

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/14/2023
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NAME OF PROVIDER OR SUPPLIER BRIA OF WESTMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 6501 SOUTH CASS WESTMONT, IL 60559
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(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 FRI of 10/14/2023/IL166342	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6 300.1220b)7</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>7) Coordinating the care and services provided to residents in the nursing facility.</p> <p>These Requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide care with two people assist during incontinent care and bed mobility. This failure resulted in R1 falling from the bed and sustaining a laceration on the top left part of her head requiring a staple and left femoral neck fracture.</p> <p>This applies to 1 of 9 residents (R1) reviewed for falls and accidents.</p> <p>Findings include:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>On 11/7/2023 at 10:09 AM, V2 (DON-Director of Nursing) said on 10/14/2023 around 1:30 AM, R1 fell from bed while V3 (CNA-Certified Nurse Assistant) and V4 (CNA) were providing incontinence care. He said while R1 was turned towards V4, R1 started coughing and shifted her weight on her air mattress causing her to fall off the bed. V4 was unable to break the fall.</p> <p>On 11/7/2023 at 11:03 AM, V3 (CNA) said on 10/14/2023 around 1:30 AM, she was providing incontinence care to R1. V3 said she was by herself and had no help. V3 said she provided care to R1 routinely by herself only. V3 said she was aware that R1's ISP (Individualized Service Care Plan) stated R1 was dependent on two people assist with bed mobility. V3 said on that day, while assisting R1 with incontinent care, V3 turned R1 away from her and V3 reached out for R1's incontinence brief at the foot part of the bed. R1 began to cough and suddenly. R1 went over the bed and fell on the floor. V3 said she went to get the nurse. The nurse called the paramedics immediately and R1 was sent to the hospital. V3 said she was traumatized by the incident and since that happened, she does not change R1 by herself. V3 said V4 was not there to help her when R1 fell.</p> <p>R1's Admission Records shows R1 was initially admitted to Facility on 6/9/2023. R1 was discharged to hospital on 10/14/2023 and was re-admitted on 10/20/2023. Diagnoses include displaced fracture of base of neck, aphasia, laceration on part of head. R1's MDS (Minimum Data Sheet) dated 9/25/2023 documented R1's cognition was severely impaired. R1 was totally dependent on 2-person physical assist with bed mobility, transfers, dressing, and toilet use.</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>On 11/7/2023 at 11:30 AM, R1 was observed hunched over on her right side in a fetal position due to contracture to both upper and lower extremities.</p> <p>On 11/7/2023 at 11:30 AM, V6 (LPN-Licensed Practical Nurse) said if there were two staff assisting R1 with bed mobility and incontinence care, R1 would not have fallen even if she started coughing. She said the air mattress might be slippery but if there is someone supporting R1 on both sides of the bed, she would not have fallen.</p> <p>On 11/7/2023 between 11:41 AM and 11:45 AM, V7 (CNA) and V8 (CNA) said if there are two staff assisting R1 with bed mobility and incontinence care, R1 would not have fallen even if she was coughing because both staff would support R1's upper and lower extremities.</p> <p>On 11/8/2023 at 10:00 AM, V13 (R1's Physician) said R1's left femoral neck fracture was because of fall she sustained from rolling out of her bed on 10/14/2023. V13 said he was informed that R1 fell while R1 was being changed by staff. He said if there were 2 or 3 staff assisting her during changing, the fall might not have happened, and she would not have a fracture. He said R1's fractured femoral neck's prognosis is not good because she is completely contracted and bed bound. The chances of healing will be poor and slow.</p> <p>R1's hospital records dated 10/14/2023 at 2:42 AM documented that due to fall, R1 had a laceration on top of her head and was repaired with a single staple in the Emergency Department. R1's CT (Computed Tomography) scan of abdomen and pelvis done on 10/16/2023 showed a mildly displaced left femoral neck</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>fracture that was new compared to CT done on 6/6/2023.</p> <p>Facility's Fall Prevention and Management Policy reviewed on 09/2023 stated the following: ..." General: The facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible."</p> <p>(A)</p>	S9999		