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
	IL6009930	A. BUILDING: ______ B. WING ______	C 05/16/2023

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 Survey: 2373861\IL159656	S 000		
S9999	Final Observations Statement of Licensure Violations 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 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 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**	

Illinois Department of Public Health

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

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 05/16/2023

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 1	S9999		

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 notmet as evidenced by:

Based on observation, interview, and record review, the facility failed to properly transfer a resident and failed to follow residents care plan. This failure resulted in the resident falling and obtaining a scalp hematoma, periorbital swelling, facial bruising, and pain and sent to hospital for treatment.

This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.

The findings include:

On 5/11/23 at 10:02 AM, telephone interview was conducted with V4 (R1's POA/Power of Attorney). V4 stated the following: "On Friday 5/5/23, an unknown female CNA (Certified Nursing Assistant) used a gait belt and tried to transfer (R1) from the bed to the wheelchair. R1 fell onto

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 05/16/2023

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 2	S9999		

the floor. Her forehead had a raised area that was like ½ inch. She had some dark bruising and her left eye was swollen. There was some bruising up her left arm. There is a sign in her room that specifically says she is a mechanical lift. The CNA did not use the lift and transferred her by herself. There is always supposed to be two people. (R1) has weak legs. I heard that the CNA did not lock the wheelchair. (R1) was sent to the hospital. (R1) has pretty severe dementia. I tried asking (R1) what happened, but she doesn't remember the incident at all."

On 5/12/23 at 9:42 AM, V4 met surveyor in the facility. V4 showed surveyor pictures from her cell phone of R1's face before and after her fall incident on 5/5/23. V4 also emailed surveyor the pictures. The pictures showed that R1 had a swollen left eye and there was purplish bruising on her left periorbital area, cheek, and forehead. There were all 3 small bruises (circular in size) to her left arm. V4 stated when she went to the ER (Emergency Room) on 5/5/23, R1 had already been discharged back to the facility. The ER nurse at the hospital told her that that paramedics were told by the facility staff that R1 had a fall because the CNA (Certified Nursing Assistant) used a gait belt to transfer R1 from the bed to the wheelchair that was not locked. The CNA did not use a mechanical lift to transfer R1.

On 5/12/23 at 10:32 AM, V3 (LPN/Licensed Practical Nurse/Unit Manager of 2nd Floor) stated the following: "I was working on Friday 5/5/23, the day of the incident. I think it was around 10 AM. I heard someone say "We need help." I believe it was V5 (Agency LPN/Licensed Practical Nurse) who said that. When I went to her room, I found (R1) lying on her back on the floor positioned diagonally to the bed and in between

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 05/16/2023

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 3	S9999		

the dresser and bed. The CNA supervisor, V5, and V6 (CNA) were all next to (R1). (R1) had a hematoma above the left eye. There was no blood. There were little marks or bruises on her arm. I assessed (R1) and we also called V7 (Nurse Practitioner) to come assess her. I interviewed (V6) on what happened. (V6) transferred (R1) from the bed to the wheelchair by putting a gait belt on (R1), standing her up, then pivoting her by herself. (V6) and (R1) lost their balance and fell to the floor. I asked her why she transferred (R1) like that. She stated that she does it all the time with physical therapy like that in (R1's) room. (V6) got mixed up. She thought it was ok. I told her that therapy can do that, but as a CNA she can't do that. (V5) called 911 and I sent (V6) home immediately. She was suspended pending investigation. Every resident should have an ISP (Individualized Service Plan) hanging on their wall beside their bed. It has a confidentiality sheet over it. The ISP will tell staff what the transfer status is for the resident. (R1) also has a magnet that says "H," which means Hoyer Lift. It's on the light fixture over the bed. We checked (R1)'s wheelchair and did an inspection of all the wheelchairs in the building."

On 5/12/23 at 11:09 AM, surveyor went with V3 to the second floor. V4 was pushing R1's wheelchair in the hallway. Surveyor and V3 asked V4 if she would bring R1 back to her room so surveyor can evaluate and ask R1 some questions pertaining to the incident. R1 was brought back to her room. R1 was sitting in her wheelchair and her sling to the mechanical lift was under her. R1 had bruises to her left side of the forehead, periorbital area, and cheeks. The bruises were fading and the left side of her face had a yellowish tone to it. R1 was asked if she remembered anything about the fall. R1 stated, "I

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 05/16/2023

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 4	S9999		

Continued From page 4

don't remember the fall. I bumped my head three times. I don't know how it happened. They haven't been using the machine on me. It hasn't healed yet." Surveyor asked R1 if she had any pain and if she could rate it. R1 paused for several seconds and stated, "It hurts on the left side of the face. It hurts a lot. I guess it would be a pain of 5 out of 10." Surveyor asked R1 if the pain is always there or when she touches it. R1 stated, "I don't know. Surveyor asked R1 if she told anyone that she has pain. R1 stated she doesn't know.

On R1's wall above the head of bed was her ISP (Individualized Service Plan) and there was a small laminated sign that says "H." As per V3, the H stands for "Hoyer Lift and is put up by the restorative nurse." V4 stated this is the first time she's seen that sign.

R1's ISP documents the following: Transferring: 1. Explain procedure. 2. Lock wheelchair brakes. 3. Apply Hoyer sling. 4. Provide encouragement during transfer if becomes fearful. Attempt transferring daily. Transferring Hoyer Lift 2 Asssist.

On 5/12/23 at 11:51 AM, telephone interview was conducted with V6 (CNA/Certified Nursing Assistant). V6 stated the following: "I've been working as a CNA for 26 years. I'm assigned to (R1) five days a week. I know her very well. On 5/5/23, physical therapy came to the unit and told me that they need (R1) ready for her therapy session. So, I put a gait belt around her. Then, I did an extensive stand and pivot with (R1) by myself from the bed to the wheelchair. I tried to sit her in the chair, but the wheelchair moved. I locked the wheelchair and checked it twice. When I was turning (R1), her bottom thigh hit the

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 05/16/2023

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 5	S9999		

wheelchair and then it started rolling away. I was like "what's this?" I tried to grab the wheelchair with my right leg, but then it was too late. We both fell and I was pinned under her. I never had a fall like this. We have been getting her up without a mechanical lift for quite a few days. We were just doing a stand and pivot technique. I got confused. I thought her transfer status got updated and we were not using the Hoyer lift anymore. On (R1's) head, there was knot and bruise on her upper frontal lobe." Surveyor asked V6 how she would find out the transfer status of a resident. V6 stated it would be either in the computer or on the wall in the resident's room. V6 stated she remembered R1 having the letter H above the head of her bed. V6 stated she was asked by V3 why she transferred R1 without a mechanical lift and another staff member. V6 stated because therapy was doing a stand to pivot on R1 and she just got confused. V6 said she was sent home until management finished their investigation.

On 5/12/23 at 12:00 PM, V7 (Nurse Practitioner) stated the following: "On 5/5/23, I was called into (R1's) room when she feel. I found her laying on her back on the floor. She had a lump on her forehead. There was a hematoma 3 x 4 inches on her left forehead. I did a trauma exam on her. She was complaining of neck pain, so we did not move her from the floor. We just waited for the ambulance and then she was sent to the hospital. This fall could have been have prevented if the CNA looked at the transfer status of the resident and used a mechanical lift."

On 5/12/23 at 12:30 PM, V1 (Administrator) stated the following: "I was working on 5/5/23. I think it was (V3) who brought it to my attention that (R1) had a fall. I immediately went up to

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 05/16/2023

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 6	S9999		

(R1's) room and did an investigation. (V6) did a stand and pivot transfer of (R1) which resulted in (R1) falling. There was bruising and hematoma to her face and forehead. According to (V6), she and the physical therapist would do a stand and pivot transfer with (R1). (V6) got confused. She was not supposed to transfer (R1) using a gait belt. Instead, she was to look at the ISP, find out her transfer status, and then transfer (R1) with a Hoyer lift, which requires the assistance of two staff members. We did re-education with (V6) and sent her home. I had maintenance bring the wheelchair down to my office. We both inspected it. V2 (Assistant Administrator) and V3 (2nd Floor Unit Manager) checked it as well. There was nothing wrong with it. When we locked it, we couldn't move it. All the wheelchairs in the facility were inspected. There were no issues noted."

On 5/12/23 at 1:12 PM, telephone interview was conducted with V5 (Agency LPN/Licensed Practical Nurse). V5 stated the following: "On 5/5/23, I was (R1's) nurse. I never personally saw (R1) fall. I was called to the room by (V6). (V6) said she transferred (R1) by herself without using the Hoyer-lift. (R1) had a large contusion to the side of her face. (V7) was in the building, so we asked her to assess (R1). I called 911 and did the paper work."

On 5/12/23 at 1:39 PM, V8 (CNA) stated, "(R1) had complained of pain in her eye area today. Her face looks swollen and it's still sore. I told the nurse and I think he gave her some pain medication."

On 5/12/23 at 2:09 PM, V9 (Agency LPN) stated, "I'm (R1's) nurse today. (V8) told me she was complaining of pain, so I gave her Tylenol."

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 05/16/2023

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 7 R1's EMAR (Electronic Medication Administration Record) shows that R1 got Tylenol for pain (2/10) on 5/12/23 at 1:00 PM. R1's incident report dated 5/5/23 progress note dated 5/5/23 documents the following: "This nurse was called to (R1's) room by (V6-CNA/Certified Nursing Assistant) who informed this nurse that she'd fallen with (R1) while transferring her from the bed to chair. (R1) was noted to be in a left side lying position at a 90 degree angle to her bed. (R1) stated, "I don't know what happened by my head hurts." This nurse assessed (R1) noting a large contusion on the left side of (R1's) face with no other obvious injuries noted. Sent (R1) to the hospital for an evaluation. Notified nurse practitioner. Left a message for (R1's) POA (Power of Attorney) to call this nurse at the facility." Incident report also documents: "(V6) was transferring (R1) to wheelchair when wheelchair shifted back and both (V6) and (R1) fell to the floor. Intervention: Inspected wheelchair for proper working function and re-educated (V6) on proper/safe transferring guidelines. Care plan in place." V7 (Nurse Practitioner)'s note dated 5/5/23 documents: Called to patient's room after she experienced a fall and sustained a head injury. Upon entering room, patient is laying on her back in the floor. Has a pillow under her head. She is awake and can answer questions. Denies any LOC (Loss Of Consciousness). Remembers falling but can't provide details. Has pain in left forehead, but no extremity/back pain. Initially did also complain of neck pain. Has 3 x 4 inches hematoma left forehead/above left eye. Skin: Hematoma left forehead as above. Small echymotic area just medial to left anticutibal area. Assessment and Plan: 1. Fall: Patient	S9999		

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 05/16/2023

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 8	S9999		

experienced a fall and sustained a head injury. Large hematoma above left eye on forehead. No LOC. Neuros at baseline. 911 called due to head injury. Initially, patient complains of neck pain, so made comfortable on floor. No transfer until paramedics present with equipment. Sat with patient until paramedics arrived. Ambulance left with patient at 10:15 AM. Primary care physician notified. Staff notified family. Patient taken to hospital ER (Emergency Room) for further evaluation.

EMS (Emergency Medical Services) report dated 5/5/23 documents the following: Called to above location for a fall. On arrival, found (R1) laying on the floor of her room with staff around her. Facility staff state they were assisting her from her bed to a wheelchair. Chair was not locked in place and rolled away as (R1) sat down. (R1) has a moderate hematoma to left forehead. Staff denies any loss of consciousness. (R1) denies any other injuries and has no other obvious sings of trauma. (R1) denies neck pain. (R1) lifted from floor and onto cot in a position of comfort. (R1) secured and moved to ambulance. (R1) transported to hospital and left in care of registered nurse.

Hospital records dated 5/5/23 documents the following: ED (Emergency Department) Attending Note-88 Year old female with dementia was able to tell me she is here for a fall but could not give me any details. EMS (Emergency Medical Services) informed the nurse that patient was being transferred from the bed to the wheelchair and the wheelchair was not locked and the patient ended up falling on the ground in front of staff but did not lose consciousness. She does not have any complaints rights now. She has hematoma to her left forehead. No

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 05/16/2023

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 9	S9999		

anticoagulation reported. Physical Exam: HENT (Head, Eyes/Ears, Nose, and Throat)-Comments: Left forehead and brow hematoma with superficial abrasions. Radiology Results CT (Computerized Tomography) Head Without Contrast Impression: 4. Large left frontal scalp hematoma and left periorbital soft tissue swelling. Left front scalp hematoma measures up to 1.3 CM (Centimeters) in thickness. Final diagnoses: Injury of head, initial encounter. Traumatic hematoma of forehead, initial encounter.

R1's face sheet documents an admission date of 3/6/23.

R1's face sheet documents the following diagnoses: paranoid personality disorder, visual hallucinations, auditory hallucinations, dementia in other diseases classified elsewhere, mild, with other behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and weakness.

R1's MDS (Minimum Data Set) dated 3/13/23 documents a BIMS (Brief Interview for Mental Status) score of 6, which is means she is severely cognitively impaired. R1's transfer score is a 4/3, which means she is total dependence with a two person physical assist.

R1's fall risk assessment dated 3/6/23 during initial admission documents a score of 13, which means she is a high fall risk. R1's fall risk assessment dated 5/5/23 (after the fall) documents a score of 23, which means she is an extremely high fall risk. Both assessments show that R1 has unsteady gait and/or use of ambulatory device (cane, walker, wheelchair).

R1's care plans document the following: Focus:

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
	IL6009930	A. BUILDING: ____ B. WING ____	C 05/16/2023

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 10	S9999		

(R1) is at risk for falls related to generalized weakness and decreased functional mobility secondary to CAD (Coronary Artery Disease), Dementia, HLD (Hypersensitivity Lung Disease), Hypertension, Psychosis, Chronic Kidney Disease, and Paranoid Personality Disorder. Goal: (R1) will remain free from falls through next review date. Interventions: 5/5/23-Inspect wheelchairs for proper working order and re-educate CNA's (Certified Nursing Assistant) on proper/safe transferring process. Focus: Hoyer Lift: (R1) has a self care deficit in transferring related to generalized weakness and decreased functional mobility. Goal: (R1) will be able to transfer safely with Hoyer and 2 staff assist daily through next review. Interventions: 1. Explain procedure. 2. Lock wheelchair brakes. 3. Apply Hoyer sling. 4. Provide encouragement during transfer if becomes fearful. 5. Attempt transferring daily.

Facility's policy titled Transfer Status (9/2022) documents: 1. Upon admission to the facility, the restorative nurse will screen the patient/resident to determine transfer status. If the restorative nurse is unavailable, the admitting nurse will use the referral information to determine transfer status prior to discharge from the hospital or from previous location. 2. The transfer status will be entered into the EHR (Electronic Health Record) via the Admission Clinical Observation.

Facility's policy titled Fall Prevention and Management (7/2022) documents: While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. 2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP

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
	IL6009930	A. BUILDING: ______ B. WING ______	C 05/16/2023

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 11 (Individualized Service Plan) with interventions implemented to minimize fall risk. Facility's policy titled Mechanical Lift-Hoyer (10/2022) documents: 6. One caregiver is to focus on the resident's head and body positioning while the other is operating the lift. (B)	S9999		