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S9999	Final Observations Statement of Licensure Violations: 1 of 3 Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. (B) 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. Restorative measures shall include, at a minimum, the following procedures: 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. 6) All necessary precautions shall be taken	S9999		

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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. (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 provide documentation on assessment and treatment of 2 wounds for 1 (R2) of 2 residents reviewed for wounds in the sample of 7 residents. This failure resulted in R2's wounds not being treated.

The findings include

On 7/11/18 at 10:54 AM on the 4th floor, R2 stated that there was a fire in the facility on 7/4/18 at 11 PM in R2's room. R2 stated that he was laying on his bed when he sees his corridor door open and a lady in a wheelchair comes into his room. R2 says he is yelling "Get out, you are in the wrong room" over and over. R2 says that the next thing he sees is a flicker and his mattress is on fire. R2 stated that his adult brief was also

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singed. R2 stated he did not think he had sustained any injury so he refused to go to the hospital. R2 stated that he was physically checked by a nurse for any burns but does not remember who or when. R2 stated that the certified nurse aides (Certified Nurse Aide/C.N.A.) were telling him that he has a burn on the back of his right thigh but does not recall which CNAs. R2 says he has no feeling and does not feel it on the back of his thigh. R2 did attempt to show the wound and pointed to the outer aspect of his right thigh. There was a 6 inch long by 1 inch wide black jagged scar which appears old on the outside of the right thigh.

At 11:18 AM, R2 is taken into his room by V17 (CNA) and V18 (Wound Nurse). R2 is assisted on to the bed by V17 and V18 so V18 can view the back of the right thigh. V18 states that it looks like a burn. There is a quarter-size burn-like circular red discoloration with the first layer of skin missing exposing the intact red discoloration on the back of the right thigh. There is no opening in the skin. V18 leaves the room to get V8 (Nurse Practitioner) to view it and obtain a treatment order. At 11:34 AM, V8 views the right thigh, V8 states it looks like a burn but not sure and puts in an order for silver hydrogel to be applied daily and as needed for wound healing.

On 7/12/18 at 9:17 AM, V3 (Director of Nursing) stated that she personally checked R2's body after the fire and saw no injury to the skin. V3 presented a form labeled Resident Body Check Sheet dated 7/4/18 documenting no reddened or open areas noted and no visible deformities. V3 was asked why this information was not in the computer. V3 stated it was very hectic at that time of the skin assessment. As for R2's resident body check sheet dated 7/10/18 for 3 PM to 11 PM

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shift documenting a black scabs on the side of the right thigh, V3 stated that V10 (Registered Nurse) had forgotten about R2's wound reported by V14 (C.N.A.).

On 7/12/18 at 10:47 AM, V8 (Nurse Practitioner) stated that he thinks the wound on the back of the thigh is from an abrasion or open wound but not totally sure. When V8 is asked why he says the wound is open when there is no opening in the skin, V8 says that wounds start out looking red and the first layer of skin is missing as to why it is considered an open wound. V8 states he can not say for sure what type of wound it is because it is unusual. When V8 is asked about the 6 inch black scar on the outer side of the right thigh, V8 responded that he did not notice the scar-looking area above the burn-like wound.

R2's resident body check sheet dated 7/4/18, 7/6/18, 7/9/18 (7 to 3 and 3 to 11 shifts) document nothing found on skin.

R2's resident check sheet dated 7/10/18 for the 3 to 11 shift documents scabs on his right leg by V14 (CNA). V14 and V10 (registered nurse) both signed the sheet. This is the only place the black scar-looking wound is documented. There was no follow up with this scar-like wound.

R2's medication administration record for 7/1/18 to 7/31/18 documents R2's skin being checked on 7/2/18 by V10 (Registered Nurse) and on 7/9/18 by V9 (licensed Practical Nurse), both nurses work the 7 AM to 3 PM shift. There is no documentation of any skin irregularities.

Review of V8's progress note dated 7/11/18 at 14:46 documents an open area to the right ischium. There is no documentation on the

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measurement or description of the red, circular, quarter-size mark on the back of R2's right thigh nor is there documentation addressing the 6 inch by 1 inch black, jagged scar.

There was no documentation that the physician was notified of the 2 wound areas on R2.

R2 is a 64 year old bilateral above the knee amputee male who was admitted to the facility on 8/23/17 with no re-admission dates per the minimum data sets (MDS). R2 requires extensive assistance with his activities of daily living (ADL) and has a BIMS of "11" indicating R2 is oriented per the 6/1/18 MDS. Nurses' notes 7/4/18 and 7/11/18 document R2 as oriented times three (person, place and time). R2's diagnoses include peripheral vascular disease, deep vein thrombosis, seizure disorder, chronic obstructive pulmonary disease and bilateral above the knee amputee. The 6/1/18 MDS documents one venous/vascular wound.

R2 does have a history of vascular wounds per the April 2018 and May 2018 wound assessment detail reports.

On 7/20/18 at 10:30 AM, V3 (Director of Nursing) stated that there is no documentation on the 2 wounds for R2 before 7/11/18.

The facility's policy labeled Skin : Non-Pressure Ulcer documents that "when a resident is identified as having a stasis ulcer, skin tear, bruise or rash, the appropriate documentation is completed." The policy does not address what the "appropriate documentation" would include.

The facility's policy labeled"Skin Care Prevention" documents "Dependent residents will be

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S9999	Continued From page 6 assessed during care for any changes in skin condition including redness (non-blanching erythema) and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider." This was not done. (B) 300.610a) 300.1210b)5) 300.1210d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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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.

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.

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.

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)

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These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow the facility(s) smoking policy and ensure that smoking materials were locked in the facility designated area, and unavailable to smokers assessed to be unsafe for 1 of 3 residents (R5) reviewed for safe smoking. These failures resulted in R5 starting a mattress fire resulting in (3) residents (R4, R6, R7,) being taken to the local hospital for smoke inhalation. The facility also failed to ensure that there were assistive devices available to include grab bars to prevent falls, call lights to request assistance when there was noted debris and spills on the floor in the resident care area for 2 of 2 residents (R3, R8) requiring assistive devices for ambulation, and the facility also failed to follow the facility transfer policy and utilize a gait belt while transferring 1of 3 residents (R2) reviewed for safe transfers. Theses failures resulted in R3 being involved in fall incident and being treated at the local hospital for fractures.

The findings include:

On 7/12/18 at 9:35 AM, V1 (administrator) stated that R5 was the resident that started the fire per staff witnessing her leaving the room and then finding a mattress on fire. V1 stated that 2 lighters were found on R5 but not sure who found them and how R5 got the lighters. V1 stated that R5 is no longer in the facility. V1 stated that since the fire, a whole house inspection was done and numerous residents were found with lighters

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which were confiscated. V1 stated that no resident is to carry their own lighter or cigarettes per facility's smoking policy. V1 stated that she attempted to interview R5 but she was saying "I'm too tired to talk" and then began mumbling her words about her sister, money and then got very loud and yelling. R5 did calm down and apologize for yelling and then asked to be left alone.

V1 presented her typed up notes that document on 7/4/18 at approximately 11:15 PM there was a fire in R2's, R4's, R6's and R7's room. The smoke alarms went off and staff responded to R2's room where R2 was on fire and staff removed R2 and his other (R4, R6 and R7) roommates from the room. Code Red and 911 were called. R4, R6 and R7 were sent to the hospital to be checked out (for smoke inhalation) and all were sent back with no injuries. R2 refused to go to hospital but was assessed and no injuries noted. R5 was found with 2 cigarette lighters in her possession which were removed and R5 placed on 1:1 monitoring until transferred to hospital. The 4th floor North hall residents were relocated to other rooms throughout the facility so the 4th floor North Unit could be cleaned.

This report lacks how R5 was able to obtain the 2 lighters. Per social service note dated 5/2/18 documents R5 being found smoking in her room by nursing staff. Social service staff searched R5's room and found 2 lighters and a pack of cigarettes which were confiscated.

On 7/17/18 at 1:05 PM, V19 (Psychiatric Rehabilitation Services Counselor/PRSC) stated he did the 6/27/18 smoking assessment on R5 and did not know that R5 had violated the smoking policy on 5/2/18 by smoking in her room. V19 stated that he would of marked substantial

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or significant problem on the 6/27/18 smoking assessment. The 6/27/18 smoking assessment documents that R5 requires supervised/controlled smoking management.

The facility's smoking policy (prior to 7/4/18) documents if a resident is unable to smoke unsupervised, their smoking materials are locked in an area designated by the facility.

On 7/12/18 at 10:39 AM, R3 walked into the interview using a cane. R3 stated he had sustained a fall on 4/4/18 at 5 PM in the 1st floor toilet room near the vending machines due to the floor being wet with urine and feces which he says is always in that condition. R3 stated that at that time he was using a walker. R3 stated that there are no grab bars or no call light and there is never any toilet paper, paper towels or soap. R3 stated he laid there yelling until a dietary staff member came to him. R3 stated he was sent to the hospital and had surgery on his fractured left femur and fractured left wrist.

It was confirmed through incident report (4/4/18) and minimum data sets (2/13/18, 4/23/18) that R3 had fallen in the toilet room and had 2 fractures requiring surgery. R3 is oriented times three per his brief interview mental score (BIMS) of "15" in the 4/23/18 minimum data set (MDS).

On 7/12/18 at 11:20 AM and 2:12 PM on the 1st floor, in the 2 resident toilet rooms off of the main dining room, both rooms were without grab bars, call light cord, toilet paper, paper towels and soap. Both toilet rooms had stale, pungent urine odors that were persistent. The floors were wet and water was pooling (2 feet by 2 feet) on the floor inside and outside the toilet room doors. The sink water was continuously running. The walls

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were splattered with dried, black and brown, fecal-like substances. Live gnats were present in and out the toilet rooms. The door to these toilet rooms are revolving constantly with resident after resident using the toilet rooms. At 11:20 AM, there were no wet floor signs but at 2:12 PM, the wet floor signs were present. R8 came out of the toilet room walking with a cane and almost lost her balance on the wet floor and trying to get around the wet floor signs.

The facility has failed to ensure the floors in the 1st floor toilet rooms are dry and safe for walking.

On 7/11/18 at 11:20 AM, in R2's room, V17 (Certified Nurse Aide/CNA) and V18 (Wound Nurse) assisted R2 on to the bed from the wheelchair by each of them putting an arm under R2's armpits and picking R2 up into the air and placing him on the bed. R2 was unable to sit upright and needed assistance with sitting up. V17 and V18 failed to ensure both wheelchair brakes were locked and failed to use a gait belt when transferring R2. V17 was wearing a gait belt around her waist. V3 (Director of Nursing) was present and informed both V17 and V18 what they failed to do correctly with R2's transfer. R2 is a bilateral above the knee amputee and requires extensive assistance with transfers.

R2's care plan for transferring documents that the wheelchair brakes will be locked and a gait belt will be used.

The facility's policy labeled How to Transfer an Individual Using a Gait Belt documents to apply the belt while individual is in a comfortable sitting position, make sure belt is tightly applied so it does not ride up or down on individual and lock brakes on equipment that individual is transferred

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S9999	Continued From page 12 from or to. (B) 300.690a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurses' notes of that resident. The facility shall notify the Department of any serious incident or accident. This requirement was not met as evidenced by: Based on observations, interview and record review, the facility failed to notify the Department of a fire inside the facility after sending 3 residents out to the hospital for smoke inhalation and failed to document in each resident's medical record about the fire for 4 of 4 residents (R2, R4, R6, R7) reviewed for the fire investigation in the sample of 7 residents. The findings include: On 7/11/18 at 10:54 AM on the 4th floor, R2 stated that there was a fire in the facility on 7/4/18 at 11 PM in R2's room. R2 stated that he was laying on his bed when he sees his corridor door	S9999		

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open and a lady in a wheelchair comes into his room. R2 says he is yelling "Get out, you are in the wrong room" over and over. R2 says that the next thing he sees is a flicker and his mattress is on fire. R2 stated that his adult brief was also singe. R2 stated he did not think he had sustained any injury so he refused to go to the hospital.

On 7/11/18 at 11:05 AM, V3 (Director of Nursing/DON) stated that there was fire on the 4 North Nursing Unit on the 4th of July around 11 PM and R5 was the resident identified as starting the mattress fire. V3 stated that R2's adult brief was singe but no injury found on R2.

The 4 North Nursing Unit was closed off, the floors were being buffed and residents were relocated to other rooms in the facility. There was no evidence of a fire or smoke damage due to area being cleaned and furnishings replaced.

On 7/12/18 at 9:35 AM, V1 (administrator) stated that R5 was the resident that started the fire per staff witnessing her leaving the room and then finding a mattress on fire. V1 stated that 2 lighters were found on R5 but not sure who found them and how R5 got the lighters. V1 stated that R5 is no longer in the facility. V1 stated that since the fire, a whole house inspection was done and numerous residents were found with lighters which were confiscated. V1 stated that no resident is to carry their own lighter or cigarettes per facility's smoking policy. V1 stated that she attempted to interview R5 but she was saying "I'm too tired to talk" and then began mumbling her words about her sister, money and then got very loud and yelling. R5 did calm down and apologize for yelling and then asked to be left alone.

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 07/24/2018

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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The facility's fire investigation was given in fragmented pieces. Each resident (R2, R4, R6, R7) involved in the mattress fire had a separate incident report. The separate incident reports document each resident was present in the room when smoke alarms were activated due to smoking violation. 911 called. R2 refused to go hospital for an evaluation and R4, R6 and R7 were sent out to hospital for smoke inhalation. There was no incident report given for R5.

On 7/11/18 at 3:20 PM, V1 was asked again for the full 7/4/18 fire investigation and the fax transmittal sheet notifying the Department of a fire. V1 stated that she did give the whole report and it was not reported to the Department because no resident were injured. V1 was asked about her working tools when investigating the fire. V1 stated that she has her own rough notes she can type up and does have staff statements.

V1 presented her typed up notes that document on 7/4/18 at approximately 11:15 PM there was a fire in R2's, R4's, R6's and R7's room. The smoke alarms went off and staff responded to R2's room where R2 was on fire and staff removed R2 and his other (R4, R6 and R7) roommates from the room. Code Red and 911 were called. R4, R6 and R7 were sent to the hospital to be checked out and all were sent back with no injuries. R2 refused to go to hospital but was assessed and no injuries noted. R5 was found with 2 cigarette lighters in her possession which were removed and R5 placed on 1:1 monitoring until transferred to hospital. The 4th floor North hall residents were relocated to other rooms throughout the facility so the 4th floor North Unit could be cleaned.

This report lacks how R5 was able to obtain the 2

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lighters. Per social service note dated 5/2/18 documents R5 being found smoking in her room by nursing staff. Social service staff searched R5's room and found 2 lighters and a pack of cigarettes which were confiscated.

On 7/13/18 at 2:31 PM, V13 (Licensed Practical Nurse/LPN) stated that the foot of R2's mattress was on fire and black smoke in the air of R2's room. V13 states that it was V4 (LPN/Charge nurse) that extinguished the fire which created additional heavy black smoke in the air making it difficult to see on the North Unit. V13 stated that V16 (Residential Services/Security) picked up R2 from the bed and carried him out of the room.

V12's (Certified Nurse Aide/CNA) written statement documents that she and V16 saw the smoke alarm go off and went to the room and found R5 rolling away down the hallway and opened the door to the room that triggered the smoke alarm and saw the mattress on fire. V16 ran in and carried R2 out of the room.

V16's written statement documents him hearing the fire alarms and went to investigate the problem and opened the door to room that triggered the fire alarm and saw the flames. V16 rushed in and removed every resident from the room and the adjacent room.

On 7/17/18 at 1:05 PM, V19 (Psychiatric Rehabilitation Services Counselor/PRSC) stated he did the 6/27/18 smoking assessment on R5 and did not know that R5 had violated the smoking policy on 5/2/18 by smoking in her room. V19 stated that he would of marked substantial or significant problem on the 6/27/18 smoking assessment. The 6/27/18 smoking assessment does document that R5 requires

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S9999	Continued From page 16 supervised/controlled smoking management. The facility's previous (before 7/4/18) smoking policy documents if a resident is unable to to smoke unsupervised, their smoking materials are locked locked in an area designated by the facility. Review of R2, R4, R6 and R7 progress notes/nurses' notes lack documentation of the 7/4/18 mattress fire in their room. On 7/20/18 at 9:30 AM, V1 (administrator) was asked for a policy on what is expected to be documented in the residents' medical records. No policy provided. (C)	S9999		