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	08/28/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview, and record review the facility failed to ensure staff were trained on how to care for a resident with a LVAD (Left-Ventricular Assist Device) prior to admission, failed to obtain orders upon admission for a resident's LVAD, and failed to implement the LVAD orders once they were received for 1 of 1 resident (R4) reviewed for quality of care in the sample of 10. The findings include: On 8/28/24 at 10:51 AM, R4 was laying in bed. R4 had an LVAD device in place. R4's Face Sheet shows that she admitted to the facility on [DATE] with the diagnoses of: cerebral infarction, diabetes mellitus, malnutrition, dysphagia, stage 4 pressure ulcer, weakness, anemia, anxiety, hypertensive heart, chronic kidney disease, atherosclerotic heart disease, ischemic cardiomyopathy, atrial fibrillation, heart failure, presence of heart assist device, thrombosis of atrium and ventricular tachycardia. R4's Physician's Order Sheet printed on 8/28/24 shows orders dated 7/14/24 (5 days after admission) for: Check vitals on LVAD reading each shift. Calculate MAP (Mean Arterial Pressure) every BP (Blood Pressure) check. Report MAP < (less than) 60 or > (greater than) 90 for two consecutive readings (MAP GOAL 60-90 mmHg). Contact VAD coordinator for temperature > 100 F (Fahrenheit), weight gain > or = to 2 lbs (pounds) in 1 day/5 lbs in 1 week MAP number has to be between 60-90 every shift .LVAD dressing changes: M (Monday), W (Wednesday), F (Friday) or as needed. Every day shift for infection prevention Monitor LVAD machine if power is on and battery life every shift . R4's Medication Administration Record for July and August shows that R4's MAP was above 90 mmHg 28 times between 7/15/24 and 8/27/24. R4's Nursing Notes from 7/15/24 to 8/27/24 show that the VAD coordinator was notified 4 times of R4's MAP readings above 90 mmHg. R4's July and August Treatment Administration Record (TAR) shows that between 7/15/24 and 8/27/24, R4's LVAD dressing was signed out as changed 6 times and was not signed out as changed 12 times. There was no documentation of R4's LVAD dressing changes in the nursing notes from 7/15/24-8/27/24. R4's Weights and Vitals Summary printed on 8/28/24 shows that she had a weight performed on 7/9/24 and 8/15/24. No other weights were documented. (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

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	08/28/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The VAD In-service presentation shows that a patients MAP goal should be 60-90 mmHg, weights should be monitored daily and dressing changes should be done daily-every 72 hours. On 8/28/24 at 10:50 AM, V22 (Licensed Practical Nurse) said that R4's blood pressure is checked every shift and the MAP is calculated. R4 said that if the MAP is below 60 or above 90, the VAD clinic should be notified. V22 said that it should be documented in the resident's nursing notes if the clinic was contacted. V22 said that he had never taken care of a resident with a LVAD in the past and had not had any training regarding care of a resident with a LVAD until the training the facility provided after R4 admitted . The facility provided schedules shows that V22 was R4's nurse on 7/10/24-7/13/24. The facility provided Education Record shows that V22 received LVAD training on 7/15/24. On 8/28/24 at 11:55 AM, V23 (VAD Clinic Registered Nurse) said that a nursing facility should make sure that all nurses taking care of a resident with a LVAD are fully trained before the resident is admitted to the facility. V23 said that standard of care for a resident with a LVAD include: ensuring the batteries are always charged and the resident's machine is plugged into the wall at night time, sterile dressing changes every Monday, Wednesday and Friday, checking vitals per facility policy and notifying the VAD clinic of any abnormalities including a MAP below 60 or above 90, checking the settings and reporting any abnormalities to the team and notifying the VAD team if there is any alarms. V23 said that daily weights should also be done and any fluctuations should be reported to the VAD clinic. On 8/28/24 at 2:17 PM, V24 (Licensed Practical Nurse) said that she admitted R4 on 7/9/24. V24 said that R4 did not arrive with orders regarding her LVAD. V24 said that she did not do any care with R4's LVAD on the day of admission. V24 said that she notified V4 (Assistant Director of Nursing) that she came with no orders for the LVAD and she said that she would take care of it. V24 said that she is not sure if the batteries got plugged in or not. V24 said that when she spoke to the nurse from the previous facility, she told her that R4 had a LVAD and the batteries should be good until in the AM and she did not have to do anything special. V24 said that she has never had training on how to care for a resident with a LVAD and had never taken care of a resident with one in the past. On 8/28/24 at 2:31 PM, V4 (Assistant Director of Nursing) said that she found out that R4 had a LVAD on the day of her admission. V4 said that they had a resident years ago with a LVAD but none recently prior to R4. V4 said that V3 (Director of Nursing) was notified of her admission and was getting orders for the LVAD. V4 said that herself or V3 would do R4's dressing changes to the LVAD every Monday, Wednesday and Friday. V4 said that once the dressing is done, it should be documented on the TAR or in the nursing notes. V4 said that the facility had their first staff training regarding the LVAD on 7/15/24 (6 days after R4 admitted). V4 said that the last training they had prior to that was when the last resident admitted to the facility years ago. V24 said that vitals should be done every shift and the MAP should be calculated. If the MAP is under 60 or over 90, they should immediately notify the VAD clinic and document that they notified them. V4 said that weights should be done at least weekly, if not daily. V4 said that they are currently checking with the VAD clinic on when they should be done. (continued on next page)

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	08/28/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 2:48 PM, V3 (Director of Nursing) said that they do not have a policy on LVADs but they follow the protocol that they were educated on from the VAD clinic. V3 said that she was aware of R4's admission on 7/10/24 (admitted [DATE]). V3 said that R4 came from an acute care facility with no orders for her LVAD. V3 said that she did not know that R4 had a LVAD prior to admission. V3 said that all nurses should be trained on how to care for a resident with a LVAD prior to taking care of them. V3 said that all MAPs under 60 or over 90 should be reported to the VAD clinic and charted in the record. V3 said that when the order reads consecutive blood pressures, it means that the nurse should verify what the blood pressure is by doing a second blood pressure immediately and if the MAP is still outside of the parameters, they should call the clinic. R4's Care Plan initiated on 7/11/24 shows, [R4 is at risk for complications related to LVAD use and requires close monitoring LVAD checks as ordered, monitor heart rate, rhythm, and batter check/change per protocol . Monitor or any s/s (signs/symptoms) of infection at drive line insertion. Sterile driveline dressing change as ordered Monitor vital signs during routine care and notify MD (Physician) of any significant abnormalities .