

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145864	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/11/2026
NAME OF PROVIDER OR SUPPLIER  Bria of Forest Edge		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that the initial physician visit was performed for a newly admitted resident which affected one resident (R1) of three residents reviewed for physician visits. Findings include: R1's Face Sheet and Census List document that R1 was admitted on [DATE] and transferred to the hospital on 2/16/26. R1's medical record revealed that V10 (Physician) did not perform an initial visit and did not fulfill the requirement of one visit every 30 days for the first 90 days. V10 did not perform any physical assessments on R1 from the time R1 was admitted to the time R1 was transferred to the hospital. All medical visits and medical assessments were performed by V8 (NP-Nurse Practitioner) and V11 (NP). On 3/11/26 at 11:30pm, a request was made for V10's visit notes for R1's visits. V3 (DON-Director of Nursing) stated that V10's notes would be provided. The facility submitted two progress notes authored by V11 and dated 12/2/25 and 1/14/26. At 12:35pm, V3 stated, Correct, there's no notes from (V10). (V10's) NP sees the patients. I'm not sure how the process goes. (V11) is the nurse practitioner for (V10). V3 confirmed that if the medical doctor sees the resident, the progress note should be in the medical record on the date that the visit is performed. On 3/11/26 at 3:30pm, V2 (Assistant Administrator) stated, We submitted what we have. We do not have any progress notes from (V10). V11 (NP) is the one that saw (R1). V2 also indicated that V10 assumed R1's medical care once R1 was in the facility and was not R1's doctor prior to her admission. The facility submitted a policy titled, Physician Services - On Call Coverage with a review date of 9/2024 which documents, in part: 5. If the physician does not make the visits required, the DON and/or Administrator are notified to attempt to contact the attending physician. 6. If the physician still does not respond, the Medical Director is notified to see the resident and contact the attending physician. 9. When the physician visits a resident, a progress note will be placed in the medical record. The facility policy does not address the time frame that newly admitted residents have to be physically assessed by the attending physician.</p>

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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