Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000954	A. BUILDING: ______ B. WING ______	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF FOREST EDGE	8001 SOUTH WESTERN AVENUE CHICAGO, IL 60620

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S 000	Initial Comments COMPLAINT INVESTIGATION: 2185581/IL136730	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240f) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to protect a resident's right to be free of abuse for one resident (R4) in the sample. This failure affected R4 who asked to have care assessment done after finishing lunch that escalated into verbal and mental abuse. This failure resulted in R4 crying, being upset and	S9999		

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feeling hurt. This has the potential to affect all 16 residents residing on the 1st floor of the facility.

Findings include:

Based on observations, interviews and record review the facility failed to ensure staff protected a resident who was screened at risk for abuse, failed to ensure staff provided supervision to a resident displaying physically aggressive behavior and failed to timely move a resident to a different floor per facility policy after assaultive behavior was reported for two (R1 and R4) of four residents reviewed for abuse. These failures resulted in R4 physically assaulting R1 who experienced right eye and facial pain, blurry vision and light sensitivity with a hospital diagnosis of traumatic iritis. R1 suffered psychosocial harm from exposure to R4 after the initial physical assault.

Findings include:

R1's Admission Record documents, in part, that R1 is a 38-year-old with a diagnosis of Quadriplegia.

R1's Minimum Data Set (MDS) dated 6/30/21, documents a Brief Interview for Mental Status (BIMS) score of 14 which indicates that R1 is cognitively intact.

R4's Admission Record documents, in part, R4 is a 51-year-old with diagnoses of Schizoaffective Disorder, Bipolar Disorder and Major Depressive Disorder.

R4's MDS dated 7/12/21, documents a BIMS score of 13 which indicates that R4 is cognitively intact.

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On 8/5/21 at 12:15 pm, R1 stated that on 7/28/21 at approximately 1:00 am, R4 came into her room and punched her in the right eye. R1 stated she was awake in bed and responding to a text message on her cellular phone. R1 stated she looked up from her phone and R4 is standing next to her bed wearing a gown. R1 stated she turned her head and said, "Hey (R4)!" R4 then hit her in her right eye with a closed fist. R1 stated she used her stylet with her mouth to press the call light and then R4 walked out. R1 stated V12 (Licensed Practical Nurse, LPN) came into her room a few minutes later as R4 tried to come back into R1's room. R1 stated that V12 and V18 (Certified Nursing Assistant, CNA) had to pull R4 out of her (R1's) room into the hallway and that she could see R4's naked buttocks during her removal. R1 stated, "Here I am, not able to move and (R4) comes in and hits me with a closed fist and says nothing. I absolutely was feeling threatened." R1 stated V12 came back into her room and R1 told V12 what happened with R4.

On 8/9/21 at 4:10 pm, V12 (LPN) stated she was R1 and R4's nurse on 7/27/21 on the 11:00 pm to 7:00 am shift. V12 stated that R1 is a quadriplegic from the neck down which requires total care assistance from staff. V12 stated at the beginning of the night shift on 7/27/21, "I had my eyes on R4" because when she first did rounds, R4 came up to her at the nurse's station, opened the back of her gown and spread her naked buttocks. V12 stated she redirected R4 back to her room and instructed V18 (CNA) to keep an eye on R4 since this was a new behavior. V12 stated she wanted to monitor R4 because she may do something else.

On 7/28/21, approximately 2 hours after the start

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of her night shift, V12 stated V18 went to perform care for R7 and noted that R4 was walking from her room towards the nurse's station and then went into R1's room. V12 stated that V18 ran into R1's room after R4. V18 turned R4 out of R1's room. (V12) responded to redirect R4. V12 stated that R1 said, "By the way, she (R4) hit me." V12 stated that she attended to R1 and asking her what happened with R4. V12 stated that R1 said R4 came up to her in her room and hit her in the right eye. V12 stated she assessed R1's right eye, applied a cold compress and R1 denied any pain at this time. V12 stated R4 was then one-to-one monitored by V18 (CNA) and that R4 did not come out of her room the rest of the shift.

When this surveyor questioned about V12 about her authored progress note regarding R4 being combative with staff, V12 stated prior to entering R1's room, R4 tried to go on the elevator and was swinging at her (V12). V12 stated R4 was swinging with both closed fists. (V12) stated she stepped back and then redirected R4 back to her room. V12 said R4 came out of her room two more times to the nurse's station, spreading her naked buttocks. The third time (R4) came out of her room, R4 went into R1's room.

In R4's Nurses Note dated 7/28/21 at 12:43 am, V12 (LPN) documented, in part, "(R4) became combative with staff and was sent to her room. (R4) attempted to leave the floor and was sent back to her room again. (R4) became combative with staff. After being in her room for about ten minutes, (R4) came out and went into (R1's room) and struck (R1) in the right eye. (R4) went back in her room on her own after this encounter. Continue to monitor (R4)."

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S9999	Continued From page 5 In R1's Nurses Note, dated 7/28/21 at 12:52 am, V12 (LPN) documented, in part, "(R1) was struck by (R4) ...for no reason." On 8/12/21 at 7:00 am, V18 (CNA) stated she was the only CNA on 7/27/21 from 11:00 pm to 7:00 am for R1 and R4's floor. V18 stated at the beginning of her shift at 11:00 pm, R4 was wearing a gown that wasn't fastened in the back and walked up to her at the nurse's station, then placed her head on the table and spread open her naked buttocks. V18 stated, "(R4) did this for an hour repeatedly." V18 stated R4 would go back to her room with redirection, then come back out to the nurse's station or garbage can to repeat the behavior. V18 stated R4 then was attacking V12 (LPN) by hitting her in the arm with a "balled up fist". V18 stated she and V12 physically escorted R4, by grabbing underneath each arm, back to her room. V18 stated that about two hours into the shift, on 7/28/21, R4 came out of her room, walked up the hallway to the nurse's station, and then R4 detoured into R1's room. V18 stated, "I jumped up from the nurse's station, and V12 ran behind me. We got to R4 and she was at the foot of R1's bed." V12 then physically escorted R4 back to her room, and R1 said to me, "(R4) smacked me." V18 stated that approximately one hour after this incident, R4 again "jetted out into the hallway," running back towards R1's door but she ran after R4 and caught her before she reentered R1's room. V18 stated after another hour, she peeked in on R4 in her room and R4 was sleeping. V18 then she finished her other work with the other residents on the floor. On 8/5/21 at 12:15 pm, R1 stated when the morning staff came in on 7/28/21, V4 (Social Services Director) came to her (R1) and asked	S9999		

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her what happened with R4. R1 stated she repeated the same story of R4 hitting her in the right eye. R1 said V4 informed her that he would be sending R4 out (to the hospital) and V14 (Nurse Practitioner) would be "taking care of it." R1 stated she informed V4 that on 7/28/21, R1 was in her room with the door closed and even though R1 didn't see R4, she was scared. R1 stated that on 7/28/21 during the day, she hears R4 in the hallway saying, "God told me to hit her (R1)." R1 stated, "It took me right back to the situation when she (R4) hit me. I was scared." R1 stated, "(R4) had already hit me, and I can't defend myself." R1 stated she told V20 (CNA) that she was scared because the facility didn't send R4 out. R1 stated, "I was traumatized all over again so I text (V2, Director of Nursing, DON)."

During R1's interview on 8/5/21 at 12:15 pm, this surveyor read R1's text message to V2, dated 7/28/21 at 8:29 pm. The text read, in part, "I don't know if you are aware but on the 11 pm - 7 am shift, (V12) was nurse and said that (R4) said God is telling her to hit me. I am afraid that she'll come in and do worse."

On 8/10/21 at 4:05 pm, V2 (DON) stated he was informed by V12 in the middle of the night on 7/28/21 that R1 had alleged that R4 hit her. V2 stated he then reported this to V1 (Administrator) who is the abuse coordinator in the facility. V2 stated he did not physically see R1 during the day on 7/28/21 and confirmed to this surveyor that he did received a text message from R1 later on 7/28/21 indicating that R1 was afraid. V2 stated the social services department helped with R4's room change.

On 8/12/21 at 9:31 am, V20 (CNA) stated she

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S9999	Continued From page 7 was on orientation with V34 (CNA) on 7/28/21 from the 3:00 pm - 11:00 pm shift. V20 stated on this date while rendering care to R1, R1 informed her that she was afraid from an incident that occurred earlier with R4 and that she didn't want it to happen again. V20 stated that she relayed R1's feelings to the nurse (V13). On 8/5/21 at 3:05 pm, V4 (Social Services Director, SSD) stated when he arrived at the facility on 7/28/21 at 7:00 am, he began his rounds and spoke to R1 in her room. V4 stated R1 informed him of the incident with R4. V4 stated he then went to check on R4, who was fast asleep and ordered to move R4 off the floor immediately. V4 stated he checked for another room and had R4 moved off that floor on the same day (7/28/21). V4 stated staff are to intervene as soon as possible when a resident is displaying behaviors. R4's document, titled "Notice of Room Transfer" dated 7/29/21, indicates R4 moving rooms to another floor in the facility on 7/29/21, which contradicts V4's statement of R4 being immediately removed from R1's floor (on 7/28/21). In R4's Social Service Note dated 7/28/21 at 9:35 am, V4 documented, in part, "Writer met with (R4) for a follow up. (R4) displayed delusional behavior with aggression towards (R1). (R4) verbalized hearing voices ("Lord calling her") urging (R4) to hit (R1). (R4) immediately placed on 1:1 monitoring." On 8/10/21 at 12:48 pm, V14 (Nurse Practitioner, NP) stated he assessed R4 in person on 7/28/21 morning and that R4 was "manic and agitated." V14 stated redirection didn't work so acute	S9999		

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anti-psychotic medication was needed and given to R4. V14 stated R4 was verbally and physically aggressive with poor impulse control, was attempting to strike others and had already stricken R1. V14 stated since R4 was still displaying these behaviors, he (V14) was trying to prevent further behaviors from R4 by debriefing staff to take cues from R4's agitation, internal stimulation, delusional thoughts and restlessness. V14 stated if acute anti-psychotic medications are not working, he will transfer the resident out to the hospital for a psychiatric evaluation. V14 stated R4 was moved to another floor, and "we started monitoring her (R4) more."

On 8/5/21 12:15 pm R1 stated that on 7/29/21, the pain was persistent in her right eye, and she was sent out to the hospital where they performed radiology studies. R1 stated the hospital staff instructed her that if the right eye pain persists, to come back to the hospital. R1 stated on 8/4/21, she was experiencing right eye pain, blurry vision and light sensitivity, so she demanded to be sent back to the hospital. Per R1's request with permission provided, this surveyor reviewed R1's hospital discharge paperwork in her room. The hospital report, dated 8/4/21, listed a diagnosis of right eye pain with the following two medications to be administered: Cyclopentolate 2% eye drops, 1 drop to right eye twice a day for 5 days and Prednisolone Acetate 1% eye drops, 1-2 drops to right eye every 4 hours for 5 days.

On 8/9/21 at 4:35 pm, V28 (Psychiatric Rehabilitation Services Director, PRSD) stated in the morning on 7/28/21, she went to take statements from R1 and R4 about the alleged physical assault. V28 wrote R1 and R4's statements for V1's abuse investigation. V28

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S9999	Continued From page 9 stated when she interviewed R4, R4 stated she hit R1 because the Lord was calling her to do it and to do it again. V28 stated R4 was placed on one-to-one monitoring with a staff member specifically assigned that the resident. Review of the facility CNA Daily Assignment Sheets on 7/27/21 for night shift and 7/28/21 for day, evening and night shifts indicate that no staff member was assigned to R4 for one-on-one monitoring. On 8/10/21 at 11:45 am, this surveyor attempted to interview R4 about the 7/28/21 physical assault on R1; however, R4 stated that she didn't want to speak to this surveyor about it. R4's written statement, dated 7/28/21 and obtained by V28 (PRSD), documents, "I hit her (R1). I feel like the Lord was contacting me so that's why I hit her (R1). I was hearing voices. The Lord was telling me to hit her. I still hear the voices." In R4's Social Service Note, dated 7/28/21 at 9:35 am, V28 (PRSD) documented: "Writer met with (R4) for a follow up. (R4) displayed delusional with aggression towards peer. (R4) verbalized hearing voices ("Lord calling her") urging her to hit a peer. (R4) is immediately placed on 1:1 monitoring, and charge nurse was notified. Staff will continue to follow up and note all progress." On 8/10/21 at 11:01 am, V13 (LPN) stated she worked as R1 and R4's nurse on 7/29/21 from 9:00 am to 9:00 pm. V13 stated R1 reported to her what happened overnight with R4 coming into her room and hitting R1. V13 stated on 7/28/21 at approximately 9:00 am, R4 came from her room into the day room with her gown on. V13 informed	S9999		

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R4 that she needed to get dressed for the day. V13 stated R4 then opened the back of her gown towards her and went back to her room. V13 stated on 7/28/21 at 10:00 to 10:30 am, R4 returned to the day room with her gown on, exposing her naked backside and gestured for V13 to "kiss her behind." V13 stated at that point, she told V34 (CNA) to take R4 back to her room and sit with her. V13 stated V34 left R4's room, and then R4 came back out of her room again to the day room. V13 stated she then called V14 (NP) to inform him of R4's behavior, and that V14 ordered "PRN" medications. V13 stated R4 laid her body on the floor of the day room with her gown on. V13 stated she called V31 (Resident Services) for assistance, and when V31 arrived R4 got up off the floor and went to her room. V13 stated she medicated R4 with the ordered anti-psychotic medications. V13 stated R4 slept through lunch and had to be woken up to eat dinner. V13 stated R4 was still residing on the same floor as R1 when she checked on her on 7/28/21 at 8:45 pm.

On 8/11/21 at 3:32 pm, V34 (CNA) stated she was the CNA on R1 and R4's floor on 7/28/21 for the 7:00 am to 3:00 pm shift. V34 stated R4 was coming out of her room, pulling her hair and banging her head on the elevator door. V34 stated R4 was opening the back of her gown and spreading her naked buttocks when she was out in open view to other residents. V34 stated V13 (LPN) tried to intervene and redirected R4 back to her room, saying that she couldn't come out of her room without putting on day clothes. V34 stated R4 repeated this same behavior again out in open view of other residents. V34 stated V13 talked to R4 and walked her back to her room. V34 stated she checked on R4 every 30 to 45 minutes for monitoring because she was working

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with other residents on the floor. V34 stated, "I was the only CNA on the floor that day." Facility document, titled "Daily Schedule" and dated 7/28/21, documents that V34 was the one CNA for 1st shift on the 5th floor.

On 8/9/21 at 2:35 pm, V11 (Registered Nurse, RN) documented that on 7/29/21 R1 informed him she was having pain to her right eye and was requesting to be sent to the hospital. V11 stated he notified V14 (NP) about R1's pain and request, and an order was received to send R1 out to the hospital. V11 stated he prepared R1's transfer documentation, called for ambulance services and transferred R1 to the hospital. V11 stated that on 7/29/21, at the end of his shift, he moved R4 to a room on another floor in the facility.

In R4's Nurses Notes dated 7/29/21 at 2:03 pm, V11 documented, in part, "(R4)... transferred to 2nd floor."

On 8/10/21 at 1:41 pm, after reviewing her authored documentation from 7/28/21 at 6:53 pm, V5 (Psychiatric Rehabilitation Services Coordinator, PRSC) stated she did not witness R4 move from the 4th floor to the 5th floor. V5 stated V4 informed her R4 had been transferred to the 4th floor and since R4 was assigned in her (V5's) case load, she needs to document R4's transfer. V5 stated she did not physically see R4 until she was relocated to the 2nd floor on 7/29/21.

In R4's Social Service Note dated 7/28/21 at 6:53 pm, V5 (PRSC) documented: "Room Change: (R4) was transferred from Room 503 (A) to Room 410 (D). (R4) was receptive to the room change at this time. Nursing made aware. Staff will continue to document all progress."

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	IL6000954	A. BUILDING: ______ B. WING ______	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF FOREST EDGE	8001 SOUTH WESTERN AVENUE CHICAGO, IL 60620

(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) COMPLETE DATE
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In contradiction, V5 (PRSC) then documented in another of R4's Social Service Note, dated 7/29/21 at 1:43 pm: "Room Change: (R4) was involved in a room change. (R4) was moved from room 503 (A) to Room 204 (A). (R4) was receptive to the room change at this time. Nursing made aware. Staff will continue to document all progress."

In R1's hospital records on 7/29/21 at 1:20 pm, V9 (Hospital Emergency Medicine Physician) documented, in part, "(R1) presents with right eye/facial pain s/p being punched in the face. (R1) states 2 days ago, another resident in her nursing home punched her in the face, striking near her right eye ... (R1) endorses blurred vision yesterday... notes persistent pain to her right eye and right face."

On 8/11/21 at 1:31 pm V27 (LPN) stated R1 is alert, fully oriented and not able to move her extremities. V27 stated on 8/4/21, R1 complained of right eye pain and was requesting to be sent back to the hospital. V27 stated the pain location was where R4 had hit her from a previous date. V27 stated she contacted V14 (NP) who provided an order to send R1 to the hospital for further evaluation of the right eye pain. V27 stated she transferred R1 to the hospital on 8/4/21 and R1 returned back to the facility on the same day with a bottle of Prednisolone eye drops and another medication prescription.

R1's Order Summary Report documents, in part: "Prednisolone Acetate Suspension 1%. Instill 2 drops in right eye every four hours as needed for 5 days" with an order dated of 8/4/21, and "Cyclopentolate HCl Solution 2%. Instill 1 drop in

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right eye two times a day for Pain until 8/14/21" with an order date of 8/8/21.

R1's hospital records on 8/4/21 at 2:07 pm, V44 (Hospital Trauma Physician) documented, in part, "(R1) presenting to ED with remote eye injury that occurred one week prior after being struck in the face by a fist. (R1) reports that since the injury... (R1) has been experiencing progressive blurry vision, light sensitivity, and increased pain with eye movement... Traumatic Iritis is leading diagnosis given history of remote trauma and physical presentation."

On 8/24/21 at 12:48 pm, V37 (Attending Physician) stated if a resident is alleged to have assaulted another resident, the facility staff "must isolate the resident and send them out" to the hospital. V37 stated, "There's no predictability" of when a resident can physically assault another resident in a facility. V37 stated facility staff "needs to do close observation" of the abuser until the resident can be transferred to the hospital or to another floor. V37 stated since R4 was not sent to the hospital after the allegation of physical assault by R1, staff "must monitor R4 to prevent any further harm." When this surveyor informed V37 the victim of R4's physical assault was R1, a quadriplegic resident who is fully oriented, vulnerable and not able to defend herself and then hears R4's voice in the hallway outside her door after R4 was not immediately removed off the floor, would he expect that this would cause psychosocial harm to R1? V37 stated, "It's a possibility." V37 stated, "If you are asking me the question if (R4) should have been transferred off the floor right away? The answer is yes."

R1's Care Plan dated 2/5/20 documents, in part,

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S9999	Continued From page 14 a focus that R1 is "vulnerable for abuse as evidenced by having a diagnosis of Quadriplegia" with a goal that R1 "will reside in the facility free of mistreatment of abuse" with interventions listed as "Staff will assure safety and provide a safe environment." Facility policy dated 9/20 and titled "Behavior Management," documents, in part: "General: It is the policy of (the facility) to manage unruly behavior of a resident in the least restrictive manor that ensures the safety of residents, employees, and family members. Responsible Party: Nursing and Social Services. Guidelines: 1. Should a resident's behavior become abusive, hostile, assaultive or unmanageable in a way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately: a. Provide for the safety of all concerned (i.e., move resident, equipment, etc.)." Facility abuse policy, untitled and dated 9/2017, documents, in part: "This facility affirms the right of our residents to be free from abuse... In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse... of residents... The facility is committed to protecting our residents for abuse... by anyone including, but not limited to, facility staff, other residents... VI. Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of	S9999		

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S9999	Continued From page 15 the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents, but not limited to, the separation of resident." (B)	S9999		