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 05/22/2024

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
S 000	Initial Comments Investigation of Facility Reported Incident of 4/29/2024 IL173029	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 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 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. 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.	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 05/22/2024

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 1	S9999		

This requirement was not met as evidence by:

Based on observation, interview, and record review the facility failed to use a two person assist to safely turn a resident requiring a two a person assist during cares. This applies to one (R2) of three residents reviewed for safety/supervision in the sample of seven. This failure resulted in R2 faling off the bed and sustainting a laceration to the forehead requiring sutures.

The findings include:

On 5/22/2024 at 10:29AM, R2 was observed laying in bed in her room. R2 had approximately ½ to ¾ inch scar in the hairline of her left eyebrow. R2 appeared to have limited range of motion to all four extremities.

On 5/22/2024 at 11:21AM, V8 Certified Nursing Assistant (CNA) said on Sunday 4/28/2024 he was providing incontinence care for [R2] between 9:00PM and 10:00PM. V8 said he was providing care to [R2] alone without the assistance of other staff. V8 said he turned [R2] to her right side and because she was on an air mattress she began to slide out of bed. V8 said he was unable to stop [R2] from sliding out of bed and she fell out of bed and onto the floor. V8 said [R2] was sent to the hospital for treatment. V8 said [R2] is a 2 person assist with transfers and incontinence care. V8 said they use two people for safety reasons. V8 said residents can slide on the air mattresses. V8 said [R2] returned from the hospital later that night with sutures above her eye.

On 5/22/2024 at 11:52AM, V10 Nurse Practitioner (NP) said [R2] was sent out to hospital following

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 05/22/2024

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 2 the fall. V10 said [R2] had sutures placed due to the fall and the laceration she sustained. On 5/22/2024 at 11:40AM, V2 Director of Nursing (DON) said [R2] is a two person assist with transfers and turning. V2 said they use two people for safety reasons, due to [R2's] limited mobility. V2 said [R2] is on an air mattress and they can be slippery. V2 said two people should be used if the resident is a 2 person assist. V2 said [R2] was sent to the hospital following the fall. V10's Progress Note dated 4/30/2024 notes physical exam other left side forehead 9 sutures - left cheek abrasion. R2's Progress Notes dated 4/28/2024 state the resident fell out of bed during a brief change and landed on the floor. R2 was sent to the hospital with emergency medical services. R2's Progress Notes dated 4/29/2024 state the resident hospital diagnosis was fall with laceration to the left forehead. Resident returned to the facility at 2:08AM on 4/29/2024 with sutures in place to the left forehead area. R2's Care Plan dated 4/23/2024 lists Bed Mobility as a focus with interventions including Dependent 2 person assist initiated on 4/24/2017. R2's Care Plan dated 4/23/2024 lists ADL (activities of daily living) toileting every two-hour dependent 2 assist. (B)	S9999		