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 04/04/2018

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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S9999	Final Observations Statement of Licensure Violation: 1 of 1 violation 300.1210b) 300.1210d)6) 300.1220b)2) 300.3240a) 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. 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: 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff were present to supervise residents on the smoking patio for two of three residents (R1, R2) reviewed for abuse. This failure resulted in R1 requiring admission to the hospital for treatment of closed head trauma, multiple facial/scalp lacerations and	S9999		

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S9999	Continued From page 2	S9999		

left hand laceration. The facility also failed to implement compensatory strategies for one of three residents (R4) reviewed for Activities of Daily Living (ADLs), in the sample of six.

Findings include:

1. Review of the facility's final incident report 02-19-2018 notes: Per investigation, (V4) stated he heard some noise from the smoking patio and when he approached the patio he saw R1 and R2 engaged in a physical altercation.
(R2) said he was on the smoking patio with (R1) when they got into a verbal altercation about a hat which led to a physical altercation between both of them. (R2) stated that he hit (R1) with a utensil while they were engaged in the altercation.

Review of R1's hospital record (Emergency Department History and Physical Note) notes R1 presented to (local hospital) with a chief complaint of getting into an altercation with another nursing home resident.
Physical Exam: Abrasion above right eye. Laceration superior (2.5 cm) and inferior (1.5 cm) to the left eyebrow. Bruise on the left eyelid. Linear (5 cm) and Curved (3 cm) laceration to the frontal scalp on the left side. Total of eight staples in place.
Radiology- Facial Bones/Sinus CT Scan: Acute medial and inferior wall blowout fractures on the left and comminuted fracture of the nasal bone.
Final Disposition: Full Admission
Final Diagnosis: Closed head trauma, multiple facial/scalp lacerations, left hand laceration.

V4 (Resident Services), 03-27-2018 at 10:51 AM, 03-27-2018 at 10:35 AM) said, on the day of the incident, he left the smoking patio to bring a resident back upstairs. There was no staff

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present, only residents. V4 said he never saw the altercation between R1 and R2, however did hear R1 and R2 exchanging words and noted blood on R1's face. V4 said he felt that had he been present, he could have prevented the altercation between R1 and R2.

2. Review of R4's Face Sheet notes diagnoses including: Toxic Encephalopathy, Attention-deficit Hyperactivity Disorder, Dysphagia and Schizoaffective Disorder.
Review of R4's MDS (Minimum Data Set-02-20-2018) documents R4 is moderately impaired and requires extensive assistance of one person physical assist for eating.

V7 (CNA-Certified Nursing Assistant) was observed feeding R4 lunch on 03-27-2018 at 1:33 PM. After R4 was finished eating, V7 offered R4 fluids by holding an opened mouth cup up to R4's mouth, without pausing. R4 began coughing after the fluids were offered. V7 said to R4, "You drink too fast." V7 then offered thickened milk to R4 from a plastic cup, using a straw, without pausing. R4 began coughing when V7 withdrew the milk.

V20 (Speech-Language Pathologist, 04-04-2018 at 2:26 PM) said staff should be alternating bites/sips, liquids/solids while monitoring rate/amount of food because of R4's impulsivity. V20 also said staff should utilize an open mouth cup rather than a straw when offering fluids to R4. V7 did not alternate small bites/sips or liquids/solids.

Review of R4's Speech Progress Report (11-15-2017-11-21-2017) notes: "Swallow therapy: facilitation of small bites/sips (1/2-1/3 teaspoon), facilitation of alternating bites/sips and instruction in alternating liquids/solids to increase

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S9999	Continued From page 4 pharyngeal clearance." "Patient and Caregiver Training: Instructed nursing caregivers in compensatory strategies and safe swallow techniques in order to enable (resident) to safely consume highest level of intake with least amount of supervision with 100% carryover demonstrated by primary caregivers." R4's care plans were reviewed. There was no care plan with appropriate interventions to address R4's dysphagia. (B)	S9999		