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	IL6000954	A. BUILDING: _____ B. WING _____	09/01/2023

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S 000	Initial Comments Annual Licensure and Certification Complaint Investigation 2386508/IL162881	S 000		
S9999	Final Observations Statement of Licensure Violaions (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure the safety of residents by not monitoring and preventing a resident (R412) from receiving and using an illegal drug for 1 (R412) out of 1 resident reviewed for incidents and accidents. This failure resulted in R412 overdosing on heroin, requiring transfer and treatment at acute hospital for treatment. Findings Include: R412's medical records show an admission date of 7/5/23 with diagnoses including but not limited to Schizophrenia, Major Depressive Disorder, Bipolar Disorder, and Epileptic Seizures. R412's progress notes dated 7/5/23 at 7:24 PM written by V3 (Director of Nursing) shows R412 was admitted in the facility from an acute hospital with	S9999		

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history of alcohol and drug abuse. R412's Minimum Data Set (MDS) dated 7/13/23 shows R412 was cognitively intact and required supervision with locomotion on and off unit.

R412's care plan with date initiated on 7/6/23 shows R412 has a history of substance abuse/chemical dependency with one intervention reads to provide "leisure counseling". Facility did not provide documentation R412 attended counseling.

Progress notes dated 7/27/2023 at 9:36 PM written by V8 (Licensed Practical Nurse/LPN) documents in part: "[R412] noted in bed lethargic unresponsive. [R412's] pupils pin point. [R412's] speech slurred and altered mental status V/S B/P 166/125, pulse 103 Temp., 98.7, O2 98, B/G 126. ADON and [V40- R412's Medical Doctor] made aware. [V40] order writer to transferred resident to (Acute) Hospital order carried out immediately."

Progress notes dated 7/28/23 at 5:11 AM documents R412 was transferred to the acute hospital and was evaluated with a diagnosis of Opioid overdose.

R412's hospital records dated 7/27/23 under "Patient Care Report Narrative", documents in part, "[R412] admitted to snorting heroin [R412] acquired in the nursing home at 2000 hours." Emergency Department Attending Note documents in part, "[R412] is a 27 y.o. male who presents to the ED for presumed heroin overdose. Per EMS patient has had similar presentation in the past, went to the top floor of his nursing facility and reportedly snorted heroin." R412's "AFTER VISIT SUMMARY" dated 7/27/23 shows R412's diagnosis was Opiate overdose and R412 received three doses of Narcan

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S9999	Continued From page 3 (reverses an opioid overdose). On 8/29/23 at 11:18 AM, V8 (LPN) stated V8 was the nurse in charge for R412 the night of the incident. V8 stated R412 went down to smoke after dinner around 6:30 PM. V8 stated R412 came back on the 2nd floor (V8 does not remember the exact time). V8 noticed R412 uncomfortable, having slurred speech, and feeling weak. V8 stated V40 ordered R412 to be sent out to the hospital. V8 stated V8 does not remember if R412 went down to smoke by himself. V8 stated R412 goes down to smoke independently. At 1:07 PM, V10 (Psychiatric Rehabilitation Services Coordinator) stated smoking schedules are after breakfast, after lunch, and after supper and staff are supposed to be always watching the residents smoke. On 8/30/23 at 9:29 AM, V12 (Psychiatric Rehabilitation Services Director) stated R412 did not have an independent pass and R412 was a smoker and needed supervision when smoking. At 11:29 AM, V3 (Director of Nursing) stated R412 did not go out the evening of 7/27/23 "but we have other residents go out, so I'm thinking maybe other resident got the drugs for [R412]." V3 stated if a resident has a history of drug overdose the staff should be doing an enhanced observation, meaning checking on them at least every hour. At 11:40 AM, V12 stated R412 was supposed to be placed for a Licensed Clinical Social Worker (LCSW) therapy sessions but did not get to start because R412 was only in the facility for a short period of time. V12 stated R412 had history of	S9999		

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S9999	Continued From page 4 drug abuse and staff supposed to check on R412 at least every two hours to make sure R412 is okay. At 1:03 PM, V28 (Certified Nursing Assistant/CNA) stated V28 was the CNA in charge for R412 on 7/27/23 evening shift. V28 stated R412 was fine all day until that evening. V28 stated R412 was going up and down the elevator that night. V28 stated R412 ate dinner around 5:00 to 6:00 PM. V28 stated R412 left the floor around 6:30 PM and took the elevator by himself. V28 stated V28 did not see if R412 went down or up. V28 stated "(R412) probably went to smoke and after that went to the 7th floor." V28 stated around 9:00 PM, R412 came back from the 7th floor and R412 was red, dizzy, and was out of it. V28 stated R412 told V8 that R412 came from the 7th floor. At 1:17 PM, V27 (Psychiatric Rehabilitation Services Assistant) stated V27 worked on 7/27/23 evening shift and does not remember watching R412 smoke for the evening smoke break. V27 stated there are staff watching residents smoke outside the patio but that does not last for more than one hour. V27 stated after residents' smoke, they either stay in the 1st floor dining room to play games or they go back to their floors on their own. V27 stated staff used to pick the residents up from each floor to bring downstairs to smoke but staff stopped doing after 4th of July. At 3:48 PM, V29 (R412's Family Member) stated during a phone interview R412 did not mention where R412 got the drugs. V29 stated whenever they visit R412 in the facility there are no staff that search the items they bring inside the facility. At 4:06 PM, V30 (Resident Services Assistant)	S9999		

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S9999	Continued From page 5 stated during a phone interview V30 worked on 7/27/23 evening shift and did not see R412 went down for smoke break after dinner. V30 stated V8 called V30 to go to the 2nd floor (V30 does not remember the exact time). V30 stated when V30 went up to the 2nd floor and saw R412, R412 was not in his usual self. R412 was not feeling well, kept standing up, and falling off. V30 stated R412 could not speak clearly and looked tired and drowsy. V30 stated when residents go for smoke break, they go down and go back up on their own. The facility's policy titled; "RESIDENTS' RIGHTS & RESIDENTS' SAFETY Enhanced Supervision Guidelines" dated 7/8/2020 reads in part: Purpose: These guidelines emphasize a proactive intervention promoting enhanced physical, psychosocial well-being and person-centered care while promoting resident/resident representative care participation. The facility recognizes there may be occasions in which standard approaches of Q2 hour rounds may need to be increased to more frequent, enhanced observation. Types of enhanced supervision that could be used: Q15-minute, Q30-minute, hourly checks - the staff will check observe the resident's status/whereabouts every 15 or 30 minutes, or hourly. (B) Statement of Licensure Violations (2 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)2)	S9999		

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S9999	Continued From page 6 300.1220b)3) 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 care needs of the resident. 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: 2) All treatments and procedures shall be administered as ordered by the physician.	S9999		

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S9999	Continued From page 7 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on interview and record review the facility; (A) Failed to recognize, evaluate, and address weight loss; and (B) failed to consistently implement interventions, monitor the effectiveness of interventions and revise them as necessary. This resulted in a significant weight loss [>10% change over 6 months] for 1 [R79] of 5 residents reviewed for nutrition in a sample of 35. Findings included: R79's clinical record indicates in part: R79 was admitted to the facility on 9/1/22, with medical diagnosis of schizoaffective disorder, vitamin D deficiency, anxiety disorder, Parkinson's Disease, essential hypertension, and human	S9999		

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immunodeficiency virus. Minimum data set [MDS] dated 7/1/23 indicates R79 scored 15 on brief interview for mental status indicating R79 is cognitively intact. MDS section K dated 7/1/23, indicates R79 did not have a swallowing disorder, or dental concerns. Section K dated 7/1/23- R79 loss more than 5% or more in the past 30 days and loss 10% or more in the past 6 months. R79 was not on a physician prescribed weight loss regimen. R79's on 12/29/22 weight was 222 pounds and on 8/3/23 186 pounds.

R79's physician orders:
[1] Dated 5/4/23 Ensure one time per day to possibly slow weight loss progression, offer at breakfast.
[2] Dated 5/4/23 House supplement one time per day - Mighty Shake with dinner.
[3] Dated 8/7/23- Ensure two times a day for prevent further weight loss, offer at breakfast and lunch.

R79's progress notes indicate in part:
5/4/23 at 8:35 PM, V42 [Dietitian] Note- Sig [Significant] Wt. [weight] Change Note: -9% in 90 days (April). R79 triggered for significant weight loss. Recommended ensure shake at breakfast and mighty shake at dinner to slow weight progression.

5/24/23 at 4:38 PM V43 Note - Significant weight loss -7.6% in 30 days. R79 continued to trigger for significant weigh loss. Recommend weekly weights for four weeks due to seven-pound weight loss in 30 days. Recommend continuing ensure daily. (Interventions were the same as 5/4/23)

6/26/23 at 12:20 AM, V43 [Dietitian] Note - Weight Warning: -10% weight loss over 180 days.

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S9999	Continued From page 9 R79's weights reviewed in the past six months - 6 months = weight loss of 31 pound (14%), 3 months = weight loss of 20 pounds (9.5%). R79 can feed self with supervision. No swallowing or chewing problems. Recommend ensure at breakfast and mighty shake at dinner. (Interventions were the same as 5/4/23) 7/17/23 at 10:15 PM, V43 Note - Weight Warning. Weight 190 pounds. -10% weight loss over 180 days. Significant weight loss in 6 months loss 28 pounds (-12.8%) recommend ensure with breakfast, might shake at dinner. (Interventions were the same as 5/4/23 dietician note) 8/7/23 at 4:46 PM V44 [Dietitian] Note- Weight Warning. Weight 186 pounds. -10% weight loss over 180 days, compared to 2/2/23 weight of 215 pounds (-13.5%) of 29-pound weight loss. Currently, ensure at breakfast and mighty shake at dinner. Increase ensure supplement to twice a day to promote weight maintenance. R79's electron medication administration record dated 8/1/23 thru 8/31/23, documents in part: Dated 8/7/23- Ensure two times a day for prevent further weight loss offer at breakfast and lunch. -Missing administration of prescribed ensure on the following dates 8/7/23 at 12 PM 8/8/23 at 8 AM and 12 PM 8/9/23 at 8 AM and 12 PM 8/10/23 at 8 AM and 12 PM 8/11/23 at 8 AM and 12 PM R79's weight record indicates the weeks of 6/9/23, 6/16/23, and 6/23/23 no weekly weights were obtained.	S9999		

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S9999	Continued From page 10 On 8/29/23 at 10:29 AM observed R79 resting in bed. R79 stated, "I'm not doing well. I keep shaking and keep losing weight. The doctors and nurses are not doing anything about it. I have no idea how much I weigh." On 8/29/23 at 10:46 AM, surveyor requested V50 [Licensed Practical Nurse] for R79 to be weighed with surveyor present. V50 stated, "We can weigh (R79) at 1PM." On 8/29/23 at 12:50 PM, surveyor reported to nursing floor. V50 stated, "R79 just left the facility on his way to the hospital due to tremors. R79 was able to feed himself, without any assistance. R79 hands would shake, but he could feed himself." On 8/30/23 at 8:35 AM, V41 [R79's Family Member] stated, "R79 has been losing weight because the facility stared him on some medication and R79 began to have tremors really bad. To the point R79 had difficulty feeding himself. The food would shake off the fork or spoon not getting into his mouth. I kept telling the nurse that R79 needs feeding assistance, but they will not listen. R79 will call me and tell me they would not help him eat. The facility has not told me that R79 loss any weight, but I can tell because his clothes is falling off. The medication that was causing the tremors was discontinued. R79 was sent to the hospital due to his tremors." On 8/30/23 at 11:17 AM, V3 [Director of Nursing] stated, "The dietitian makes recommendations for weekly weights. The order is placed in vital signs and the weight is completed weekly. The reason for weekly weight is to closely monitor a resident's weight loss and to prevent a significant weight loss that can occur within 30 days. If a physician's	S9999		

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order is not signed out on the electronic medication administration record, then the medication or supplement was not given. If a resident does not receive a prescribed nutritional supplement, the resident could potentially have more weight loss. The nurse should notify the family of the weight loss. I do not have (V42) or (V43) phone numbers. They worked here through a contracted agency."

On 8/31/23 at 1:15 PM, V44 [Dietitian] stated, "I been working at this facility since 8/1/23 through a consultant company. R79's last weight was 186 pounds. -10% weight loss over 180 days, compared to 2/2/23 weight of 215 pounds, total of 29-pound weight loss. I increased ensure supplement to twice a day to promote weight maintenance. R79 will be re-evaluated upon return from the hospital. R79's weigh loss is probably from the progression of Parkinson's disease, which require more calorie intake due to all the involuntary movements. I have not observed R79 eat and have not received reports that he needs assistance due to shaking. The beginning of August was my first time looking over his record, I will observe R79 eating once he return from the hospital. R79's weight loss was not desired or planned. Weekly weights are ordered to develop a baseline and to prevent an accumulative weight loss that may happen in 30 days. If weekly weights are not completed it could potentially cause the resident to have a higher weight loss, because interventions were not in place to slow weight loss. The weekly weight helps the dietitian to monitor the resident closely. If a resident continues to lose weight with dietary interventions in place; the weight loss dietary interventions should be monitored, evaluated, and adjusted as necessary to prevent further weight loss and stabilize a resident weight. On

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8/7/23, I increased R79's ensure supplement to twice per day. If R79 misses the prescribed ensure, he could potentially loss more weight. I do not notify family of a residents weight loss; the facility is responsible for notification."

On 8/31/22 at 2:05 PM V45 [R79's Primary Care Physician] stated, "I was told about R79's weight loss two months ago and recommended for R79 to see dietitian. I do not document every single thing in my notes. I verbally tell the nursing staff. I ordered blood work but I think R79 refused. I did not document R79 refused blood work. If R79 continues to lose weight, I will order blood work and CT scan. R79 should've been placed on a calorie count to be closely monitored. I believe R79's weight loss came from contracting Covid19 earlier this year in January. If R79 is not receiving his recommended shake supplements, R79 could potentially loss more weight the supplement would not be effective. R79 weight loss was not planned. If weekly weights were ordered for R79, the facility should have taken R79's weight as ordered so the dietitian could monitor R79 weight closely, if not it could potentially cause more weight loss. R79 is under infection disease physician. R79's HIV has not progressed. The antiviral medication has been working well. I did not notify the family of R79's weight change, the nurses should complete family notification."

Policy: Documented in part: Weight Change Policy dated 1/2023;
-It is the policy of this facility to monitor the nutritional status of all residents, including all significant or trending patterns of weight change.
-Review weights and vital dashboard for significant weight changes.
-Upon identification of a newly significant weight change, the dietician, physician, and resident

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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 representative will be notified. (B)	S9999		