STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009930	A. BUILDING: _____ B. WING _____	C 03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF WESTMONT	6501 SOUTH CASS WESTMONT, IL 60559

(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 Investigations: 1871445/IL100789- F760 1871418/IL100761- F689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)2) 300.1630c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

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Based on observations, interviews and record reviews the facility failed to follow their policy for medication administration and failed to ensure that ophthalmic eye drops were re-ordered as needed.

This failure led to R5 received the incorrect medication resulting in an overdose of medication with resulting lethargy, decreased blood pressure and hospitalization.

This applies to 7 residents (R1, R3, R4, R5, R6, R7 and R8) reviewed for medications.

Findings include:

1). The Face Sheet reads R5 is 89 years old and was admitted to the facility on 12/4/17 with the following diagnoses: acute kidney failure, heart failure, muscle weakness, diabetes mellitus type 2, peripheral vascular disease, hypothyroidism, hyperlipidemia, dementia, coronary artery disease and diabetic neuropathy.

The face sheet reads R3 was admitted to the facility on 12/2/17.

The Incident Report to DPH (Department of Public Health) for R5 dated 12/9/17 documents that R5 "received incorrect AM medication. NP (Advanced Nurse Practitioner) aware. 15 minutes checks initiated. Decline in BP (Blood Pressure) and lethargy noted. Sent to ER (Emergency Room)." The statement by signed by V6 (Registered Nurse) reads: I pulled R3's medication but when I went to give the meds I went to R5's room instead. When I entered R5's room the family member was in there and looked at the medications I was giving R5. She

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S9999	Continued From page 3 questioned why R5 was getting ASA (Aspirin) so I pulled it out and held it. I then administered the rest of the medication. When I left the room I asked V17 (Nurse) about the ASA and she said "Wait are you talking about R3 or R5?" That's when I realized that I had gone to the wrong room and gave the medication to the wrong resident. The POS/MAR Physician's Order Sheet/Medication Administration Record for R3 documented the following orders: Amlodipine Besylate 5mg, give 1 tablet by mouth one time a day related to hypertension; Losartan 25mg, give 1 tablet by mouth two times a day related to hypertension; Duloxetine 60mg give 1 capsule by mouth one time a day; Gabapentin 300mg, give 1 capsule by mouth three times a day; Lyrica 100mg, give 1 capsule by mouth two times a day; Aspirin 81mg, give 1 tablet by mouth one time a day; Montelukast 10mg, give 1 tablet by mouth one time a day; The Nurse's Notes by V6 (Registered Nurse/RN) read: 12/8/17 14:28, nurse entered residents room to administer medication. After administration of medication nurse relies (sic) that she had administered wrong residents (sic) medication. NP (Nurse Practitioner) and DON (Director of Nursing) were notified. Daughter was notified at bedside. Ordered to monitor resident and take vitals every 15 minutes for the remainder of shift. 12/8/17 at 1530pm, R5 was noted with low blood pressure and R5 was discharged to the hospital for treatment.	S9999		

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The Employee Report for V6 dated 12/12/17 reads: Date of incident "12/11/17" Above employee administered incorrect medication to a resident resulting in hospitalization. The report was signed by V2(Director of Nursing), V4 (Assistant Director of Nursing) and V6.

On 3/7/18 at 9:19 AM during interview, V6 stated she gave R3's medication to R5 during the morning of 12/8/17. V6 stated "I pulled R3's medication, and instead of going to R3's room I went to R5's. R5's daughter recognized ASA (Aspirin) and was questioning it so I held the ASA and gave R5 the rest of the medication. R5 went to the hospital for low blood pressure." When asked the process for administering medication and identifying the resident, V6 stated "make sure I enter the right room. I know all the residents." V6 stated she knew R3 and thought she was in R3's room. When asked how she identified the resident prior to administering the medication, R5 replied "the family was there and I just introduced myself like I always do."

On 3/7/18 at 9:45 AM, V2 (Director of Nursing) stated V6 had given the wrong medications to a resident. V2 stated the medication error was identified because the family of R5 had asked about the ASA. V2 stated the policy is to verify the 5 rights (right patient, route, dose, drug, and time) prior to administering medication. V2 stated if family is there, the policy is to identify the resident's name. V2 also stated "We have pictures on the MAR. All MARs have pictures." V2 then pointed to the printed MAR showing the picture.

On 3/7/18 at 3:45 PM, V7 (Medical Doctor) stated R5 was hospitalized because "R5 was given the

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wrong medication and R5's blood pressure didn't come up. We sent R5 to the hospital. The medication definitely caused R5's blood pressure to drop and required hospital treatment. You have to be very careful." V7 stated R5 was admitted to the hospital.

The facility's policy for Medication Administration reads:
-Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident and time.
-Read each order entirely.
-Identify resident using two resident identifiers.
The facility's policy for "Medication Error Prevention" reads:
All residents will be identified for medication pass with two identifiers. If these are both not present, the nurse will take a "time out" and assure they are present before proceeding.
The ALS (Advance Life Support) report dated 12/8/17 reads: lethargic, given wrong medication at Nursing Home at 9:00 AM.
The Emergency Room documentation reads:
Visit Reason- Unintentional ingestion- Overdose; Acuity- lethargic.
-Admit to Cardiac/Neuro unit.
The report also documented the hospital received a list of the above medications that were administered to R5.

2). The Face Sheet for R1 documents the following diagnoses: Diabetes Mellitus 2, hypertension, schizophrenia, anemia, hyperlipidemia, depression, angle-closure glaucoma, and convulsions. The MDS (Minimum Data Set) dated 12/11/17 reads R1 has a BIMs (Brief Interview for Mental Status) score of 15/15 indicating no cognitive impairment.

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R1 stated on March 6, 2018 at 12:24PM, "I am not getting my medication. I am not getting my glaucoma eye drops." R1 stated "they just got somebody's bottle and it is not mine. I haven't had Timolol since Sunday. They told me it was too early to order."

The POS/MAR documented the following orders for R1:
Brimonidine Tartrate Solution 0.2%, Instill 1 drop in both eyes 3 times a day related to residual stage of angle-closure glaucoma;
Dorzolamide HCL-Timolol Solution 22.3-6.8 mg/ml, Instill 1 drop in both eyes two times a day related to residual stage of angle-closure glaucoma.
Citalopram Hydrobromide tablet 20mg, give 1 tablet by mouth one time a day related to major depressive disorder;
Tramadol HCL 50mg, give 1 tablet by mouth every 12 hours as needed for pain

On 3/6/18 at 12:30 PM, V8 (Licensed Practical Nurse/LPN) was asked to review R1's medication. V8 pulled out an empty bottle of Dorzolomide-Timolol from the top drawer of the cart. V8 stated "I just tried to give it and nothing came out but air." The plastic bag the Timolol was stored in read "Dispense 10/29/17." There was also a bottle of Brimonidine on the cart. The label containing the patient's name had been peeled off the bottle. The Tramadol and Citalopram were both missing. V8 looked for the medication and did not find them. V8 stated the policy is to reorder medication prior to it running out. V8 stated R1's eye drops were ordered on 2/21/18, but the facility lost them and attempted to reorder on 2/25/18 but the pharmacy stated "order too soon." When asked who signed for the medication on 2/21/18, V8 stated "V4 (Assistant

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S9999	Continued From page 7 Director of Nursing/ADON) has everything. You have to talk to her." On 3/6/18 at 12:47 PM, V4 (ADON) stated the policy is to reorder medication prior to it running out. V4 stated medication should be reordered within 48-72 hours of them running out. V4 stated we just switched to V9 (Pharmacy) and "R1's eye drops were delivered on 2/21/18. I was just told the Brimonidine just ran out this morning and all the other eye drops are in the cart." V4 stated R1's informed her this morning that R1 was improperly administering eye drops and was pouring too much from the bottle. V4 stated R1 was self administering the medication with supervision from the nurses. V4 stated "The nurse was supervising R1, it was supervised." When asked what the nurse's response was while R1 was pouring out the medication, V4 stated the medication was to be kept on the med carts since January. But now the nurse's administer the medication. V4 was informed that V8 stated the eye drops were lost in February and the facility attempted reorder. V4 stated "I just told you R1 poured out the medication. Those are the bottles on the medication cart that were sent 2/21/18." On 3/6/18 at 1:55 PM, V10 (Pharmacy Supervisor) stated R1's eye drops were delivered on 2/21/18, and then the facility attempted to reorder them on 2/25/18 but was informed of "reorder to soon." V10 stated the facility has not called again in relation to the eye drops. V10 was provided with the prescription number (RX) on the bottle of eye drops for R1 which began with #1. V10 stated "That's not a prescription from our pharmacy. Our numbers begin with #9. We took over as the facility's pharmacy on 12/1/17."	S9999		

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S9999	Continued From page 8 On 3/7/18 at 11:00 AM, R1 came to the conference room window and was waving to the surveyor. Upon being invited inside, R1 stated "I still don't have my eye drops. It really makes me angry. I'm concerned with my eye drops because I have glaucoma and my eyes hurt. At times I can't see." 3). On 3/6/18 at 4:23 PM, V11 (Registered Nurse/RN) was asked to see R6's eye drops. The POS/MAR for R6 read: Brimonidine Tartrate-Timolol 0.2-0.5%, Instill 1 drop in both eyes every 12 hours related to acute angle-closure glaucoma; Latanoprost Solution 0.005%, Instill 1 drop in both eyes at bedtime related to acute angle-closure glaucoma There was an empty bottle of Brimonidine on the cart for R6 dated 1/18/18. The Latanoprost was 1/3 full and dated 1/8/18. V11 stated The Brimonidine is empty. "It should've been reordered." 4). On 3/6/18 at 4:29 PM, V12 (RN) was asked to see the eye drops for R7. The POS/MAR read: Combigan Solution 0.2-0.5% (Brimonidine Tartrate-Timolol), Instill 1 drop in both eyes two times a day; Dorzolamide HCL Solution 2%, Instill 1 drop in both eyes two times a day related to borderline glaucoma with ocular hypertension. V12 searched through the medication cart and did not locate either bottle of eye drops. V12 stated "They must've run out. It should be in here in the top drawer." On 3/7/18 at 12:10 PM R7 had yellow crusty secretions in the eyes. R7's right eye was sticking together at the edge of the lids. R7 stated "That's because I didn't get my eye drops. I don't get my eye drops every day."	S9999		

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5). On 3/6/18 at 4:34 PM, V13 was asked to see the eye drops for R4 and R8.
The POS/MAR for R4 read: Brimonidine Tartrate Solution 0.2%, Instill 1 drop in both eyes 1 time a day for glaucoma; Latanoprost Solution 0.005%, Instill 1 drop in both eyes at bedtime related to glaucoma. V13 checked the cart and stated "I don't see anything. V13 then checked the other 2 carts on the unit and stated 'I don't see them, if it's not here- it's not here."

The POS for R8 read: Latanoprost Solution 0.005%, Instill 1 drop in both eyes at bedtime related to open angle with borderline findings; Timolol Maleate Solution 0.5%, Instill 1 drop in both eyes two times a day related to open angle. The Timolol packaging was dated 9/19/17; the bottle read opened 9/20/17. The bottle was full. The Latanoprost read sent 10/12/17. The bottle was not opened. The cap remained with the plastic safety seal in place.

On 3/7/18 at 1:11 PM, R4 had dried yellow secretions in the eyes. R11's left eye had a dried crusty round yellow ball of secretion hanging from the bottom lid. V14 (Certified Nursing Assistant/CNA) stated she was taking care of R11. V14 stated "I will clean R11's eyes."

On 3/7/18 at 1:38 PM, V2 (Director of Nursing) stated "I went through the carts last night. R4's eye drops still are not here. We are reordering all of the medication."

The policy titled "Medication Administration" read: If medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication.

(A)

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300.610a)
300.1010h)
300.1210b)
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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

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of five percent or more within a period of 30 days. 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

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:

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. (Section 2-107 of the Act)

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S9999	Continued From page 12 These Regulations were not met as evidenced by: Based on record review and interview the facility failed to safely transfer a resident using two staff members and as a result, R2 sustained a fracture injury during an improper transfer. This applies to 1 resident (R2) reviewed for safe transfers. Findings include: The Face Sheet documents R2 is a 93 year old resident with the following diagnoses: Hyperlipidemia, hypertension, Gastro Esophageal Reflux Disease, muscle weakness, osteoarthritis, Alzheimer's, generalized anxiety disorder, and fractured left fibula. The MDS (Minimum Data Set) dated 11/14/17 reads: BIMs (Brief Interview for Mental Status) score 1/15 indicating severe cognitive impairment. The MDS also documents R2 requires extensive physical assistance for transfers by 2 staff. Moving from seated to standing position and surface-to-surface transfer (transfer between bed and chair or wheelchair) -Not stead, only able to stabilize with staff assistance. Lower extremity- impairment on both sides. Mobility device- wheelchair. Nursing notes of December 15, 2017 document that the V15 (nurse) was called into R2's room by the nurse aide to check R2's knee. V15 noted that that the right knee was swollen and warm to the touch. R2 was also noted with pain to the area. The physician was notified and an order was obtained for an X-ray. The Occurrence Report dated 12/15/17 reads: Resident expressed pain when staff member	S9999		

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touched right lower extremity.

The Facility Incident Report dated 12/16/17 reads: "Resident was observed with swelling bruising to right lower leg. MD was contacted and order received for right tibia/fibula x-ray. X-ray completed and results revealed fracture of the distal tibia and neck of the fibula. MD notified and orders to send resident to the ER for further evaluation." The diagnostic report dated 12-15-17 reads, "Impression: Fractures of the distal tibia and neck of fibula."

On 3/6/18 at 1:23 PM, V14 (Certified Nursing Assistant/CNA) stated "I transferred R2 by myself, which I shouldn't have because we are always short of staff. I picked R2 up because R2 is very light weight. I held R2 around the torso area." V14 stated "I lifted R2 up totally. R2 is transferred with 1 person by a lot of people because R2 it's easy to do. I'm not the only one who would transfer R2 alone. I put R2 to bed and the second shift noted swelling. At the beginning of the job, they say (sic) we should always have a second person. I started in September." V14 stated she did not use a gait belt.

On 3/6/18 at 2:53 PM, V5 (Licensed Practical Nurse/LPN) stated R2 is high risk for falls. V5 also stated the resident's transfer status is documented on care cards, printed, and put in the resident rooms. V5 stated the CNAs and nurses are then made aware of the resident's transfer status. V5 added there is also a code above the resident's bed. V5 added "R2 was changed to a 2 person assist on 11/20/17. R2 can't pivot safely with 1 person. R2 is a 2 person assist."

On 3/6/18 at 3:30 PM, V15 (Nurse) stated on 12/15/17 "I was called by the CNA and noted R2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009930	A. BUILDING: _____ B. WING _____	C 03/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF WESTMONT	6501 SOUTH CASS WESTMONT, IL 60559

(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 14 right knee swollen and warm. I called the doctor and he ordered an X-ray. On 3/7/18 at 3:22 PM, V2 (Director of Nursing) stated she was present when R2 was transferred to the hospital. V2 stated "R2 had a bruise and R2's leg was swollen from the knee to the ankle and was warm, with a bruise by the ankle. R2 was exhibiting expressions of pain." V2 stated the X-ray showed fractures. V2 stated "R2 was a mechanical lift/2 person transfer. The CNA transferred R2 by herself. She did not transfer R2 the way R2 was supposed to be transferred and the care card was right in front of her." V2 presented the facility's policy titled "Transfer Status." The policy did not explain how to transfer residents with 1 or 2 person assist. On 3/7/18 at 3:54 PM V7 (Medical Doctor) stated he was informed R2 had a fall, not a transfer. However, V7 stated "It caused R2 harm. R2 had to go to the hospital. There was deformity in the leg. It looked like a fracture." The Employee Report for V14 reads: The above employee failed to follow transfer policy which resulted in resident injury. The report was signed by V14 and V2. (B)	S9999		