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 07/27/2023

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

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S 000	Initial Comments Complaint Survey: 2375946/IL162194	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**	

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S9999	Continued From page 1 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 not met as evidenced by: Based on interview and record review, the facility failed to ensure one resident (R1) was free from a fall with serious injury out of 6 residents reviewed for falls. This failure resulted in R1 sustaining a pelvic fracture. This applies to 1 of 6 Residents (R1) reviews for falls Findings include: R1's Admission Record documents that R1 is a 92-year-old with diagnoses including but not limited to osteoarthritis and pain in left ankle and joints of the left foot. R1's original admission date is listed as July 24th 2017.	S9999		

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S9999	Continued From page 2 R1's MDS (Minimum Data Set) section C for Cognitive Patterns dated May 4th 2023 documents that R1's cognition is severely impaired; Section G for Functional Status documents that for the ADL (Activities of Daily Living) tasks of bed mobility and transfers, R1 requires two-person physical assist; and Section GG for Functional Abilities and Goals documents that for the ability to roll left and right, R1 was coded as "01. Dependent-Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required to complete the activity." On July 24th 2023 at 4:34 PM, the surveyor attempted to contact R1 at the hospital, however, R1's nurse stated that R1 was not alert enough to answer questions at that time. On July 25th 2023 at 11:07 AM, V18 (R1's Family Member) stated that when he asked R1 what happened, R1 told him that the CNA (Certified Nursing Assistant) was changing her (R1) and she (R1) fell down. V18 added, "She was in tremendous pain and was screaming" when the x-ray technician arrived to the facility and was placing the x-ray plate underneath R1. On July 24th 2023 at 2:33 PM, V4 (Agency CNA) stated that she (V4) was providing incontinence care by herself to R1 at the time of R1's fall out of the bed. V4 explained that after positioning R1 on her (R1) left side, she (V4) quickly ran into the bathroom inside of R1's room to get more supplies, leaving R1 unattended "for no more than 10 seconds." V4 acknowledged that she (V4) witnessed R1 fall out of the bed as she (V4) stepped out of the bathroom. V4 stated that R1 landed onto her right side on the floor. On July 27th 2023 at 3:06 PM, inquired what position the	S9999		

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S9999	Continued From page 3	S9999		

bed was in. V4 stated, "It wasn't that high. I'm 5'3" so it was at my waist length."

On July 24th 2023 at 3:06 PM, V5 (RN/Registered Nurse), who was the nurse on duty at the time, stated that when she (V5) asked R1 what happened, R1 pointed at the CNA and told her (V5) to ask the CNA. V5 affirmed that V4 told her that while providing incontinence care, V4 went into the bathroom for more supplies. V4 stated that when she (V4) arrived to the room, R1 was lying on her back and had a spilled cup of water next to her (R1). V5 stated that R1 complained of pain to the right hip.

On July 24th 2023 at 4:57 PM V3 (ADON/Assistant Director of Nursing) stated that she (V3) conducted the fall with serious injury investigation and submitted the Initial Report to the state agency on July 21st 2023 . V3 affirmed that based on V4's interview, V4 "stepped away very quickly" while providing incontinence care to R1. V3 added that she (V3) educated V4 on not leaving a resident unattended during incontinence care. V3 stated that she (V3) also told V4 to ensure that a resident is lying on his or her back in the center of the bed, if she (V4) ever needs to step away to get something or to use the call button for assistance if she's unable to step away.

On July 24th 2023 at 3:52 PM, the surveyor inquired if a resident should be left unattended while being provided with incontinence care. V7 (Nurse Practitioner) replied, "No, not until they're done." V7 added, "Depending on how much they move, they could roll off the bed. They could break something."

On July 26th 2023 at 10:21 AM, V18 (R1's Family Member) denied that R1 told him (V18) that she

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S9999	Continued From page 4	S9999		

(R1) was reaching for water at the time of the fall. V18 stated, "That kind of explanation does not make any sense." V18 stated that the only time R1 can reach for something is when it is placed directly in front of her (R1). V18 added, "She (R1) cannot turn and pick it up." The surveyor inquired if R1 was capable of holding onto a side rail. V18 stated that R1's bed has never had side rails. V18 stated that if R1's bed had a side rail, there's a possibility she (R1) would have held onto it and not just the corner of the bed sheet.

On July 26th 2023 at 12:28 PM, V19 (Restorative Director) acknowledged, "Since, I've been here, I don't believe she's (R1) had rails." V19 stated that she (V19) has been at the facility since October 2022.

R1's 8/8/22 Restorative: Side Rail Review documents, in part, "The resident will not use side rails at this time."

On July 26th 2023 at 1:09 PM, V21 (MDS Coordinator) explained that if a resident is coded as "Dependent," then that resident would be considered a total assist and is unable to provide any assistance with that particular ADL. V21 stated, "They're not able to maintain a side-lie, for example." V21 clarified that the resident would not be able to stay in a turned position on their own. V21 gave an example stating that the facility pretty much does not use side rails so if a resident does not have anything to hold onto and keeps falling back from a turned position then that resident would require a two-person assist, one to hold onto the resident and the other to provide the incontinence care.

R1's 7/20/23 Right hip and pelvis x-rays done at the facility document, in part, "Impression: Right

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S9999	Continued From page 5 hip pinning with fractures to the right superior and inferior pubic rami." R1's 7/20/23 ED (Emergency Department) Provider note authored by V20 (ED Physician) documents, in part, that R1 was diagnosed with a closed nondisplaced fracture of the right acetabulum and a closed fracture of the right pubis. R1's care plan initiated on 3/9/19 documents, in part, "Fall: (R1) is at high risk for falls r/t (related to) weakness and limited mobility secondary to type 2 DM (Diabetes Mellitus), asthma, anxiety, osteoarthritis, hypertension and anemia." Interventions include but are not limited to "Anticipate and meet the resident's care and safety needs." The 10/2021 "Fall Prevention and Management" facility policy documents, in part, "This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all 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." (B)	S9999		