STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145864	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Forest Edge	8001 South Western Avenue Chicago, IL 60620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32819 Based upon observation, interview and record review the facility failed to ensure nursing staff arrive timely to work, failed to ensure medications are dispensed for one resident at a time, failed to ensure that dispensed medications are discarded if not administered, failed to ensure medication administration is documented, failed to ensure medications are not left at the bedside, failed to administer (R1, R3, R4) medications (as prescribed) and failed to ensure staff administer medications within regulatory requirements for 37 of 37 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37) in the sample reviewed for medication administration. These failures have the potential to affect 45 (6th floor) residents. Findings include: On 3/21/24, IDPH (Illinois Department of Public Health) received allegations that R1's medications were not administered. R1, R2, R3 and R4 reside on 6th floor. The (3/27/24) census includes 45 (6th floor) residents. On 3/27/24 at 10:04am, surveyor observed V5 (Licensed Practical Nurse) passing medications on 6th floor. Surveyor inquired when AM medications are scheduled for administration. V5 (Licensed Practical Nurse) stated, It's scheduled from 7 to 9 (am). V5 continued passing medication. Surveyor inquired which (6th floor) residents had not yet received 9am medications. V5 advised she (V5) was passing medications to residents in the hallway as they approach the medication cart and going from room to room however did not answer the question. Surveyor inquired if V5 had a list of residents who received or did not receive 9am medications, V5 responded No. Surveyor inquired why several (6th floor) resident names were highlighted red (indicating overdue) on the EMAR (Electronic Medication Administration Record), V5 replied Some are like vitals and weight not done. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's name was highlighted red on the EMAR. V5 accessed R4's EMAR (as requested) and affirmed that Nuedexta (scheduled for 9am administration) was not documented. Surveyor inquired why R4's (3/27/24) Nuedexta was not documented. V5 replied, I left it open as a reminder to myself to reorder. Two (unlabeled) medication cups (containing several medications) and unopened packaged medications (for another resident) were noted atop of the medication cart at this time. Surveyor inquired why several residents dispensed medications were atop of the medication cart. V5 discarded the unlabeled medications after inquiry. On 3/27/24 at 10:21am, V5 administered R2's (9am) medications (Amlodipine, Ergocalciferol, Risperdal, Timolol, Ferrous Sulfate) however this was after 10am therefore not administered on time. On 3/27/24 at 10:25am, V5 accessed the (6th floor) EMAR a total of 37 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37) were highlighted red and 283 overdue medications was observed on the computer screen. Surveyor inquired how many medications were overdue at this time V5 stated, It says 283. Surveyor inquired why 283 scheduled medications are overdue, V5 stated, Like what I told you the blood sugar, medication, the vitals I didn't enter them. Surveyor inquired what time V5 arrived at the facility today V5 responded, I got here at 7:30(am). Surveyor inquired what time V5's shift started. V5 replied, at 7 (am), therefore V5 arrived 30 minutes late. On 3/27/24 at 10:28am, V4 (Assistant Director of Nursing) approached V5 and stated, You cannot pass anymore medications until you call the doctor. Surveyor inquired why V4 instructed V5 to stop passing medication. V4 responded, It's past time you know, and she (V5) needs to let the doctor know, so she can get an order from the doctor. Surveyor inquired about the regulatory requirement for medication administration. V4 replied, An hour before or hour after. Surveyor inquired if medications are scheduled for 9am administration what's the required time to complete the medication pass. V4 stated, 10am. Surveyor advised that the EMAR states, 283 overdue medications at this time. V4 responded, It says medications are not given however I know she (V5) must have given the medication. Surveyor inquired if the (9am) medications for residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37) highlighted red on the EMAR were documented as administered V5 replied, It should have been. On 3/27/24 at 10:35am, R3's name was highlighted red on the EMAR, surveyor inquired if R3 received today's (9am) medications. V5 stated, No, he hasn't. R3's EMAR affirmed the following medications were prescribed for (9am) administration: Amiodarone, Ferrous Sulfate, Furosemide, Asper cream, Bupropion, Calcium, Apixaban, Gabapentin, Lidocaine patch, Metoprolol, and Sertraline. On 3/27/24 at 10:36am, surveyor inquired if R1 received prescribed (9am) medications today. V5 stated, Yes she did. However, R1's name was highlighted red on the EMAR. V5 accessed R1's EMAR (as requested) and affirmed all (9am) medications were not documented as warranted. Surveyor inquired why R1's (9am) medications were not documented if they were administered. V5 responded, I thought I did. Surveyor inquired about the regulatory requirement for medication administration. V5 replied, You sign, you document it after resident has taken the medication. V5 subsequently opened the medication cart and an (unlabeled) cup of pills were observed in the top drawer. Surveyor inquired about the cup of dispensed pills in the medication cart. V5 replied, The medication for the resident, he was not in the room that was (R36's name). [At 10:21am, R36 was observed by V5 and surveyor in his room]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	__ R3's (1/30/24) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact). On 2/27/24 at 10:48am, R3 affirmed he did not receive 9am medications today. Surveyor inquired when AM medications are administered at the facility. R3 stated, From 8 in the morning till 10:30 or so. Sometimes they have a tendency to run out of sh** and I have to wait till it's reordered and restocked. A couple months ago they ran out of my blood thinner. R3's POS (Physician Order Sheets) include the following active orders as of 3/27/24: Amiodarone, Apixaban (Anticoagulant), Lidocaine Patch to left shoulder, Bupropion, Calcium + Vitamin D, Ferrous Sulfate, Furosemide, Gabapentin, Metoprolol Tartrate, and Sertraline which are scheduled for 9am administration. R3's (March 2024) MAR (Medication Administration Record) affirms the Lidocaine patch was not documented on 3/14/24 (blank space). Levothyroxine was not documented on 3/14/24 and 3/22/24 (blank space). __ R1's (2/13/24) BIMS (Brief Interview Mental Status) determined a score of 12 (moderate impairment). On 3/27/24 at 10:50am, surveyor inquired about concerns at the facility. R1 stated, The other day, I didn't get my medication. I got my meds (medications) today, but the two vitamin D were not the same, so I spit em out, they in the trash. R1 removed the 2 white pills from the trash at this time. Surveyor inquired if V5 left the medications at bedside. R1 responded, She (V5) just set the cup down and walked away. R1's POS includes the following active orders as of 3/27/24: Cymbalta, Ferrous Sulfate, Gabapentin, Hydrochlorothiazide, Losartan Potassium, Meloxicam, Topiramate, and Vitamin D scheduled for 9am administration. R1's (March 2024) MAR (Medication Administration Record) affirms all (9am) medications were not documented on 3/23/24 (blank space). __ R4's POS includes the following includes the following active orders as of 3/27/24: Aspirin, Cyanocobalamin, Folic Acid, Levothyroxine, Protonix, and Vitamin B1 scheduled for 6am administration. Humalog (Insulin) per sliding scale scheduled for 7:30am and 11:30am administration and Amlodipine Besylate (Antianginal), Ferrous Sulfate, Metformin, Nuedexta for PBA scheduled for 9am administration. R4's (March 2024) MAR affirms the following: On 3/14/24 all (6am) medications were not documented (blank spaces). On 3/23/24 all (9am) medications were not documented (blank space). On 3/23/24 the 7:30am Humalog was not documented (blank space). On 3/22/24 and 3/23/24 the 11:30am Humalog was not documented (blank space). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/24 at 2:53pm, V2 (Director of Nursing) reviewed R1, R3, and R4's (March 2024) MAR and affirmed (aforementioned) blank spaces were noted. Surveyor inquired what a blank space on the MAR indicates. V2 stated, It means the nurse did not indicate what happened if he's (resident) refusing or out for appointment. There's a code for that, they (staff) are supposed to use a code. The Medication Administration policy (revised 5/2017) states verify that the medication is being administered at the proper time. If medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider if required. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner, and a note should reflect the situation in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 32819 Based upon observation, interview, and record review the facility failed to ensure medications were administered as ordered and failed to ensure that four of four residents (R1, R2, R3, R4) reviewed for medication administration remained free from significant medication errors. Findings include: On 3/21/24, IDPH (Illinois Department of Public Health) received allegations that pain, blood pressure and neurological medications were not administered to R1. On 3/27/24 at 10:36am, surveyor inquired if R1 received prescribed (9am) medications today. V5 (Licensed Practical Nurse) stated, Yes she did. However, R1's name was highlighted red (indicating late administration) on the EMAR (Electronic Medical Record). V5 accessed R1's EMAR (as requested) and affirmed all (9am) medications were not documented as warranted. Surveyor inquired why R1's (9am) medications were not documented if they were administered. V5 responded, I thought I did. Surveyor inquired about the regulatory requirement for medication administration. V5 replied, You sign, you document it after resident has taken the medication. R1's (2/13/24) BIMS (Brief Interview Mental Status) determined a score of 12 (moderate impairment). On 3/27/24 at 10:50am, surveyor inquired about concerns at the facility R1 stated, The other day, I didn't get my medication. R1's MAR (Medication Administration Record) affirms all (9am) medications were not documented (4 days prior) on 3/23/24 (blank space). R1's POS (Physician Order Sheets) include the following significant medications scheduled for 9am administration: (9/20/23) Cymbalta (Antidepressant), (2/8/23) Gabapentin (Anticonvulsant), (2/8/23) Hydrochlorothiazide (Antihypertensive), (2/8/23) Losartan Potassium (Antihypertensive), (3/7/23) Meloxicam (Non-steroidal Anti-inflammatory) for pain, and (5/15/23) Topiramate for headaches. –– R4's POS includes the following significant medications: (11/30/23) Levothyroxine (Thyroid Hormone) scheduled for 6am administration. (11/7/23) Humalog (Insulin) per sliding scale scheduled for 7:30am and 11:30am administration and (11/6/23) Amlodipine Besylate (Antianginal), (11/30/23) Metformin (Hypoglycemic), (11/6/23) Nuedexta for PBA (Pseudobulbar Affect/Neurological Condition) scheduled for 9am administration. R4's MAR affirms the following: On 3/14/24 all (6am) medications were not documented (blank spaces). On 3/23/24 all (9am) medications were not documented (blank space). On 3/23/24 the 7:30am Humalog was not documented (blank space). On 3/22/24 and 3/23/24 the 11:30am Humalog was not documented (blank space). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/24 at 10:04am, R4's name was highlighted red on the EMAR. V5 accessed R4's EMAR (as requested) and affirmed that Nuedexta (scheduled for 9am administration) was not documented. Surveyor inquired why R4's (3/27/24) Nuedexta was not documented. V5 replied, I left it open as a reminder to myself to reorder. __ On 3/27/24 at 10:35am, R3's name was highlighted red on the EMAR. Surveyor inquired if R3 received today's (9am) medications. V5 stated, No, he hasn't. R3's EMAR affirmed the following significant medications were prescribed for (9am) administration: Amiodarone (Antiarrhythmic), Furosemide (Diuretic), Bupropion (Antidepressant), Apixaban (Anticoagulant), Gabapentin (Anticonvulsant), Lidocaine (Anesthetic) patch, Metoprolol (Antihypertensive), and Sertraline (Antidepressant). R3's (1/30/24) BIMS (Brief Interview Mental Status) determined a score of 15 (cognitively intact). On 2/27/24 at 10:48am, R3 affirmed he did not receive 9am medications today (as stated). R3 stated, Sometimes they (facility) have a tendency to run out of sh** and I (R3) have to wait till its reordered and restocked. R3's POS (Physician Order Sheets) include but not limited to (2/1/24) Lidocaine Patch to left shoulder for pain. (2/29/24) Levothyroxine related to hypothyroidism. R3's (March 2024) MAR (Medication Administration Record) affirms the Lidocaine patch was not documented on 3/14/24 (blank space). Levothyroxine was not documented on 3/14/24 and 3/22/24 (blank space). __ On 3/27/24 at 10:21am, V5 administered R2's (9am) medications however it was after 10am therefore administered late per regulatory requirements (within 1 hour). R2's EMAR affirmed the following significant medications were prescribed for (9am) administration: Amlodipine (Calcium Channel Blocker to prevent angina) and Risperdal (Antipsychotic). On 3/27/24 at 2:53pm, V2 (Director of Nursing) reviewed R1, R3, and R4's (March 2024) MAR and affirmed (aforementioned) blank spaces were noted. Surveyor inquired what a blank space on the MAR indicates. V2 stated, It mean the Nurse did not indicate what happened if he's (resident) refusing or out for appointment. There's a code for that, they (staff) are supposed to use a code. The Medication Administration policy (revised 5/2017) states verify that the medication is being administered at the proper time. If medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider if required.