

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145864	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2020
NAME OF PROVIDER OF SUPPLIER BRIA OF FOREST EDGE		STREET ADDRESS, CITY, STATE, ZIP 8001 SOUTH WESTERN AVENUE CHICAGO, IL 60620	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0607 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow its abuse prevention program by staff not reporting resident to resident abuse to the administrator. This failure has affected one (R1) of five residents reviewed for physical assault in a sample of six residents. Findings include: On 9/8/20 at 12:05 PM, V13 (CNA) stated, I was the one that reported R1's fall to V8 (Wound care nurse who was covering for agency nurse V14 during her break). The fall happened around 12:40 PM on 8/19/20. While I was making rounds, I heard a sound and found R1 in the doorway with her upper body in the hallway. She was lying on her right arm with a 3 to 4-inch bump on her middle forehead. R1's right arm was painful. I thought they were going to transfer her to the hospital right away. I saw R1 flew to the doorway, but I didn't see R1's roommate (R2) push or hit R1. R1's wheelchair was inside her room, 4-5 feet away from her laying position. I am not sure her wheelchair was locked/unlocked. On 9/4/20 at 12:00pm V15, (licensed practical nurse) stated, I am a floater and work on 7-3 pm shift. I heard a resident pushed another resident. I didn't witness anything. On 9/8/20 at 1:10 PM, V1 (Administrator) stated, Nobody reported to me that R2 might have pushed R1 down. Our camera is just for resident monitoring purposes, it is not recording. My staff are supposed to report to me any kind of abuse. Facility presented abuse prevention program (page 6) revised on 9/2017 document: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately.		
F 0804 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews, the facility failed to serve lunch within acceptable serving temperatures and has the potential to affect all 32 residents on the 4th floor. Findings include: On 9/4/20 at 12:10 PM, observed R5 on his bed and stated, Food is always cold. The third floor has no hot water in bathrooms. On 9/4/20 at 11:00 AM, observed R2 in her room sitting at the bedside and stated, Food is sometimes cold, water is OK. On 9/4/20 at 11:20 AM, observed R4 in her bed and stated, Food is cold, and water is fine. On 9/4/20 at 11:30 AM, R3 stated, Food is cold, CNAs don't want to pass trays on time. Water temperature is fine with bathrooms. On 9/4/20 at 1:30 PM, observed the lunch cart arrived on the fourth floor with a test-tray in it as per surveyor request. Observed V11 (Dietary Manager) requesting V12 (fourth-floor nursing assistant) to start passing lunch trays. V12 was hesitant to start passing trays, and after repeated requests from V11, V12 began to pass trays. Temperature check on the test tray revealed a temperature (temp) of 132F with pork ribs. On 9/4/20 at 1:55 PM, V11 stated, The serving temp should be minimum 135F. We need more staff to pass trays on time. On 9/8/20 at 1:00 PM, V1 (Administrator) stated, We just follow regulations and don't have any specific policy for food serving temp.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.