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Form Approved OMB
No. 0938-0391

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	10/03/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45346 Based on interview and record review the facility failed to ensure staff protected one resident (R394) (out of three residents who were screened at risk for abuse) from employee to resident physical abuse. Findings include: R394's diagnosis includes but are not limited to chronic obstructive pulmonary disease with (acute) exacerbation, unspecified asthma, uncomplicated, anxiety disorder, unspecified, shortness of breath, bipolar disorder, unspecified, schizophrenia, unspecified, and dyspnea, unspecified. R394's MDS (Minimum Data Set) dated 9/19/2024 indicates a Brief Interview for Mental Status was not completed. Staff Assessment of Mental Status documents in part, C0700. Short-term Memory OK 0. Memory OK. C1000. Cognitive Skills for Daily Decision Making 0. Independent-decisions consistent/reasonable. R116's diagnosis includes but are not limited to schizophrenia, unspecified, drug induced subacute dyskinesia, major depressive disorder, recurrent, unspecified, other migraine, not intractable, with status migrainosus, and idiopathic progressive neuropathy. R116's Brief Interview for Mental Status (BIMS) dated 7/31/2024 documents R116 has a BIMS score of 15 which indicates R116's cognition is intact. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/2024 at 12:38 pm surveyor met R394 on the third floor in the hallway near the elevator. R394 alert and oriented. Surveyor and R394 went to R394's room to discuss the allegations. R394 stated, Me and my ex-roommate (R116) had a disagreement on 9/19/2024 at about 1:30pm. I owed R116 two dollars. On that day I had dropped my cellphone in the toilet, and I could not make any phone calls, so I was upset. I was trying to tell R116 about my phone situation and I would give him (R116) the two dollars later. R116 pushed me, and I fell to the floor. When I got up from the floor R116 hit me again. I picked up a chair and hit R116 with the chair. There were no witnesses to this, it was just me and R116. Staff did hear the commotion in my room from the hallway and that is when staff came into my room. Staff separated me and R116. I was told to go into the dining room on the third floor by staff. Staff escorted me into the dining room. I do not remember what staff person escorted me to the dining room. When I got to the dining room V44 (former Social Service Director) asked me to sit down. I sat down in the chair, but I wanted to ask V44 a question, so I got up out of the chair. When I got up out of the chair, V44 pushed me down to the floor and took his hand and mashed my head against the floor. I could not get V44 off me. Another manager came to pull V44 off me. This same manager pulled me up from the floor and asked me if I was okay. V44 was escorted off the third floor by another manager. The police came to the facility at about 5:30pm that day and spoke with me. The police made it clear to me that I was not in any trouble. I was shaken up bad. The police told me if I wanted to press charges it would be a civil matter. There were no residents around during the incident because the residents were told by staff to go into their rooms. I don't know if any other resident saw the incident. On 10/03/2024 at 4:38pm R48 stated on 9/19/2024 at about 1:30pm all residents in the hallways on the third floor were told to go into their rooms and remain there. R48 stated, I heard the confusion in the third-floor dining area; but I did see what was going on. On 10/03/2024 at 2:01pm V45 (LPN/Licensed Practical Nurse) stated V45 is familiar with R394. V45 stated on 9/19/2024 at about 1:30pm R394 was observed being verbally abusive towards staff on the third floor in the dining room area. V45 stated V44 (former SSD/Social Service Director) was trying to redirect R394. V45 stated R394 was not redirectable at that time. V45 stated R394 hit V44 in the face. V45 stated V44 grabbed R394 by both arms, holding both of R394's arms to the side of R394's body. V45 stated V44 and R394 were struggling and both V44 and R394 went down to the floor. V45 stated V44 was trying to do CPI (Crisis Prevention Intervention) on R394. V45 stated R394 was trying to fight V44 back and trying to get up off the floor. V45 stated R394 was able to get up from the floor and sit back in the chair in the dining room. V45 stated it did not get physical again with V44 and R394. On 10/03/2024 at 2:30pm V8 (PRSC/Psychiatric Rehab Service Coordinator) stated V8 is familiar with R394. V8 stated, I was at a care plan meeting on the second floor when the incident happened with R394 on the third floor on 09/19/2024 at about 1:30pm. When I did return to the third floor, because I am the PRSC assigned to the third floor, it seemed that things had calmed down. The nurse on the third floor informed me that R394 was yelling, screaming, and cursing at the staff. When I was able to verbally speak with R394, R394 was hard to redirect, and I could not make out what R394 was saying to me. I am trained to use CPI (Crisis Prevention Intervention) and usually we do not get to the point where we are physically touching a resident. The staff should talk with the resident to deescalate the situation first. R394 did talk with the police regarding the incident and a police report was made. R394 was sent to the hospital for evaluation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/2024 at 3:00pm V46 (CNA/Certified Nursing Assistant) stated, I am familiar with R394. I was behind the third-floor nurse's station on 9/19/2024 between 1pm-2pm when the incident occurred with R394. R394 was being verbally aggressive and would not calm down. A Code Yellow was called by third floor staff. A Code Yellow is called when we need more staff on the floor to assist with calming down a resident. V44 (former social service director) was the first to arrive on the third floor. V44 told R394 to have a seat in the third-floor dining room. R394 did not sit down and got into V44's face and R394 hit V44 in the face. After V44 was hit in the face by R394, V44 grabbed R394's arms to hold R394's arms to the side of R394's body. R394 continued tossing his body, trying to get away from V44. At that time both R394 and V44 fell to the floor, and V44 was still holding R394's arms trying to get R394 to calm down. Next both R394 and V44 got up from the floor. It did not get physical between R394 and V44 again. R394 was still being verbally aggressive. I would not put my hands on the resident who is being verbally aggressive, I would try talk with the resident first. I was in-serviced regarding abuse on 9/20/2024, the day after the incident. On 10/03/2024 at 4:10pm V40 (Assistant Administrator) stated the incident regarding R394 occurred on 9/19/2024 in the afternoon, V40 didn't remember the exact time. V40 stated, A code yellow was called, and staff rushed to the third floor. A code yellow is called when a resident is having behaviors. I witnessed R394 displaying verbal outbursts near the nurse's station. I did not witness staff to resident physical assault. R394 did report an allegation of physical assault to me, and an investigation was started. While doing the investigation I found out V44 (former Social Services Director) tried to use CPI (Crisis Prevention Intervention) to deescalate the verbally aggression with R394. V44 did get physical with R394 I prefer staff to verbally deescalate the situation, instead of being physically aggressive. The situation between V44 and R394 could have been handled better by V44. The police were called regarding this incident and a police report was made out. On 10/03/2024 at 4:53am V1 (Administrator) stated the incident with R394 was on 9/19/2024 around 2pm. V1 stated, I was in the facility and went up to the third floor. I did not witness R394 being physically abused. R394 was stating V44(former social service director) hit me and hit R394's head against the wall. The third-floor staff told me V44 was trying to use CPI (Crisis Prevention Intervention) to deescalate V394's behaviors by holding R394's arms down by his side and this eventually led to both R394 and V44 falling to the floor. CPI skills do not require for staff to put a resident on the floor. The staff should try to verbally deescalate the situation first. Sometimes the de-escalation process can get physical, but this should be the last resort. That is why I had a problem with the way V44 did CPI. V44 should have not placed hands on R394. R394 went to the hospital for evaluation. Reviewed R394's care plan dated 10/02/2024 which documents in part, Focus: R394 Risk for Abuse, Goal: R394 will remain free from abuse through the next quarter. Facility's Abuse Prevention Program Policy dated 02/07/2017(with a revision dated of 01/30/24) documents in part, Policy: The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The Residents' Rights for People in Long-term Care Facilities policy presented by the facility documents in part, you have the right to safety and good care. You must not be abused by anyone-physically, verbally, financially, or sexually. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed R44's (former Social Service Director) Employee Report which documents in part, on 9/19/2024 employee was discharged for improper use of CPI (Crisis Prevention Intervention).

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45196

Based on interview and record review, the facility failed to provide adequate supervision to a resident (R194) who is high risk for falls. This failure resulted in R194 sustaining a fall which required R194 to go to the local hospital due to sustaining a laceration above R194's left eyebrow, an acute interior column fracture of the C6 vertebrae without significant displacement and R194 to wear a neck brace for 8 weeks.

Findings include:

The facility's Initial Report to local State Agency dated 08/26/24 at 8:12 am, documents, in part R1 sustained a fall with a cut to the upper left eyebrow requiring staples.

The facility's Final Report to local State Agency dated 09/02/24 at 6:46 pm, documents, in part R194 was transferred to the local hospital. R1 sustained a laceration to left eyebrow when R194 fell and hit her head on a chair in the dining room area. R194 readmitted from the local hospital with 8 stitches above the eyebrow. R194 was also diagnosed with acute interior column fracture of the C6 vertebrae without significant displacement . R194 was discharged with instructions to wear neck braces to reduce movement of the vertebrae.

R194's hospital record dated 08/25/24 at 4:45 pm, documents, in part: History of Present Illness: R194 is a [AGE] year-old with history of schizophrenia, schizoaffective disorder, transferred after a fall. Patient fell off a chair and laceration on left eyebrow and struck her (R194) head . Imaging: MRI (Magnetic Resonance Imaging) Cervical Spine without contrast final result: Acute oblique-horizontal fracture of the C6 (Cervical) vertebral body extending to the ossified anterior longitudinal ligament and adjacent bridging osteophytes at C6 and C6-C7 with minimal displacement. Suspected fracture extension to the adjacent discs at C5-C6-and C6-C7 with annular tears. Wound: Musculoskeletal Immobilization Hard Collar Neck. Wound forehead right.

R194's Brief Interview for Mental Status (BIMS) dated 09/12/24 shows R194 has no BIMS score and indicates R194 has memory problems.

R194's Minimum Data Set (MDS) dated [DATE] shows R194 requires substantial/maximal assistance for sit to stand and Supervision or touching assistance for walking.

R194's Face sheet documents R194 admitted to the facility on [DATE], discharged from the facility 09/12/24 and has a diagnosis which include but not limited to nondisplaced fracture of sixth cervical vertebra subsequent encounter for fracture with routine healing and schizoaffective disorder and bipolar type. R194 no longer resides at the facility and surveyor was unable to interview R194.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 09/30/24 at 12:40 pm, V16 (Licensed Practical Nurse, LPN) stated on 08/25/24 around 6:00 am, V16 was passing medication to residents on the sixth floor and observed V24 (Certified Nursing Assistant, CNA) ambulating R194 to the sixth-floor dining room. V16 explained V16 assumed V24 sat R194 down in the sixth-floor dining room. However, shortly after V24 left R194 in the dining room, V16 saw R194 walking from the dining room. V16 redirected R194 back to the dining room and sat R194 in a chair in the sixth-floor dining room. V16 then explained V16 continued to administer medications to residents on the sixth floor. V16 then was standing at V16 medication cart in the sixth-floor hallway slightly down from dining room area, with V16's back to the dining room area when V16 heard a loud noise. V16 stated V16 turned around and looked across the hallway and saw R194 laying on the floor in the entry way of the dining room with R194's head against the wall and the leg of another residents chair. V16 stated V16 went to assess R194 after R194's fall in the dining room and observed a laceration to R194's left eyebrow. V16 stated R194 always has a staff member walk with R194. R194 is a resident who walks fast with an unsteady gait on her (R194) toes and requires assistance from staff for safe ambulation. V16 explained on 08/25/24 prior to R194's fall, R194 was not wearing shoes when V24 (CNA) ambulated R194 to the dining room or when V16 redirected R194 to the dining room prior to R194's fall on 08/25/24. V16 stated, We try our hardest to sit and monitor the dining room but this particular day it was chaotic. I (V16) still had two people to pass medication to, so I (V16) was at my cart (referring to the medication cart) and didn't see R194 in the dining room get up. I (V16) just turned around and looked over to the dining room and saw R194 had fallen on the floor. V16 explained R194's left eye was bleeding. V16 applied a cold wet towel to R194's eye, called R194's physician (who gave orders to send R194 to the local hospital), R194's family, and V2 (Director of Nursing, DON). V16 denied R194 had lost consciousness when R194 sustained a fall on 08/25/24. V16 stated there was no staff to monitor the dining room during R194's fall and all staff was providing care to other residents. V16 explained V16 would have monitored the dining room however V16 remembered V16 still had to administer medication to other residents. When V16 was asked regarding what can happen if residents who are high risk for falls are in the dining room without any staff supervision and V16 stated, Falls and incidents can occur. On 09/30/24 at 1:03 pm, V24 (Certified Nursing Assistant, CNA) stated on 08/25/24 around 5:30 am, V24 gave R194 a bed bath, got R194 dressed and took R194 to the dining room. V24 explained V24 then sat R194 in the dining room and went to take care of another resident. When V24 was asked regarding R194's mobility, V24 explained R194 does not use any assistive devices for ambulation. V24 stated, Someone always walks with R194 to make sure R194 doesn't fall. About 15 minutes after R194 was in the dining room. I (V24) heard a loud bang noise like something hit the wall and someone fell from the dining room. V24 stated V24 rushed into the dining room and saw R194 laying on the floor and V16 (LPN) attending to R194. V24 explained V24 and V16 assisted R194 to a chair and V16 asked V24 to hold pressure to R194's eyebrow until the ambulance arrived. V24 stated R194 was not wearing shoes and R194 was wearing friction socks. When V24 was asked regarding what staff was monitoring the dining room when V24 left R194 in the dining room prior to R194's fall on 08/25/24 and V24 stated, Everyone was working at that time. I (V24) don't remember any staff in the dining room. No staff was assigned to the dining room. My (V24) job is to get up the residents and give them showers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/01/24 at 10:49 am, V2 (Director of Nursing, DON) stated R194 is a resident with dementia, confused and alert to self. V2 stated R194 is to be monitored when placed in the dining room. V2 explained V2 requires staff to ambulate with R194 due to R194's leg (V2 was unable to remember which leg) is not very strong for R194's safety. On 08/25/24 V2 stated V2 received a call from V16 (LPN) that R194 stood up and started to walk and sustained a fall before the nurse could intervene. V2 explained V16 stated R194 tripped over another resident, fell , and cut R194's eye. V2 stated V2 instructed V16 to call V37 (R194's Physician) and send R194 to the hospital. V2 stated the local hospital applied sterile strips to R194's eyebrow and R194 had a X-ray showed a fracture of C6 (Cervical 6). V2 explained R194 was placed in a neck collar with orders to follow up with orthopedic surgeon in 8 weeks. V2 explained staff should be monitoring the dining room at all times when a resident who is high risk for falls is in the dining room. When V2 was asked regarding what staff was assigned to monitor the dining room on 08/25/24 during the time of R194's fall and V2 stated, I (V2) really don't know. Staff should be in the dining room to monitor the residents safety. When V2 was asked regarding what could happen if a resident who is high risk for falls is not supervised by staff in the dining room and V2 stated, There could be a fall with injury, a patient can touch another resident, residents can wander, and staff won't be able to prevent falls. When V2 was asked regarding the importance of supervising residents who are high risk for falls and V2 stated, To prevent the resident from falls and injury. On 10/01/24 at 11:05 am, V37 (R194's Physician) stated, I (V37) don't recall R194's fall on 08/25/24 but I (V37) saw her (R194) at the hospital. V37 stated V37 recalls R194 admitting to the hospital with a hairline fracture of the spine with a C (Collar) applied. When V37 was asked regarding R194's functional status and care needs at the facility, V37 explained V37 recalls R194 was not really alert with cognitive impairments and not redirectable. When V37 was asked regarding what assistance R194 required at the facility V37 stated, I (V37) don't recall how much assistance she (R194) needed. Whatever the notes reflect in her (R194's) chart is what she (R194) needs. When V37 was asked what could happen if a resident who is high risk for fall is left unsupervised and V37 stated, High risk for falls residents are going to fall. They (referring to the residents) can fall if they (referring to the residents) have an unsteady gait and an injury can be caused if they (referring to the resident) fall. R194's progress note dated 08/25/24 at 7:07 am, and authored by V16 (Licensed Practical Nurse, LPN) documents, in part: R194 walked past the writer (V16) and fell . R194 hit her (194) head on the lower part of a chair another patient was in. The writer (V26) notified ADON (Assistant Director of Nursing) DON (Director of Nursing) and left a message or the patient POA (Power of Attorney) to call the facility. The writer (V16) called 911 and set the patient out to the local hospital due to the ambulance service stating it will be a two hour wait. R194's progress note dated 08/28/24 at 11:49 am and authored by V6 (Licensed Practical Nurse, LPN) documents, in part: R194 admitted back to from the local hospital into facility accompanied by 2 EMT's (Emergency Medical Technicians) . R194 with a C (Cervical) collar brace around neck. Collar to remain in place for 8 weeks. Resident (R194) has sterile strips on laceration to tope of left eyebrow. R194's incident report dated 08/25/24 at 6:30 am, authored by V16 (LPN) documents, in part: R194 was walking and when she (R194) was behind the writer (V16). She (R194) fell hitting her (R194) head on the lower part of a chair a patient was sitting in injuring herself . Notes: R194 ambulates without any assistive device and with unsteady gait. R194 requires staff assistance to total assistance with ADL's (Activities of Daily Living). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R194 was walking when she fell hitting her head on the lower part of a chair. Staff to provide morning ADL care and closely monitor resident ambulation on unit. R194's Fall Risk Assessment Evaluation dated 04/01/24 shows R194 has a Falls risk score of 19 which indicates R194 is high risk for falls. R194's Fall Risk Assessment Evaluation dated 08/27/24 shows R194 has a Falls risk score of 16 which indicates R194 is high risk for falls. R194's Fall Risk Assessment Evaluation dated 08/28/24 shows R194 has a Falls risk score of 19 which indicates R194 is high risk for falls. R194's care plan dated 08/28/24 document, in part: Focus: R194 requires the use of C collar brace to related to fracture. R194's care plan dated 10/17/23 document, in part: Focus: R194 is a high risk for falls. Interventions: R194 Velcro shoes was provided to the resident . Provide proper well-maintained footwear. The facility's document dated 08/2024 and titled Fall Prevention and Management documents, in part: General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. The facility's policy dated 09/2023 and titled Hazards and Supervision documents, in part: Policy: The facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents .4. Monitoring and Modification - Monitoring and modification processes include: a. Ensuring interventions are implemented correctly and consistently . 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. The facility's job description titled Certified Nurse's Aide documents, in part: Basic function: To provide assigned residents with routine daily nursing care in accordance with established nursing care procedures, state and federal guidelines, and as directed by your supervisor. Essential Duties: 25. Follow established safety precautions in performance of all duties. The facility's job description titled Registered Nurse/Licensed Practical Nurse documents, in part: Basic Function: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, resident nursing care, staff performance and adherence by staff members to facility policies and procedures. Essential Duties: 12. Adhere to all facility and department safety policies and procedures.