Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000954	A. BUILDING: ______ B. WING ______	C 11/30/2020

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: Complaint #2082177/IL121243 #2081390/IL120367 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	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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

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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This Requirement is not met as evidenced by:

Based on interview and record review, the facility failed to supervise and monitor a resident whom sustained fractures when she fell two different times in the facility. This failure resulted in the resident suffering a right knee fracture and a right femur fracture. This failure affects one of three residents reviewed for falls (R3) in a total sample of ten residents.

Findings include:

R3 is 69 year old female resident of the facility. R3 has the following diagnoses: lack of coordination, schizophrenia, bipolar disorder, and high blood pressure.

Review of R3's care plan notes that she is alert and oriented and able to make her needs known. She is a high risk for falls due to her medication, osteoarthritis, muscle weakness, unsteady gait, and ambulating with her wheelchair. Review of the fall log notes R3 has had three falls in the facility. R3 had falls on 1/25/2020, 02/03/2020, and 06/24/2020.

Progress note dated 1/25/2020, notes R3 was found lying face down on the floor in her room next to her nightstand. Her nose was bleeding and a complete body check was completed. She was noted with some swelling to her right knee. An x-ray was ordered. The x-ray noted right knee fracture. Fall intake form dated 1/25/2020, notes her predisposing factors are gait imbalance and ambulating without assistance.

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On 11/29/2020, at 11:13AM, V16 (Nurse) stated, I found R3 on the floor, face down. A CNA (Certified Nursing Assistant) and I came to help assess her. I sat her up and looked at her knee. It was swollen. I called the medical doctor. She was sent to a local hospital for further assessment. I monitor her because she likes to get up, move around and go to the restroom. She is wheelchair bound. The residents are monitored to make sure they are safe and that there are safety measures and precautions.

Progress note dated 06/24/2020, notes R3 observed on the floor with complaint of pain to the right hip and knee. The resident stated that she was attempting to help another resident and she tripped over her wheelchair. An x-ray was completed. The x-ray notes fracture of right femur.

The initial report sent to IDPH (Illinois Department of Public Health) dated 06/24/2020, notes R3 had an unwitnessed fall. The fall intake form dated 06/24/2020, notes the fall occurred in the day room. Her predisposing factors are: gait imbalance, noncompliant with safety guidelines and ambulating without assistance.

On 11/29/2020, at 12:42PM, V17 (CNA) stated, my job as a CNA is to monitor residents for their safety, needs and wants. The nurse was at the nurses' station, I was in the day room. R3 slid and fell from her wheelchair. I told her not to do it, but she does what she wants. She does not listen. R3 told me that she was trying to help another resident. I do not recall if the wheelchair was locked or what she was saying.

On 11/29/2020, at 10:47AM, V15 (Restorative

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Nurse) stated, after a resident falls, we evaluate them for what we can do to prevent future falls. In both cases of R3 falls, staff should be more proactive. She has behaviors and is not easily redirectable at times. The fall on 06/24/2020, was in the day room. She was trying to assist another resident. She was medicated and was refrained from doing what staff should be doing. Staff should be in the day room with the residents to make sure residents are monitored. The interdisciplinary team and I update the care plan and interventions after each fall. I will go up and speak with the residents and witnesses based on the information I have. I will come up with interventions. Some falls can be prevented, some cannot. But, the best way to prevent falls and fractures is by monitoring.

On 11/29/2020, at 1:11PM, V13 (CNA) stated, R3 needs monitoring and rounding every two hours because she will try to get up and requires more monitoring, at times.

On 11/29/2020, at 1:54PM, V12 (Nurse Practitioner) stated, R3 has fallen in the facility. Her patella fracture could be from falling. She is high risk for falls. She is alert and oriented, but has a mood disorder and finds it difficult to follow the facility protocols and does not listen to staff.

R3's care plan interventions include: explain call light and assess residents ability to use it, monitor and document perceptual changes, observe for gait unsteadiness, anticipate resident's need to use the restroom, remind resident to refrain from doing the staff's job.

Facility policy titled Fall Prevention and Management, dated 10/2019, notes the facility will identify and evaluate those residents at risk

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S9999	Continued From page 5 for falls, plan for preventive strategies, and facilitate as safe as an environment as possible. (B)	S9999		