakness, reduced mobility, hemiplegia and hemiparesis following cerebral infarction. R3's (10/16/25) BIMS determined a score of 8 (moderate impairment) with disorganized thinking. R3's (10/16/25) functional assessment affirms resident is dependent on staff for tub/shower transfer. Toilet transfer and walking were not attempted due to medical condition or safety concerns. R3's (10/17/25) fall risk assessment determined a score of 12 (high risk). R3's (1/28/23) care plan states resident is at high risk for falls secondary to hemiplegia and hemiparesis, interventions: keep bed in lowest position. On 11/17/25 at 11:17am, V7 (CNA) was seated in the hallway directly across from R3's room however she (V7) provided no redirection or assistance to lower R3's bed - which was noted to be in high position - while he (R3) was lying in bed. On 11/17/25 at 11:57am, (40 minutes later) R3 was lying in bed however the bed remained elevated (waist high) therefore not in “lowest position” per care plan intervention. R3 stated "I'm (R3) in bed most of the time because I had a stroke.” Surveyor inquired if R3 can walk R3 responded, “No.” 3.R4's diagnoses include morbid obesity, muscle weakness, reduced mobility, abnormal posture, hypertension, and altered mental status. R4's (10/2/25) BIMS determined a score of 13 (cognition intact). R4's (10/2/25) functional status affirms resident is dependent on staff for chair/bed to chair transfers. Toilet transfer and walking were not attempted due to medical condition or safety concerns. R4's (7/14/21) care plan states resident is at high risk for falls due to gait/balance problems, muscle weakness, and psychoactive drug use that may potentiate falls. On 11/17/25 at 12:07pm, R4 was lying in bed. R4 stated “I'm (R4) here (in bed) all the time. I'm supposed to get up every Monday, Wednesday, and Friday but I'm not doing it.” R4 also affirmed that she's incontinent, doesn't walk, and requires 2 persons assist with transfers.	S9999		

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S9999	Continued from page 7 R4's (7/29/25) fall risk assessment determined a score of 9 (at risk) however elimination status was not marked (2 points) and predisposing factors "none" was selected however R4 is diagnosed with Hypertension (2 points) – therefore the assessment was scored incorrectly. On 11/17/25 at 3:00pm surveyor relayed concerns with R4's (7/29/25) fall risk assessment score. V2 (DON) affirmed R4 is likely high risk for falls due to diagnoses and inability to walk. The fall prevention and management policy (revised 10/2018) states the facility will identify and evaluate residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. Residents at risk for falls will have fall risk identified on the interim plan of care with interventions implemented to minimize fall risk. Facility guideline following a fall incident: A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at "high risk" for falls; a score of less than 10 indicates "at risk" for fall. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence. (B)	S9999		