STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145405	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Westmont	6501 South Cass Westmont, IL 60559

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on interview and record review the facility failed to correctly transcribe and reconcile a resident's hospital discharge medication orders upon readmission to the facility for one resident (R1) of three residents reviewed for medications orders received upon admission/readmission to the facility in a sample of three. This failure resulted in R1 being prescribed and administered the wrong medication regimen, including an opioid, antibiotic and anticoagulant medications resulting in R1 having a change in condition that required transfer to the local hospital emergency room with subsequent hospital admission. The findings include: R1's EMR (Electronic Medical Record) showed R1 was [AGE] years old and admitted to the facility on [DATE], initially, and transferred to the hospital for psychiatric symptoms on March 21, 2024. R1 was readmitted to the facility on [DATE]. R1 had multiple diagnoses including spinal stenosis, Alzheimer's disease, protein calorie malnutrition, bipolar disorder, history of suicide ideation and suicide behavior. R1's MDS (Minimum Data Set) dated April 7, 2024, showed R1 with severe cognitive impairment, and required staff assistance with ADLs including dependent on staff for toilet hygiene, lower body dressing, required substantial assistance with transfer, upper body dressing and bathing and supervision/set up assistance with eating and bed mobility. On April 17, 2024, at 12:18 PM, V4 (Physician) stated R1's readmission medication orders were verified by an on-call Physician, however when V4 was approached on April 3, 2024, by the facility nurse to sign a prescription for Buprenorphine, an opioid medication for R1, V4 stated he refused to sign the prescription and instructed the nurse to contact the Psychiatrist at the hospital R1 was readmitted from. V4 stated R1 was not receiving that medication prior to hospitalization and V4 did not think the opioid medication was needed for R1. V4 stated he did not know the name of the facility nurse he had spoken to. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Actual harm Residents Affected - Few	On April 17, 2024, at 5:07 PM, V8, (RN (Registered Nurse)) stated she had processed R1's admission orders on April 1, 2024, and was working on April 3, 2024. V8 stated she prepared the prescription for Buprenorphine (opioid medication) for R1 and asked V3 (Nurse Practitioner) to sign the prescription for the opioid medication on April 3, 2024. V8 stated she had previously taken care of R1 prior to her hospitalization and readmission but did not realize that the discharge orders from the hospital had a different patient's name on the page and processed the orders for R1. On April 17, 2024, at 12:18 PM, V3 (Nurse Practitioner) stated she was presented a prescription form to sign on April 3, 2024, that had been prepared by a facility nurse. V3 stated she signed the prescription as a continuation of a medication that was initiated in the hospital and stated she was not starting the medication for R1. V3 stated at the time the prescription for Buprenorphine (opioid medication) was presented to her for signature, V3 was unaware of V4's objection to signing the prescription and was not aware that V4 had instructed the facility nurses to contact the Psychiatrist regarding the medication. V3 also stated she had not seen the discharge medication list for R1 from the hospital. On April 18, 2024, at 10:15 AM, V9 (Pharmacist, Director of Clinical Services for the Pharmacy) stated the only FDA (Federal Drug Administration) approved use for the opioid medication that R1 had been prescribed was for the treatment of opioid dependence. Davis's Drug Guide for Nurses, 14th edition show side effects including confusion, hallucination, and sedation for Buprenorphine HCL. R1's EMR did not contain a medical diagnosis of opioid dependence. On April 17, 2024, at 5:07 PM, V8 (RN) stated she observed a change in mental status, increased lethargy, of R1 on April 5, 2024, and reported the change to V3. V8 stated in response V3 ordered laboratory tests be done. V8 stated when she worked on April 7, 2024, R1 was observed to be more lethargic, would not open her eyes or take any food or fluids and contacted V4 who ordered R1 be sent to the hospital emergency room for evaluation. R1's medical records showed the medication orders for R1 on March 21, 2024, at the time of discharge to the hospital, compared to R1's medication orders implemented on April 1, 2024, were completely different medications. R1's MAR (Medication Administration Record) for April 2024 showed that R1 received the following medications while at the facility that had not been ordered for R1 prior to April 1, 2024. 1). Buprenorphine HCL (opioid) 2 mg was given once on April 4, April 5; and twice on April 6, 2024. 2). Apixaban tablet (anticoagulant) 5 mg was given two times a day on April 2, April 3, April 5, April 6, 2024 and once a day on April 1 and April 4, 2024. 3). Cephalexin (antibiotic) 500 mg was given 4 times per day on April 2, April 3, April 4, April 5, April 6, 2024; and 3 times on April 1, 2024. 4). Albuterol Sulfate HFA 108 mcg/ACT (inhaler) was given 4 times a day on April 2, April 3, April 5, April 6; 3 times a day on April 4 and twice a day on April 7. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	5). Cardizem LA tablet extended release (Antihypertensive medication) 180 mg was given once on April 2, April 3, April 4, April 5, and April 6, 2024. 6). Metoprolol tartate (Antihypertensive medication) 25 mg was given two times a day on April 2, April 3, April 5, and April 6, 2024; once time a day on April 1 and April 4, 2024. 7). Venlafaxine HCL ER (antidepressant) 150 mg was given twice a day on April 2, April 3, April 5, April 6, 2024 and once a day on April 4, 2024. 8). Levothyroxine sodium (medication to treat hypothyroidism) 150 MCG was given once a day on April 2, April 3, April 4, April 5, and April 6, 2024. V2 (DON (Director of Nursing)) stated on April 17, 2024, at 10:46 AM, that she became aware of the medication error on April 7, 2024, when the hospital requested R1's medication orders be clarified. V2 stated it was on April 7, 2024, when V2 reviewed R1's discharge documents from the hospital that V2 recognized the documents had R1's name on them, but the discharge order summary had a different patient's name on them, and that patient did not reside in the facility. On April 7, 2024, at 11:30 AM, R1's ED (Emergency Department) note written by V12 (Physician Emergency Department) documented that R1 had received completely different medications than that were originally ordered upon discharge to the nursing facility. V12 documented since both hospitals were part of the same health system, V12 was able to access the records for R1 from the previous hospital. V12 documented R1 received anticoagulant medication that was not previously ordered, an antibiotic and opioid medication at a higher dose than would be expected for an [AGE] year-old. V12 documented R1's assessment at the time of transfer to the ED, showed R1 was lethargic, noncommunicative, and pupils were constricted but reactive. V12 documented that R1's urine test showed ketones +80 and V12 opined that the test results were indicative of R1 being too sedated to eat or drink while in the nursing facility. V12 documented that R1's progressive change in condition appeared pretty severe and was secondary to R1 receiving an aggressive overall med change. V12 admitted R1 to the hospital for further observation. R1's hospital record showed R1 remained in the hospital from April 7, 2024, through April 15, 2024, when R1 discharged to a different nursing facility. The facility's policy titled Admission/Re-admitted d reviewed April 2024, showed .g. All medications should be reconciled with the resident/resident representative and verified with the primary physician or nurse practitioner .h. Physician order sheet should reflect any standing orders specific to the resident as well as medications and treatments that are ordered throughout the stay.