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 01/17/2024

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 Investigation Survey : 2470101/IL168414-300.615 e)f) cited 2470182/IL168510	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.	S9999		

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This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to submit background checks, check the Illinois Department of Corrections (IDOC) website, and check the Illinois State Polcie (ISP) website within 24 hours of admission.

This applies to 4 of 4 residents reviewed for criminal background checks in the sample of 17.

The findings inlcude:

R3's Resident Background Check Checklist shows R3 was admitted on 11/7/22. R3's Criminal Background Check is dated 1/8/24. There were no ISP or IDOC checks provided for R3.

R4's Resident Background Check Checklist shows R4 was admitted 9/12/23. R4's Criminal Background Check is dated 1/11/23 (8 months prior to admission). There were no ISP or IDOC checks provided for R4.

The facility could not provide any background checks on R14.

R15's Resident Background Check Checklist shows R15 was admitted 3/14/23. R15's Criminal background check is dated 1/10/24 (almost 10 months after admission). There were no ISP or IDOC checks provided for R15.

On 1/11/24 at 9:50 AM, V1 Administrator said resident background checks should be done upon admission. V1 said she was not sure why R3, R4, R14, R15's were not done.

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On 1/11/24 at 10:37 AM, V14 Admission Director said once we get a resident referral and the resident is accepted we run the IDOC and the ISP checks. V14 said if there is no hits, they accept the resident. V14 said once the resident is in the building they run the criminal background checks. V14 said she ran R14's background check on 1/10/24 and was waiting for the results. V14 said she could not find any other background checks for R3, R4, R14 or R15.

The facility's Abuse Policy and Prevention Program dated 10/2022 shows "This facility shall check the criminal history background for any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will: Request a Criminal History Background Check within 24 hours after admission of a new resident, Check for the resident's name on the Illinois Sex Offender Registration Web site, Check for the resident name on the Illinois Departrment of Corrections sex registrant search page."

(C)

2 of 3 Violations

300.1210b)
300.1210d)6
300.3210t)

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

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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.

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 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review the facility failed to ensure residents were free from physical abuse. This applies to 4 of 4 residents (R3, R4, R14 and R15) reviewed for abuse in the sample of 17. This failure resulted in R3 being hospitalized with multiple facial fractures.

The findings include:

1. On 1/10/24, R3 was sitting in his room. R3 had bilateral periorbital bruising and both of his

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eyes were red.

On 1/10/24 at 10:45 AM, R3 said that he got punched multiple times by R4 and he now has an orbital fracture and nasal fracture. R3 said that his eyes were swollen shut for quite some time as well. R3 said that he now has daily headaches. R3 said that he went into R4's room to deliver him some things that he had purchased for him and R4 got upset with him. R3 said that at first they were both standing in the room yelling at each other and then R4 started punching him in the face. R3 said that he then started punching R4. R3 said that he eventually tripped over the edge of the bed and fell to the floor and R4 got on top of him and was punching him in the face multiple times. R3 said that he was sent to the hospital after the incident. R3 said that R16 was in the room and witnessed the incident.

On 1/10/24 at 10:51 AM, R16 said that he was in the room when R3 and R4 had an altercation. R16 said that they first started arguing about money or something. R16 said then they started pushing each other and then they started punching each other. R16 said that R3 fell on the ground and R4 was on top of him and they were punching each other.

On 1/10/24 at 1:39 PM, V3 (Nurse Practitioner) said that she saw R3 when he returned from the hospital. R3 received multiple facial fractures from the incident that happened.

R3's Minimum Data Set Assessment Dated 11/9/23 shows that his cognition is intact. R3's Nursing Notes dated 1/1/24 at 3:45 PM shows, "Writer walked into room [R4's previous room] and noted [R4] on top of a this resident that is from [R3's room number], this resident is face

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down on the floor and they have been fighting and resident is in a hold.........noted this resident face swollen, and noted bleeding....." R3's Hospital Notes dated 1/2/24 shows, "Patient got punched in the face multiple times. Ended up sustaining left orbit fracture and bilateral nasal fractures. Patient's eyes quite swollen and difficult for him to see out of these." R3's After Visit Summary from the local hospital shows that R3 was admitted to the hospital on 1/1/24 with multiple facial fractures and discharged on 1/4/24.

R4's Minimum Data Set Assessment dated 12/24/23 shows that his cognition is intact. R4's Nursing Notes dated 1/1/24 at 9:21 PM shows, "Resident arrested by police."

R3's Final Facility Reported Incident dated 1/8/24 shows, "Interview of alleged victim: [R3] went to the store and upon return, brought items to the room.......[R4] allegedly hit him in the face. R3 hit him back and fell to floor. [R4] got on top of him and hit him in face a few more times......Interview of alleged perpetrator: ...[R3] hit him in the face which started the fight. [R3] fell to ground and he got on top of him and hit him....Police arrive and removed him from the facility....."

The facility's Abuse Policy and Prevention Program dated 10/2022 shows, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means.

2. On 1/10/24 at 10:30 AM, R15 was sitting in his room. R15 said that the other day, his mother, his roommate (R17) and himself were in his room getting ready to go for a walk when R14 came into their room. R15 said that R17 asked him to

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leave and he did not. R15 said that then his mother told R14 that it was not his room and he needed to leave. R15 said that at that time, R14 'lunged" at his mom and said, "Who's going to make me?". R15 said that at that time he told R14 that he needed to leave since he was threatening his mother. R15 said that R14 then took a piece of a hard plastic cup that looked like a knife and cut him on the back of his head/neck area and punched him in the face/throat area. R15 said that at that time, he punched R14 and R14 fell down and he punched R14 him multiple times. R15 showed this surveyor a piece of paper that was a court document showing that R14 has a court hearing set for 1/29/24 for the charges of battery.

On 1/10/24 at 10:30 AM, R17 said that R14 had walked into the room and he had told him to leave because it was not his room. R17 said that then R15's mother told him that he needed to leave and R14 started saying "stuff" to her so R15 started yelling at him. R17 said that he took R15's mother out of the room when R14 and R15 started hitting each other.

R15's Minimum Data Set Assessment dated 10/16/23 shows that his cognition is intact. R15's Nursing Notes dated 1/1/24 at 9:00 PM shows, "Writer performing rounds at this time and observed resident in a physical altercation with another peer. Writer observed resident [R15] seated in wheelchair with right fist clenched striking resident [R14] while resident [R14] striking resident [R15] with clenched fists......Resident [R15] states, he just walked into my room, I asked him to leave and he wouldn't. Then he started threatening me and my mom, then he tried to cut me with a sharp piece of plastic so I defended myself and I had to make

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sure my mom was ok. Police assistance requested.....Staff observed sharpened plastic from drinking cup on resident [R14] persons. Item confiscated and given to PD (Police Department). Writer performed body gram, noted thin laceration to right side of back of head noted 10 cm (centimeters) in length, minimal bleeding observed. Swelling to left side of mandible, measured 6 cm...."

R14's Minimum Data Set Assessment dated 11/20/23 shows that his cognition is impaired. R14's Behavior Care Plan created on 1/8/24 shows, "[R14] is observed by staff to be easily agitated due to confusion and cognitive deficits, becoming physically aggressive towards other staff and residents, along with being difficult to redirect." R14's Nursing Notes do not document anything about the incident on 1/1/24.

The facility's Abuse Policy and Prevention Program dated 10/2022 shows, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means.

(A)

3 of 3 Licensure Violations

300.1210b)
300.1210d)6

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

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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.

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 observation, interview, and record review the facility failed to ensure safety interventions were in place for a resident with a history of seizures for 1of 3 residents (R5) reviewed for safety in the sample of 17. This failure resulted in R5 having seizure like activity and falling from his wheelchair sustaining frontal skull fractures and a laceration.

The findings include:

On 1/8/24 at 12:00 PM, R5 was sitting up in a high back wheelchair in the dining room. R5 had a laceration on the right towards the middle his forehead, starting in R5's hairline and going down his forehead approximately one inch. R5's laceration was crusted with dried blood. R5 was alert but not able to answer any questions. V18 (R5's wife) said R5 fell out of his wheelchair on

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Friday morning (1/5/24) and had just returned from the hospital last night (1/7/24). V18 said the nurse said R5 had a big yawn and leaned over. V18 said the paramedics told her R5 had a seizure. V18 said R5 hit his head on the floor and has stitches in his forehead and sinus cavity fractures. V18 said the nurse could not tell her if R5 had the leg rests on in the wheelchair. V18 said R5 has had seizures before and staff is supposed to keep an eye on him and have his leg rests on the wheelchair for support.

R5's Facility Reported Incident Report dated 1/8/24 shows R5 on 1/5/24 "nurse noted resident had a fall; 911 notified; resident sent to hospital for evaluation and treatment; upon return 1/7/24, record review show resident sustained a depressed communicated fracture of the right frontal sinus."

On 1/10/24 at 10:12 AM, V16 Licensed Practical Nurse (LPN) said she was working when R5 fell but was not the nurse assigned to R5. V16 said V23 LPN told her R5 fell and she went down the hall to see him. V16 said R5 was on the floor right outside his room. V16 said V23 told her R5 was sitting in the chair, yawned, jerked and then fell out of the chair. V16 said R5 had bleeding from his head and V23 said he hit the floor hard with his head. V16 said V23 called 911. V16 said she was not aware that R5 had epilepsy until she looked up R5's history. V16 said R5 was twitching on the floor and shaking uncontrollably.

On 1/10/24 at 12:11 PM, V19 and V20 Certified Nursing Assistant (CNA) said they were working on other halls and heard the nurse call for help. V19 said she saw R5 on the floor and he was not alert or talking, and was bleeding but she was not sure where it was coming from. V20 said when

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she approached R5 on the floor he was twitching and was bleeding from the nose and the head. V20 said R5 was on the floor in the hall in front of the door to his room. V20 said R5's wheelchair did not have leg rests on.

On 1/10/24 at 12:23 PM, V21 CNA said she was taking care of R5 that shift. V21 said R5 was trying to get out of bed, so her and another CNA transferred R5 to his wheelchair. V21 said R5 has a high back wheelchair and is supposed to have leg rests on but they were not in his room so she didn't put them on. V21 said she was pushing R5 out of his room and had just gotten out the door and into the hall when she stopped for a moment. V21 said R5 started to yawn and then leaned forward and fell. V21 said she tried to catch R5 but it happened so fast. V21 said she was directly behind R5's wheelchair and couldn't stop him. V21 said R5 hit the floor really hard and then started having a seizure. V21 said she was not aware of R5 having a history of seizures or any seizure precautions. V21 said R5 can't propel himself in the wheelchair and is supposed to have leg rests for stability.

On 1/10/24 at 10:35 AM, V3 Nurse Practitioner (NP) said R5 fell out of his wheelchair face first and hit his face. V3 said R5 has a laceration on forehead with sutures and had facial fractures from his fall. V3 said R5 has had a couple seizures since admission.

On 1/10/24 at 2:52 PM, V23 LPN said she was the nurse on duty for R5 when he fell. V23 said she was at the nurses station and saw V21 push R5 out of the room and then stop. V23 said R5 yawned loudly and then leaned forward like he was resting his head on his knees and then fell out the wheelchair. V23 said R5 hit his head hard

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on the floor. V23 said she went to R5 and he had blood on the right side of his forehead. V23 said R5 wasn't talking, was breathing, and then had some seizure like twitching behavior for less than a minute. V23 said she called 911. V23 said R5 was in a high back wheelchair with no leg rests prior to leaning forward. V23 said she didn't know R5 has history of seizures or what seizure precautions he was supposed to have.

On 1/10/24 at 1:35 PM, V3 NP said R5 should have seizure precautions in place to keep him safe and prevent injury. V3 said it should be part of his Care Plan. V3 said leg rests on the wheelchair are for positioning and support and also a fall prevention to keep the legs from getting caught under neath the wheelchair causing injury or causing the resident to fall forward.

On 1/11/24 at 9:15 AM, V24 Restorative CNA said R5 can't his move legs on command due to cognition and can't propel himself in wheelchair. V24 said R5 has leg rests so that the doesn't put his feet down when you are pushing him and get his legs underneath making him fall forward. V24 said R5 should have leg rests on when in the wheelchair.

On 1/11/24 at 9:30 AM, V25 Physical Therapy Director said leg rests on wheelchairs are for positioning and support. V25 said if a resident is unable to propel themselves the wheelchair should have leg rests on. V25 said R5 should be in a high back wheelchair with leg rests for positioning and support.

R5's Hospital Encounter Notes dated 1/5/24 shows "patient lives in a nursing home and was sitting in the chair, per Emergency Medical Service (EMS) fell forward and hit his head on the

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ground per EMS that was due to seizures. EMS noticed patient was post ictal on arrival. EMS brought patient to the emergency room (ER) and patient had another seizure in the ER. Also there is a laceration on the right forehead absorbable stitches were placed. CT head showed depressed commuted fracture involving the anterior wall of the right frontal sinus with fluid, hemorrhage and air extending into the right frontal sinus and right anterior ethmoidal air cells. Patient baseline is mostly bed bound and wheelchair bound at nursing home and the last seizure was about 2 or 3 moths ago per wife."

R5's Nurse Practitioner Progress Note dated 1/8/24 shows "R5 was hospitalized after he fell forward out of his wheelchair and his his head. R5 experienced a seizure in the ambulance as well as one in the emergency room. Sustained a laceration to his right forehead that required stitches in the emergency room. CT of the head showed a depressed commuted fracture of the anterior wall of the right frontal sinus with fluid. Depakote increased to 1000 mg twice daily. Monitor. Seizure precautions per protocol."

R5's Face sheet shows R5 was admitted on 1/25/23 with diagnoses of unspecified psychosis, epileptic seizures related to external cause, dementia, depression and anxiety.

On 1/10/24 at 11:21 AM, V2 Director of Nursing said R5 has a history of seizures but was not sure what seizure precautions R5 was supposed to have and if R5 had them in place.

On 1/10/24 at 11:30 AM, V1 Administrator said the facility should have some sort of seizure precaution protocol or procedure to put in place for residents with seizures.

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 01/17/2024

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 13 R5's Fall Risk Evaluation dated 10/25/23 shows R5 is at high risk for falls related to: decreased mobility, predisposing conditions of hypertension, cerebral vascular accident, hypotension, and seizures, mentation-confused, impaired memory or judgement, and history of falls. R5's Minimum Data Set dated 10/25/23 shows R5 has severely impaired cognition, uses a wheelchair, and is dependent on staff for mobility in wheelchair. R5's Care Plan shows R5 is at high risk for falls related to weakness, limited mobility, and cognitive impairment secondary to dementia, psychosis, and anxiety. This same Care Plan does not address R5's seizures or contain seizure precautions. R5's Physician Orders shows R5 is on divalporex twice daily for epileptic seizures but does not contain any orders for seizure precautions. R5's Nurse Practitioner Progress Note dated 10/31/23 shows "called to patient's room as it was reported that he was experiencing a seizure. Staff witnessed that he became glassy eyed and then his extremities began shaking. May have lasted 1 minute. Witnessed seizure just occurred and now patient is post ictal but stable. Post seizure monitoring. Seizure precautions per protocol." R5's Progress Note dated 11/21/23 shows "resident was in wheelchair complained of "I cannot see anymore," Observed resident sitting in wheelchair eyes rolling to back of head and not responding to stimuli for 30 seconds. Resident then flinched and became responsive."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIA OF WESTMONT	**6501 SOUTH CASS WESTMONT, IL 60559**

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S9999	Continued From page 14 The facility's Seizure Precaution Policy dated 10/2023 shows "to put appropriate precautions in place for a resident who has a history of seizures. The care plan coordinator will be notified of the resident's seizure diagnosis and an appropriate care plan put into place." The facility's Fall Prevention and Management Policy dated 9/2023 shows "while preventing 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." (A)	S9999		