STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145735	A. BUILDING _____ B. WING _____	C 06/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF RIVER OAKS	**14500 SOUTH MANISTEE BURNHAM, IL 60633**

(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
F 000	INITIAL COMMENTS Complaint Investigations 2095331 / IL124599 - Refer to F600 2095330 / IL124598 - Refer to F600	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a resident (R1) was free from abuse. This affected 1 out of 3 residents reviewed for abuse. This failure resulted in R1 receiving "a blunt assault to left eye with left globe-rupture." Findings include: On 6/25/2020 10:07 AM, record review of R1's progress note, dated 3/28/2020 07:45, reads: "Resident was noted to have bleeding to left eye	F 600	P.O.C. FOR F600 CORRECTIVE ACTION(S) TO BE TAKEN FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: 1. R1 is no longer a resident at the facility. IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL	6/26/20

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

Electronically Signed | 08/11/2020

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F 600	Continued From page 1 and was agitated and unable to state what happened." On 6/25/2020 at 10:45 AM, surveyor reviewed Facility Incident Report Forms related to the 3/28/2020 incident. Facility Incident Report Form reads R1 and V14 (CNA, Certified Nursing Assistant) as the individuals involved in the incident. Final report reads: "While the evidence is inconclusive it leads to the following conclusion: C.N.A. had a broom, the broom caused injury to [R1's] eye. Have to substantiate abuse although we cannot determine the intention whether it was an accident or intentional." V13's (Resident Services) written statement is attached to Facility Incident Report Forms. It reads "I [V13] was in Back of the annex when [V14] came to get me when [R1] was giving them complications. [V14] then removed the chairs from [R1] Room and [R1] then picked up the chair and threw it at [V14]. [V14] then took the Broomstick and hit [R1] with it." On 6/25/2020 at 11:15 AM, V5 (CNA, Certified Nursing Assistant) stated if a resident is having a behavior, staff is to call the supervisor to talk to the resident. V5 stated staff are not to hit the residents. On 6/25/2020 at 12:13 PM, V8 (Resident Services Supervisor) stated if a resident is having a behavior, staff is to calmly approach the resident. Staff is to find the cause of the disruption and try to deescalate the situation. V8 stated staff is to call for help and have social services and nursing involved. On 6/25/2020 at 12:54 PM, V9 (Personnel)	F 600	TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: 1. All residents have the potential to be affected by the alleged deficient practice. 2. Any allegation of abuse involving a resident, which a staff member becomes aware of, will be reported immediately to the Administrator or designee and will be thoroughly investigated and reported to IDPH in accordance with facility policy and Federal and State law. MEASURES AND/OR SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: 1. All staff has been and will again be in-serviced regarding types of abuse, proper documentation and reporting of allegations of abuse on a timely basis in order that a thorough investigation may be conducted as required by facility policy and Federal and State law. 2. Administrator or designee will review incident/accident reports daily and DON will review shift logs daily to ensure that all incidents are thoroughly investigated. QUALITY ASSURANCE PLANS TO MONITOR FACILITY PERFORMANCE TO MAKE SURE THAT CORRECTIONS ARE ACHIEVED AND ARE PERMANENT: 1. A quality assurance will be done in regard to effectiveness of facility's policy	

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F 600	Continued From page 2 stated V14 was terminated due to the 3/28/2020 incident. On 6/25/2020 at 1:00 PM, record review of V14's Termination Notification reads: "[V14] was involved in an incident on 3/28/20 which led to an injury to a resident." On 6/25/2020 at 1:22 PM, V12 (Nurse) stated on 3/28/2020 staff members informed [V12] that R1's eye was bleeding. Per V12, R1 stated someone hit [R1]. On 6/25/2020 at 2:57 PM, V1 (Administrator) stated V14 was terminated due to the incident on 3/28/2020. V1 stated V14 was seen in R1's room and V14 was seen with the broom. V1 stated R1 received an injury with the broom which led to V14's termination. V1 stated V14 had no reason as to why V14 would have the broom. V1 stated there is no reason for V14 to hit R1 with the broom. V1 stated it is not part of a CNA's duty to hit a resident with a broom. On 6/25/2020 at 3:11 PM, V13 stated the written statement was written and signed by V13. V13 stated written statement is factual. V13 stated on 3/28/2020, V14 came for help stating R1 was acting up. V13 stated while on the way back to R1's room, V14 grabbed a broomstick from V15's (Housekeeping) cart located in the hallway. V13 stated V14 told R1 that [R1] was not allowed to have two chairs. R1 told V14 to leave the chairs alone but V14 yelled stating R1 could not have two chairs. V13 stated R1 picked up the chair and tossed it towards V14. V13 stated V14 then started speaking in another language and started jabbing R1 with the broomstick. V13 stated by	F 600	and procedure relating to F600. It will include reporting by staff of incidents/accidents on a timely basis. The Administrator and/or designee will review incident and accident reports daily with the PRSD and DON. . The monitoring schedule will be subject to change based on changes in facility practices and will be adjusted accordingly. COMPLETION DATE: June 26, 2020	

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F 600	Continued From page 3 the time [V13] realized what V14 did, R1 was holding [R1's] eye. On 6/26/2020 at 11:28 AM, record review of R1's care plan reads: "Focus: [R1] is at risk for potential abuse and neglect due to [R1's] diagnosis of Dementia. [R1] present with bx such as being anchored in delusional thoughts, becoming easily agitated and anxious." Last revision on 02/24/2020. R1's care plan also reads: "Goal: Staff will monitor well being of [R1] and others around [R1]. [R1] will have no episodes of being the recipient /aggressor of abuse and neglect." Last revision on 3/13/2020. On 6/26/2020 at 11:40 AM, record review of R1's initial hospital records read final diagnosis of "s/p (status post) blunt assault to left eye with left globe-rupture." Hospital records read R1 was transferred to a higher acuity hospital for trauma care. On 6/26/2020 at 11:57 AM, record review of facility's abuse policy, last revised on 9-2017, reads: "This facility affirms the right of our resident to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment."	F 600		