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 10/26/2021

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
S 000	Initial Comments Complaint Invstigations: 2187427/IL138989 2187412/IL138967 2187337/IL138879	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)4)5) 300.1210c) 300.1210d)1)6) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest	S9999	Attachment A Statement of Licensure Violations	

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 10/26/2021

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
S9999	Continued From page 1 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.	S9999		

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 10/26/2021

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
S9999	Continued From page 2 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observations, interviews and review of records: 1) The facility failed to provide safety intervention and supervision for 2 of 2 residents (R1 and R2) reviewed for accidents and supervision. R1 sustained multiple 2nd degree burns to right	S9999		

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 10/26/2021

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
S9999	Continued From page 3	S9999		

hand, fingers, chest and thigh. R2 expired as a result of being discovered submerged under water in a tub at the shower room for approximately 3 to 4 hours.

2) The facility failed to assess, monitor and document change in condition for one resident (R1) of one reviewed for change in condition. This caused delay in emergency treatment for R1 whom suffered 2nd degree burns. R1 was hospitalized ten hours later after a change in condition was noted. Facility failed to ensure staff performed correct CPR (Cardiopulmonary Resuscitation) for one resident (R2) after being found submerged in water while in a deep soaking tub.

3) The facility failed to administer pain medication to one (R1) of one resident with 2nd degree burns.

These failures have the potential to affect the safety of 144 residents that requires supervision / assistance per facility form CMS 672.

Findings include:

R2 a 62-year-old female admitted with medical diagnosis to include myasthenia gravis, seizures, schizophrenia, lack of coordination, major depressive disorder, pain in unspecified joint, aphasia (deaf and non-speaking). Per clinical record R2 expired on 10/6/21.

After R2 was discovered submerged in water in a deep soaking tub (depth 16 inches, width 24 inches and length 61 inches), staff failed to correctly perform CPR for R2 who expired on 10/6/21. Minimum Data Set (MDS) dated 9/7/21 in part documents: "R2 required a 2-person

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 10/26/2021

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
S9999	Continued From page 4 extensive assist with transfers in/out of tub/shower. R2 required physical assistance with bathing activity." Review of the ambulance run sheet dated 10/6/202, R2 found unresponsive, not breathing with obvious signs of death to include rigor mortis. According to the run sheet R2 was not defibrillated, R2 was considered dead. R2 pronounced dead in the field by the local fire department. Physician order dated 09/01/2021 documents code status for R2: FULL CODE. Current Face Sheet for R2 documents full code status. On 10/7/21 at 11:21 AM surveyor accompanied V5 (Registered Nurse) to 4th floor shower/tub room near the elevator. Surveyor observed two shower/tub rooms adjacent to each other. Both rooms were labeled tub room with the same number. V5 unlocked the door using a key to open. V5 stated no one can enter if the door is locked unless the nursing staff opens the door with the key. When asked what happened with R2, V5 stated, "When I arrived late today on the floor, the night shift nurse had already left, I do not know what happened to R2." V5 further stated, "I do not even know the nurse who worked 11 PM to 7 AM shift and I did not receive any endorsement from the night nurse." On 10/7/21 at 11:26 AM V6 (Certified Nursing Assistant) stated, "I was not here when it happened. The last time I saw R2 was yesterday morning when I worked 7 AM to 3 PM shift. But from what I heard, somebody left her in the bathroom by herself. I don't know if she fell in the bathroom."	S9999		

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 10/26/2021

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
S9999	Continued From page 5 On 10/07/21 at 1:45 PM V2 (Director of Nursing) stated, "We are still investigating what happened to R2 and I cannot give you any information. As for now, we don't have any names of staff or who saw R2 first when it happened. It was very busy yesterday, so I asked the nursing staff on the floor to go home and rest. I did not make any incident report, I do not think we should do any incident report until we know the cause and why R2 expired. That is why we are doing the investigation to determine if we need to report this incident. Not all death in the facility needs to be reported. Besides, we considered R2 as independent, she does things on her own and we let her be." On 10/7/21 at 3:24 PM V3 (Certified Nursing Assistant) stated that she was threatened by V2 (Director of Nursing) to be put to jail because she (V3) killed R2. And that there was camera footage showing her (V3) bringing R2 to the shower room. V3 stated that staff working 10/06/2021 on 3 PM to 11 PM shift when the incident happened were V4 (CNA), V17 (CNA) and V10 (Registered Nurse). V3 added R2 was independent and able to perform activities of daily living by herself. V3 stated "It is always that way, that nursing staff always left R2 in the shower room because she was independent." V3 stated that shower / tub room had been left opened during the (7AM-3 PM) shift and that it was always open every time she worked on the 4th Floor. V3 then said, she does not know what really happened to R2 on 10/6/21. On 10/07/21 at 3:49 PM V4 (Certified Nursing Assistant) stated she was assigned to R2 when the incident happened. V4 stated she left the floor around 4 PM went down for Covid-19 testing. V4	S9999		

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 10/26/2021

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
S9999	Continued From page 6	S9999		

stated she came back on the 4th floor around 5:00 PM. She (V4) was informed by V17 (Certified Nursing Assistant) that she (V17) provided towels to R2. V4 stated around 7:00 PM, V17 informed me that she found R2 was in the shower / tub room. V4 then said, "When I went inside the shower / tub room, R2 was in the tub and her head was submerged in the water. The water was still running in the tub. R2 looked pale when, V10 (Registered Nurse) was called and we (V4, V17 and V10) took her out of the water. CPR was done by the nurse (V10) and water and blood came out of R2's mouth. R2 was considered by all nursing staff as independent including bathing." V4 also stated that there was no staff monitoring the shower/tub room and at least 1 of the shower / tub room's door was always left open to be used by residents.

On 10/07/21 at 4:07 PM V10 (Registered Nurse) stated "Around 7 PM I was passing medication when I heard some of the CNAs calling me to the shower room. When I entered the shower room, I saw R2 in a sitting position inside the tub with CNAs supporting her (R2) in a sitting position. We (V10, V4 and V17) took her (R2) out of the tub, and I performed CPR by doing chest compressions only. V10 was asked if a resuscitation bag was used to resuscitate R2. V10 responded, "No, but we have it on the crash cart." V10 was asked why only chest compression were done, V10 did not respond. V10 stated that nursing staff on the floor considers R2 as independent in her ADLs, (Activity of Daily Living) including showers or during bath. Nursing staff does not assist, supervise, or monitor R2 because she was independent. During the interview, V10 said, "We (V4, V10 and V17) removed R2 from the shower room to R2's room and during that time, CPR was

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 10/26/2021

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
S9999	Continued From page 7	S9999		

stopped. When asked the reason for V10's action, V10 did not answer.

V1 (ADM) and V2 (DON) were asked on 10/5/2021 at 1:25 PM, 10/6/2021 at 1:20 PM and 3:20 PM to see footage of camera of both R1 and R2. V1 and V2 said the camera did not store information.

On 10/8/2021 at 10:25 AM, V2 (DON) was asked about the shift-to-shift report during change of shift. V2 said "It was not necessary for the outgoing staff to write a detailed account on the 24-hour report to follow up with residents' care. It was the responsibility of the oncoming nurse to find out for themselves on what happened on the previous shift."

According to American Heart Association CPR and First Aide and Emergency Cardiovascular Care article posted 10/22/21 reports: High Quality CPR-should be performed by anyone -including bystanders. There are five critical components: Minimize interruptions in chest compressions; Provide compressions of adequate rate and depth; avoid leaning on the victim between compressions; show proper hand placement; avoid excessive ventilation.

On 10/8/21 at 1:00 PM V18 (Maintenance Technician) measured the tub on the 4th Floor. Dimensions were as follows: inner depth 16 inches, inner width 24 inches and length 61 inches, outer height 28 .75 inches, outer width 28 .75 inches and outer length 66 inches. Both tubs have the same measurements. A resident was heard inside the shower / tub room knocking. After 20 minutes, R9 was came out of the shower

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 10/26/2021

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
S9999	Continued From page 8 / tub room using walker unattended. R9 was 43 years old, originally admitted on 9/16/21, with medical diagnosis that includes major depressive disorder, schizoaffective disorders. Minimum Data Set (MDS) of R9 dated 9/27/21 on Functional Status are as follows: 1. Transfers - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position was 1-person extensive assistance needed. 2. Walk in room and corridor - how resident walks between location in her room was 1-person limited assistance. 3. Bathing - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower. R9 needs physical help in part of bathing activity. 4. Shower / bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) was supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. On 10 /08/21 at 2:18 PM V17 (Certified Nursing Assistant) stated, that she was the staff who first found R2 submerged in the bathtub on her left side position at the foot of the bathtub. R2 was found with water was still running. V17 stated at the beginning of the shift, around 3:15ish PM, she gave R2 face and large/bathing towels. But she denied bringing her to the shower / tub room. V17 said it was around 6:30 PM to 7:00 PM when she saw R2 was already submerged in the water	S9999		

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 10/26/2021

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
S9999	Continued From page 9 inside the tub. Per V17, R2 was independent including taking the shower and that R2 takes long showers. On 10/08/21 at 2:53 PM during an interview with V18 (Restorative Nurse) and V2 (Director of Nursing) V18 stated, "Nursing staff on the floor should not leave resident unattended during bathing or shower. It does not matter if the resident was assessed that they need supervision, assistant or they are independent. Residents' in the shower room should not be left unattended." V2 then stated, "Yes, I agree residents should not be left inside the shower room and should be checked from time to time." V2 further stated, "You have to understand that R2 was assessed as needing assistance, because R2 has poor condition. Hospital Record dated 8/31/21 reads that R2 declined as to her ADL when she came back from the hospital." In a prior interview, with V2 (dated 10/7/21 at 1:45 PM) V2 stated R2 was independent. On 10/08/21 At 4:30 PM V24 (Medical Doctor) stated medical diagnosis does not tell whether a person needs assistance or not. It is through the facility assessment that will tell if a resident needs assistance. On 10/9/21 at 11:49 AM V21 (R2's sister) stated a male staff informed her that R2 expired in the shower room while taking a shower, there was no additional information mentioned. V21 also stated R2 went to the hospital recently because her health had declined. While in the hospital R2 was noted to have multiple bruising and abrasions. Nurses notes dated 07/22/21 documents R2 has multiple bruises and abrasions before R2 went to the hospital.	S9999		

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 10/26/2021

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
S9999	Continued From page 10 On 10/9/21 at 2:54 PM V23 (Assistant Director of Nursing) stated she was informed on 7/22/21 by V26 (LPN) that R2 had multiple bruising and abrasions on different areas of her body. V23 further stated that was partly why R2 was transported to the hospital on 7/23/21. Per V23 (ADON) and V2 (DON) there was no report filed to the State Agency and no investigation was done because V26 (LPN) did not do the correct assessments and they did not review V26's notes from the incident. On 10/11/21 at 10:50 AM V25 (Rehab Medical Doctor) stated, "R2 was declining, that is the reason she was on Physical and Occupational Therapy. R2 has Myasthenia Gravis which can cause balance issues. R2 has an unsteady gait for her to get into the tub, she cannot do that without assistance. Someone needs to help her get into the tub. She may use soap to clean herself or rinse herself but for sure someone needs to help her going inside the tub." 10/11/21 at 2:24 PM V31 (Certified Occupational Therapy Assistant) stated he was seeing R2 on a regular basis 2 or 3 times a week. V31 said R2 was doing therapy due to safety concerns, safe transfer training, task attention and self-care. V31 said when R2 came back from the hospital she was very weak and cannot perform ADLs, R2 is not safe to go inside the tub by herself and not safe to be left alone in the shower room due to balance problem and has no safety insight or awareness. R2 requires at least contact guard assist or minimum assistance. Moreover, R2 must not be left alone or by herself in the shower room. Hospital Record for R2's discharged dated 8/31/21 reads: During discharge from the hospital	S9999		

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 10/26/2021

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
S9999	Continued From page 11 R2 unable to sit in the wheelchair for more than 20-30 minutes. R2 continues to demonstrate deficits with strength, coordination, endurance, balance, and safety. Discharge instruction recommends R2 to continue with Physical Therapy to address functional deficits. Minimum Data Set (MDS) of R2 dated 9/7/21 reads: R2's Functional Status are as follows: 1. Transfers - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position was 2-person extensive assistance needed. 2. Walk in room and corridor - how resident walks between location in her room was 1-person limited assistance. 3. Locomotion on unit how the resident moves between location in her room and adjacent corridor on the same floor was 1-person extensive assist. 4. Locomotion off unit how the resident moves to and return from off-unit was 1-person limited assistance. 5. Toilet - how resident uses toilet on / off toilet was 2-person extensive assistance. 6. Bathing - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower. R2 needs physical help in part of bathing activity. 7. Balance during transitions: Moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface are all not steady, only able to stabilize with staff assistance. 8. Mobility Devices what R2 normally used was wheelchair prior device use was walker. 9. Shower / bathe self: The ability to bathe self, including washing, rinsing, and drying self	S9999		

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 10/26/2021

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
S9999	Continued From page 12	S9999		

(excludes washing of back and hair) was substantial / maximal assistance - Helper does more than half the effort. Helper lifts, holds trunk or limbs, and provides more the effort.

R2's current quarterly Care Plan in part reads:

R2 is at risk for complications related to impaired functionality. R2 requires extensive assistance with Activity of Daily Living (ADLs). R2 is at high risk for falls related to generalized weakness, observed with unsteady gait, mobility with wheelchair. Intervention includes: Staff to anticipate toileting needs / wants, observed resident's routine and personal environment, staff to assist as needed. R2 requires limited assist with daily care needs related to decrease strength, balance and endurance. Intervention includes: One assist for transfers and wheelchair for mobility. R2 has loss range of motion (ROM) to left extremities related to generalized weakness. R2 is at risk for difficulty with communication related to deaf non-speaking.

V25 (Medical Doctor) notes dated 10/6/21 at 8:10 AM, it reads in part: R2 was having lately decline in her strength, mobility, transfer, ADL, and cognition. R2 to be kept in the facility to be managed. R2 was admitted under subacute rehab and she is currently working with PT, OT, and speech therapy.

On 10/12/21 at 3:02 PM V35 (Medical Examiner/Forensic Pathologist) stated during examination, R2 was without injury resulting from trauma, but was found to have water in her lungs consistent with drowning.

Per email dated 10/13/21, V1 (Administrator) informed the regional office cameras in the facility

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 10/26/2021

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
S9999	Continued From page 13	S9999		

does not record. This information was provided to V1 by V42 (Corporate/IT). V1 indicated via email no written policy concerning the camera footage exist.

Findings include:

R1 56 years old male originally admitted 2/16/16, with medical diagnosis that includes schizophrenia, conversion disorder with seizure or convulsion, dementia, and loss of hearing (deaf). Per notes dated 10/4/21, R1 was admitted to local hospital with multiple 2nd degrees burn. He did not speak much and R1's mental status was impaired with a Brief Interview for Mental Status (BIMS) score of 6. R1 was ambulatory with supervision.

On 10/6/2021 at 10:40 AM, R1 was observed by surveyor at local hospital. R1's right hand was wrapped V27 (Physician's Assistant) was in R1's room. R1 was awake and spoke very little. V27 wrote on paper "What happened? "and showed R1. R1 said," Hot water." R1 did not say anything else.

R1's wound assessments dated 10/4/21 shows that R1 has multiple burns on various parts of his body. Specific to the following areas: right hand that measures 5.2 X 2.2 cm, right hand top 1.4 X 0.4 cm, chest 9.9 X 4.5 cm and right thigh 3.3 X 1.5 cm.

On 10/06/21 at 12:30 PM V28 (Nurse Practitioner) stated he saw R1 before R1 was sent out to the hospital. Initially V28 stated the condition of the hands may be due to irritation or Dyshidrosis condition. V28 stated, he did a full body assessment including the chest. V28 was

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 10/26/2021

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
S9999	Continued From page 14 asked did you look at R1's chest V28 responded, "Yes." V28 was then shown a picture of R1's chest V28 then stated, "That is not an irritation that's a burn." V28 further stated if the hospital assessed it as burns then it's burns." On 10/06/21 at 2:30 PM V2 (DON) stated, "We did not treat it as burns, because we considered it as irritation or Dyshidrosis." When informed V28 was shown pictures of R1's chest area and the hospital assessment V2 insisted the hospital assessment of R1 was wrong and he still considers R1 diagnosis as an irritation or Dyshidrosis. V2 said, "Until now I still consider it as Dyshidrosis." According to The Nurse Practitioner journal vol.43, No.11 (2018): Dyshidrosis is condition in which tiny, fluid -filled blister appears on the palm and fingers. On 10/7/21 at 1:10 PM V12 (CNA) stated she was the CNA for R1 on 10/3/2021, 11PM to 7AM shift and noticed R1's hands with blisters and open areas at around 5:30 AM. V12 stated she showed R1's hands to V9 (LPN). V12 stated, "V9 looked at it and said it looked like an allergic reaction." But V12 said, "It looked like burns." R1's records, does not include an assessment related to R1's burns. On 10/7/21 at 1:30 PM V14 (CNA), stated she worked on 10/3/21 from 3 PM to 11 PM and gave R1 his dinner tray. V14 stated R1 was on the bed staring in space between 5:30 to 5:45 PM. R1 kept clenching his teeth and rubbed his lips and teeth with the unaffected hand. V14 said she showed R1's condition to V8 (LPN) who said, "Leave him alone, he will soon snap out of it." R1's records show there was no follow up and no	S9999		

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 10/26/2021

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
S9999	Continued From page 15 assessment completed for R1. Progress notes dated 10/4/2021 at 7:28 AM, written by V9(LPN) reads: "Resident received in bed asleep. Upon passing medication this morning, writer observed resident shaking and trembling. Medication given. CNA upon doing final rounds observed that resident was wet and changed resident's clothes and his bedding. CNA observed resident right hand swollen and blistered. Scarring to right thigh that appears to be healing observed. Continue to monitor" However, the above progress note written by V9 does not indicate V9, as the nurse, acknowledged resident skin injuries as reported to her by CNA and therefore, V9 did not report change in skin condition to the doctor or family. On 10/06/21 at 12:30 PM V28 (Nurse Practitioner) stated he saw R1 before R1 was sent out to the hospital. At first, V28 stated the condition of the hands may be due to irritation or Dyshidrosis condition. V28 stated, he did a full body assessment on R1's body. When asked. "Did you ask R1 what happened." V28 said, "He (R1) was in too much pain". There was no documentation that pain medication was administered to R1. Pain policy dated 9/2021 documents in part: "Pain management is a multidisciplinary care process that includes 1) effectively recognizing the presence of pain and 2) identifying the characteristics of pain". On 10/4/2021 at 9:5AM, V28 (Nurse Practitioner/NP) documented, "judgment assessed with localized large blisters on the right arm filled with clear fluid and tenderness. but	S9999		

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 10/26/2021

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
S9999	Continued From page 16 asymptomatic of shortness of breath, nausea pruritis and with pain of 6/10." V28 also documented the plan was to administer 2 tablets of Tylenol #3, Medication Administration Record (MAR) noted the order was written on the MAR, However, the medication was not documented as administered. Care plan for R1 dated 7/21/2021 noted problem of pain and interventions to include , "Address pain promptly and report to MD of Signs and symptoms of pain" Facility's policy on pain dated 9/2021 documented," Pain management is a multidisciplinary care process that includes 1) effectively recognizing the presence of pain and 2)identifying the characteristics of pain". On 10/11/2021 at 12:15PM, the coffee sent to be served on the 6th floor was 144.8 degrees Fahrenheit. The coffee's temperature was taken by V30 (Dietary manager). On 10/11/2021 at 2:10 PM, V30 said when the coffee left the kitchen, the temperature was usually between 169 to 170 degrees Fahrenheit. State Operation Manual for hot water temperature for Long Term Care: Serving Hot Water Temperatures: 120 degrees Fahrenheit / 48 degrees Celsius, the recommended temperature setting for home water heaters, skin requires five minutes of exposure for a full thickness burn to occur. When the temperature of a hot liquid is increased to 140 F / 60 C. it takes only five seconds or less for a serious burn to occur. On 10/11/201 at 11:50 am observed several	S9999		

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 10/26/2021

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
S9999	Continued From page 17 residents pour their own coffee from the coffee dispenser. On 10/11/2021 at 12:20 PM, several residents including R11 and R12 said the coffee was usually hot and sometimes they could not drink it but sipped it. On 10/7/21 at 1:24 PM V1 and V2 DON said they have no answer to what may have happened to R1's hand. V2 said stated he spoke with staff and residents and no one knows anything. Progress note dated 10/4/21 at 10:50 PM, written by V23(ADON) reads: It was reported to the nurse in charge that R1 was admitted to the hospital with Sepsis, Skin Tear and 2nd Degree Burns. Hospital Records dated 10/4/21 reads: R1 skin: Second degree burns on right hand, fingers, chest, and thigh. Minimum Data Set (MDS) of R1 dated 7/21/21 reads: 1. Transfers - how resident moves between surfaces including to or from: bed, chair, wheelchair, supervision and set up needed. 2. Walk in room and corridor - how resident walks between location in her room was supervision and set up needed. 3. Locomotion on unit - how the resident moves between location in her room and adjacent corridor on the same floor was supervision and set up needed. 4. Toilet - how resident uses toilet on / off toilet was 1-person limited assistance. 5. Eating - how resident eats and drinks, regardless of skill was supervision and set up	S9999		

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 10/26/2021

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
S9999	Continued From page 18 needed. Incident/Accident Reports Policy dated 3/2021 in part reads: The incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. The facility shall send a narrative summary of each reportable accident or incident to the Department within (5) working days after report of the occurrence. If the incident or accident results in a death, after notifying law enforcement. The IDPH Regional Office must be notified by phone. A narrative summary still needs to be sent to IDPH within 5 working days of the occurrence. In addition to keeping a file of all written reports submitted, you must keep documentation of the verbal conversation with the IDPH Regional Office or IDPH Complaint Hotline, (make sure you get the name of the person you spoke with). Per V1 (Administrator) the facility does not have any policy related to prevention of accidents. (AA)	S9999		