Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6009930		( ' ' ) ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED  C 04/26/2024	
		B. WING					
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BRIA OF	WESTMONT		UTH CASS ONT, IL 60559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPL DATE	
S 000	Initial Comments		S 000				
	Complaint Investiga	ation: 2473063/IL172074					
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations					
	300.610a) 300.1010h) 300.1210b) 300.1210d)3)						
	Section 300.610 Re	esident Care Policies					
	procedures governing facility. The written be formulated by a land Committee consisting administrator, the admedical advisory coof nursing and other policies shall comply The written policies the facility and shall	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed					
	Section 300.1010 N	ledical Care Policies					
	of any accident, injuing resident's condition to safety or welfare of a limited to, the preser decubitus ulcers or a percent or more with	notify the resident's physician ry, or significant change in a that threatens the health, a resident, including, but not noce of incipient or manifest a weight loss or gain of five hin a period of 30 days. The not record the physician's plan					

**Electronically Signed** 

6899

05/07/24

DN0M11

PRINTED: 05/22/2024 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 04/26/2024 IL6009930 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 SOUTH CASS **BRIA OF WESTMONT** WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 Continued From page 1 S9999 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

These requirements were not met as evidence by:

3) Objective observations of changes in a

emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the

resident's condition, including mental and

seven-day-a-week basis:

resident's medical record.

Based on interview and record review, the facility failed to notify the physician of a change in the resident's condition in a timely manner. This failure resulted in a delay in treatment for R1, who experienced a decrease in activities of daily living and increased pain after sustaining a right hip fracture following a fall 4 days earlier. This

applies to one of three residents (R1) reviewed

Illinois Department of Public Health

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Illinois Department of Public Health

AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		COM	(X3) DATE SURVEY COMPLETED  C 04/26/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BRIA OF	WESTMONT		UTH CASS ONT, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE		
S9999	for accidents in a s	sample of eight.	S9999				
	Agent) said R1 wa February 22, 2024 ER (Emergency R right wrist fracture she had right hip p	at 09:47 AM, V9 (Insurance s in the facility and had a fall of . V9 said R1 was sent to the oom) and was found to have a . V9 said on February 27, 2024 ain and it was unclear whether said an X-ray was done, which	4				
	Therapist) said she V3 said R1 fell on the facility the sam on February 23, 20 evaluation, R1 had was non-weight be prior to the fall, R1	at 01:36 PM, V3 (PT/Physical e evaluated R1 after her fall. February 22, 2024, returned to be night, and she evaluated her 024. V3 said during her d a cast on her right arm and earing to the right arm. V3 said was independent with without an assistive device.	•				

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V3 said after the fall, R1 was not able to get up. V3 said R1 can be confused, but when it comes to pain, she knows. V3 said when she tried to move R1's right leg, R1 started to exclaim "ow!" and was tapping her right hip. V3 said when she asked her where her pain was, R1 pointed to her right hip. V3 said she tried to get R1 to sit on the edge of the bed, but she was unable to do so because of her pain. V3 said R1 was in pain even during passive range of motion exercises. V3 said she spoke to the floor nurse about R1 and communicated the resident was not able to sit at the edge and even a little movement caused R1 to complain of pain. V3 said she discontinued treatment for R1 because she was unable to conduct the therapy and wanted to wait until diagnostics were completed for the resident.

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED		
		IL6009930	B. WING		C <b>04/26/2024</b>	
	PROVIDER OR SUPPLIER WESTMONT	6501 SOU	DDRESS, CITY, STATE, ZIP CODE  UTH CASS  ONT, IL 60559			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S9999	On April 23, 2024 a Therapy Aide) said February 25, 2024 said on February 25 treatment with R1, the right leg and so ask if there were ar she mainly did active for the left leg beca and when she tried exercises for the rigand was unable to February 26, 2024, the NP (Nurse Practo the treatment. VR1, R1 wanted to ut to sit R1 on the edged os o because of Riguarding.  On April 23, 2024 a Practical Nurse) said 2024 from 7 AM to 23, 2024, the PT has was complaining of assessed R1 to not pain but had to leavendorsed to the new waiting for a call bashe wrote a note in Record) and told the On April 24, 2024 at (RN/Registered Nurher to call the doctonurses chart someth oncoming shift know called the doctor imunable to reach the	t 2 PM, V4 (PTA/Physical she worked with R1 on and February 26, 2024. V4 5, 2024, prior to starting R1 was complaining of pain in she spoke with the nurse to by restrictions for R1. V4 said or range of motion exercises use the right leg was painful, to do passive range of motion ght leg, R1 complained of pain colerate it. V4 said on she spoke with the nurse and citioner) about R1's pain prior 4 said during her session with se the toilet so V4 attempted the of the bed but was unable to 1's pain, grimacing, and to 02:12 PM, V5 (LPN/Licensed and she worked on February 23, 3 PM. V5 said on February and told her during therapy, R1 pain in her hip. V5 said she ify her physician of the hip are a message. V5 said she at shift nurse that she was ck, and to follow up. V5 said the EMR (Electronic Medical e supervisor.	S9999			

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6009930	B. WING		04/2	26/2024
NAME OF PROVIDER OR SUPPLIER STREET ADI  BRIA OF WESTMONT 6501 SOU		ADDRESS, CITY, STATE, ZIP CODE OUTH CASS ONT, IL 60559				
	CUINANA DV OTA					-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
\$9999	was the nurse on do noticed R1's wrist wout to the ER and register wrist. V6 said "kind of bed bound, if someone touched (Certified Nurse Assher, she would screnurse's had passed waiting for a call from On April 25, 2024 at was not made aware February 26, 2024, never discussed with but it was her expectange in condition complaining of hip pan X-ray right away. February 26, 2024 was returned to the first way for the EMR (Electronic diagnoses including difficulty in walking, dysphagia, fracture Intertrochanteric frapsychosis, dementic chronic kidney disease osteoarthritis. R1's dated March 28, 2000 cognitive impairment eating, partial assist body dressing, and toileting hygiene, shid ressing, putting on personal hygiene.	at 04:40 PM, V6 (RN) said she uty when R1 fell. V6 said she was crackling, so she was sent eturned with a fracture of the when R1 returned, R1 was." V6 said R1 would be crying d her, and when the CNA's sistants) were trying to change eam. V6 said none of the d along to her that they were	S9999			
10	K is progress notes	documents the following:				

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/22/2024 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED. A. BUILDING: \_ B. WING IL6009930 04/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 SOUTH CASS **BRIA OF WESTMONT** WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG DEFICIENCY) S9999 S9999 Continued From page 5 On February 22, 2024 at 06:17 PM, V6 wrote. "Resident was witnessed by staff stumbling over and fell on her right side in the hallway. Staff immediately notified writer. Writer assessed resident and V/S (Vital Signs) were stable. During assessment writer noticed a lump above resident's right eye. No other bruising was noted. Resident complained of pain and discomfort on the right side of the face, right shoulder, right arm, and right leg. Writer immediately applied ice pack to right eye to decrease swelling. Staff helped assist resident to bed via [mechanical] lift. Residents' family, DON (Director of Nursing), and NP were notified. Resident is immediately being sent out to [Hospital] via ambulance with all paperwork." On February 22, 2024 at 10:42 AM, V6 wrote, "Resident returned from [Hospital] with all paperwork. V/S were stable. Resident returned with a closed fracture of the right wrist. Resident will need assistance with ADLs (Activities of Daily Living). Resident returned with a new medication order of hydrocodone. Resident is currently in bed resting, will continue to monitor." On February 23, 2024 at 12:44 PM, V5 wrote, "Writer received a script for residents signed by NP hydrocodone-acetaminophen (5-325), faxed to pharmacy, resident in stable conditions, resting in bed all needs attended to, no signs of distress

Illinois Department of Public Health

on going."

or discomfort, PRN (As Needed) given r/t (Related To) pain in right hand d/t (Due To) fracture that occur d/t recent fall on 2/22/24. Resident kept comfortable. call light in reach care

On February 23, 2024 at 03:31 PM, V5 wrote, "Writer informed that while resident was in PT/OT

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today for right hip pain, [X-Ray] reviewed and shows right hip impacted intertrochanteric fracture. Discussed with DON likely occurred during previous fall."

V3's Summary of Skill, written on February 23, 2024, showed "Therapist initiated moving R LE (Right Lower Extremity) however patient c/o pain, refusing to move the leg. Patient unable to tolerate [PROM/Passive Range of Motion] and {AROM/Active Range of Motion] on RLE and pointed on [Right] anterior hip as location of pain, unable to roll and perform bed mobility. Nurse notified."

V4's Summary of Skill, written on February 25, 2024 showed, "[Patient] report of pain on [Right] knee during [Range of Motion], nothing on [Right] hip for today's session, initially only able to tolerate 5 reps during PROM on RLE however with repetition [Patient] was able to tolerate 10 [Times]. Nursing is aware regarding [Patient] report of pain. [Patient] was seen at bedside."

Illinois Department of Public Health

**FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING IL6009930 04/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 SOUTH CASS **BRIA OF WESTMONT** WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG** DEFICIENCY) S9999 Continued From page 7 S9999 On February 26, 2024, V4 wrote, "Coordinated with NP and nursing regarding [Patient] report of pain and if therapy can continue, per NP and nursing [Patient] can continue with therapy. Attempted to work on sitting on [Edge of Bed] as [Patient] reporting of wanting to use the toilet during this attempt [Patient] started screaming despite not being able to move [Bilateral Lower Extremity], [Patient] reporting of R knee pain." The facility's Physician Notification policy reviewed in September 2023 showed In a non-emergent, but acute medical situation the physician will be paged and if there is no return call in 30 minutes, the physician will be notified again. If there is no return call in 30 additional minutes (30 minutes total), the Medical Director will be notified. (B)

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