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 09/21/2023

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 Investigation 2387678/IL164401	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240d) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These requirements were not met as evidenced by: Based on record review and interview the facility failed to provide supervision and failed to substantiate physical abuse resulting in serious injuries (laceration, subdural hematoma) for one of four residents (R2) reviewed for abuse. As a result of this failure, R2 was struck in the head (with a chair) sustained a laceration to left eyebrow and subdural hematoma due to trauma. Findings include:	S9999		

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S9999	Continued From page 2 On 9/15/23, IDPH (Illinois Department of Public Health) received allegations R2 was hit in the head a few times by an unknown resident weeks ago and has a brain bleed. R2's (7/25/23) progress notes states writer was informed resident R2 was engaged in verbal argument with peer which led to physical altercation. Resident R2 has cut on his upper eyebrow. The (7/25/23) initial incident report states resident allegedly abused or neglected: (R2). Alleged perpetrator: (R6). Allegation type: "Other reason for submitting this report "was selected which states "resident to resident altercation" [Abuse was not selected as warranted]. It was reported that both residents were involved in an altercation. (R2) sustained a cut to his upper eyebrow and was sent to the hospital for evaluation." The (7/25/23) follow-up investigation states (R2) stated, "We (R2 and R6) were playing cards and it happened, there were words between us. That was it." (R6) stated he was having words with (R2) when (R2) grabbed a pen and it looked like (R2) was about to attack him so (R6) tried to defend himself and accidentally hit him above his eye. (R6) stated he did not mean to hurt (R2). Resident statements affirm: (R2) & (R6) were having an argument. (R2) made a statement about (R6's) mother. (R6) became physically aggressive towards (R2)." V19 was also interviewed however nothing was documented about the chair involved in the incident. On 9/19/23 at 11:09 am, surveyor inquired if R2 was involved in a physical altercation with another resident. V3 (Assistant Director of Nursing) stated, "He (R2) had an incident about 2 months	S9999		

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S9999	Continued From page 3	S9999		

ago with another resident (R6). I believe it was reported to (V1) so she will have the details." Surveyor advised that the (July-September 2023) abuse binder was received however the incident involving R2 was excluded. V3 responded, "It may not be an abuse; it may be just physical aggression" however "physical aggression" is in fact abuse.

On 9/20/23 at 2:44pm, surveyor inquired about the (7/25/23) incident. V5 (Licensed Practical Nurse) stated, "I was in the washroom when I heard commotion in the dayroom. The residents were playing cards around 1:00 am. The CNA (Certified Nursing Assistant) told me he (V19/CNA) was making rounds when it happened and the other CNA was on break. He (V19/CNA) told me that he heard a commotion and rushed down. (R2) and (R6) had a verbal altercation that led to physical altercation. (R2) had a laceration on his upper eyebrow so I cleaned it, took his vitals, and gave him pain pill because he was having a little bit of pain. I informed the ADON (Assistant Director of Nursing). " V5 affirmed she did not witness the (7/25/23) incident.

On 9/20/23 at 3:15pm, surveyor inquired about the (7/25/23) incident. V19 (CNA) stated, "That night, I had them (residents) play cards. They (residents) were in good mood. (R2) was not there at that time. He (R2) joined them (residents) later. After an hour, it was time to do my rounds. I was on the north side of the building (far end) where they (residents) watch the TV." Surveyor inquired if V19 witnessed the (7/25/23) incident. V19 responded, "I heard a commotion. (R6) had already thrown the chair on (R2). He (R6) was aggressive. He (R6) was cussing about you (R2) talk about my mom. He (R6) was difficult to calm down. (R2) got a cut on his upper eye that was

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S9999	Continued From page 4 bleeding. I called the nurse she came to help me." Surveyor inquired if any staff witnessed the (7/25/23) incident. V19 replied, "The Nurse was in the washroom and the CNA went on a 15-minute break. It was only me on the floor at that time." On 9/20/23 at 3:31pm, V1 (Administrator) affirmed she's the abuse coordinator. Surveyor inquired about the regulatory requirements for abuse V1 (Administrator) stated, "The requirement for abuse is once it's brought to my attention, I have to report it (to IDPH) within 24 hours, if there's an injury involved, we have to report it within 2 hours. An investigation is initiated and then we inform the doctor, family and of course we inform the State and law enforcement if there was an injury. Surveyor inquired if the Police were notified (7/25/25) V1 responded "Yes." Surveyor inquired why "abuse" was not marked on the (7/25/23) initial report submitted to IDPH V1 responded "That was an honest omission, it wasn't intentional to do that" and affirmed "other" was marked. Surveyor inquired why the (7/25/23) follow-up investigation was marked "Unsubstantiated" if R6 was physically aggressive towards R2 and R2 sustained a reportable injury V1 replied "Because the other (R6's name) was not an intentional behavior he (R6) did not intend to hurt him (R2). It was poor impulse control." R2's (9/15/23) history & physical states patient alert, oriented to place and person, able to provide history that he was hit on the head with a chair a couple weeks ago. R2's (9/15/23) head CT (Computed Tomography) affirms subdural hematomas in multiple locations. Acute/subacute bilateral subdural hematoma likely traumatic. On 9/21/23 at 1:03pm, surveyor inquired about	S9999		

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S9999	Continued From page 5 potential harm to an (unsupervised) resident hit in the head with a chair. V22 (Medical Director) stated, "There is potential for harm. There's potential for bleeding on the inside of the brain or skull fracture. Those would be the 2 things that are concerning." The (10/2022) abuse policy and prevention program states this facility desires to prevent abuse, neglect, exploitation, mistreatment, deprivation of goods and services by staff and misappropriation of resident property. This will be done by filing accurate and timely investigative reports and by establishing a resident sensitive and secure environment. This will be accomplished by a comprehensive quality management approach involving the following: staff supervision. When an allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has been made, the administrator or designee, shall notify Department of Public Health's regional office. The report shall include the following information, if known at the time of the report: Type of abuse reported (physical, verbal, or mental abuse). The final investigation report shall contain the following: the original allegation (note the specific allegation). Conclusion of the investigation based on known facts. (A)	S9999		