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	12/10/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide transfer, toileting and dressing assistance to residents who were dependent on staff for ADLs (Activities of Daily Living). This applies to 7 of 7 residents (R5, R6, R10, R11, R12, R18 and R29) reviewed for assistance with ADLs in a sample of 29. The findings include:1.Face sheet, printed 12/6/25, shows R11's diagnoses included dementia, legally blind, anxiety, mood disorder, depression, and diabetes. MDS (Minimum Data Set), dated 10/15/25, shows R11's cognition was intact, R11 was dependent on staff for toileting hygiene and lower body dressing, required substantial/maximal assistance for showering/bathing, upper body dressing, and personal hygiene, and required partial/moderate assistance for toilet transfers. Review of R11's care plan shows R11 required hand over hand assistance with food and beverages due to a self care deficit in feeding related to visual and cognitive impairments, required substantial/maximum assistance from staff for upper / lower body dressing and personal hygiene, was incontinent of both bowel and blader, required total assist from staff for toileting hygiene, and required a staff to assist R11 to stand and pivot to transfer. On 12/6/25 at 3:01 PM, R11 was sitting in the dining room in his wheelchair with a gown on which was soiled with dried food down the front of the gown. V22 (Family) was standing next to R11 and stated she often arrived to see R11 not dressed. R11 had a very strong smell of urine around him. V22 checked R11's incontinence brief and the brief was bulging and appeared full of urine. V22 stated the brief was soaked with urine and the urine had soaked through to his blanket on the seat of his wheelchair. V23 (LPN- Licensed Practical Nurse) and V9 (CNA - Certified Nursing Assistant) took R1 to his room and V9 left after stating she would be back to help change R11. V22 stood R11 up and R11's incontinence brief appeared to be very heavy and was sliding down R11's waist and legs. There was a very strong and pungent smell of urine in the room when R11 stood up from his wheelchair. V23 stated R11's incontinence brief was soaked with urine and some stool was present in the brief. V9 never returned to assist with R11's care. On 12/6/25 at 3:15 PM, V24 (Assistant Director of Nursing) examined R11's wheelchair and the blanket on R11's wheelchair seat was wet with urine. On 12/6/25 at 3:18 PM, V27 (CNA) stated she last checked / changed R11's incontinence brief between 9:00 AM and 10:00 AM that morning. V27 stated she had not checked / changed his brief since that time because she was busy the whole day. On 12/6/25 at 9:46 AM, V17 (Director of Nursing) stated if a CNA can not assist a resident as requested, another staff should respond. V17 stated nurses are able to assist residents to transfer out of bed. On 12/6/25 at 10:09 AM, V1 (Administrator) stated staff were not to turn off resident call lights if the resident's concerns were not addressed. Facility document Call Light Response, reviewed 9/2025, shows 6. Answer the patient or resident's call as soon as possible. 9. Do what the resident asks of you, if permitted. If you are uncertain as to whether or not a request can be fulfilled or you cannot fulfill the patient/resident's request, ask for assistance. 10. If assistance is needed when you enter the room, summon help to the room. 11. After meeting the patient/resident's needs, turn off the call light. Facility document Incontinence Cand Perineal Care, reviewed 9/2025, shows Perineal care is provided to clean the perineum, prevent infection and odors, and provide comfort. 1. Perineal care is done daily and prn (as needed) for all residents requiring assistance and/or those residents with a foley catheter. 2. Face sheet, dated 12/6/25, shows R5's diagnoses included paraplegia, schizoaffective disorder, conduct disorder, and psychosis. MDS, dated [DATE], shows R5's cognition was intact and R5 required partial/moderate assistance from staff for upper body dressing and was dependent on staff for transfers, toileting, bathing, and lower body dressing. R5's care plan shows R5 transferred utilizing a mechanical lift. On 12/6/25 at 8:10 AM, R5's call light was on, R5 was in bed, and R5 was talking on the phone stating her call light was on for hours and no one was coming to get her out of bed. V8 (LPN) was standing at her medication cart in the hall a few doors from R5's door and R5's call light was on above the door of her room. On 12/6/25 at 8:23 AM, V36 (Transportation) walked into R5's room, turned off R5's call light and walked out of the room. R5 was still lying in her bed. At 8:28 AM, V36 stated she went in to see what R5 needed and turned off the call light before looking for a CNA to tell her R5 wanted to get out of bed. On 12/6/25 at 8:23 AM, R5 stated she originally put her call light on at 5:55 AM because she wanted to get out of bed but the staff turned it off and did not get out of bed. R5 re-activated her call light. On 12/6/25 at 8:26 AM V8 (LPN) was standing at her med cart a few rooms from R5's room and R5's call light was on. On 12/6/25 at 8:32 AM, R5's call light was off and R5 was still in bed. V9 (CNA) walked into R5's room with V10 (CNA) and V9 stated she did not start her shift until 8:00 AM and did not see R5's call light on

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to serve coffee per the facility planned/approved menu. This applies to 5 of 9 residents (R6, R10, R14, R16, R17) reviewed or coffee in a sample of 29. The findings include: On 12/6/25 at 12:42 PM, V10 (CNA - Certified Nursing Assistant), stated during meals the coffee cart initially is placed in the second floor dining room. V10 stated by the time the coffee is served to the dining room residents and the residents receive seconds, there is no more coffee for the residents served in the hallway. V10 stated the staff can call food service for coffee if the coffee runs out on the second floor and will receive it. On 12/6/25 at 9:01 AM, R6 stated the prior week there was no coffee served and the facility runs out of coffee often. On 12/6/25 at 9:14 AM, R10 stated it was hard to get coffee at the facility during meals. V10 stated there was not enough coffee at the facility. On 12/6/25 at 9:18 AM, R14 stated, Sometimes we get coffee, sometimes we don't. On 12/6/25 at 9:25 AM, R16 stated she often did not receive coffee or other beverages during her meals. On 12/6/25 at 9:35 AM, R17 had her breakfast meal served but had no coffee. R17 stated, I drink coffee but I didn't get any. It's missing all the time. They sit it outside and it probably runs out. On 12/6/25 during breakfast service on the second floor at 9:37 AM, V16 (Dietary Aide) stated toward the end of the week the facility runs out coffee and the staff go to the store to by coffee. On 12/6/25 at 10:09 AM, V1 (Administrator) stated the facility should not run out of food because she is able to provide her credit card for food purchases if needed. On 12/6/25 at 3:45 PM with V1 (Administrator), V27 (Dietary Aide) stated the facility has run out of coffee for the residents at times. Facility menus, dated 11/2/25 to 12/14/25, showed coffee was to be served at every breakfast meal daily.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to serve palatable coffee during meals. This applies to 9 of 9 residents (R2, R4, R6, R10, R13, and R28) reviewed for coffee in a sample of 29. The findings include: On 12/3/25 at 2:20 PM, R4 and R28 both stated the coffee served at the facility was horrible and looked and tasted like brown water. There was a disposable cup on R4's dresser with translucent, light brown water in the cup. R4 and R28 both stated the liquid was served that morning at breakfast as the facility coffee. Concern form, dated 12/3/25, shows R4 and R28 reported the coffee was not prepared properly. The form shows V1 (Administrator) met with V28 (Food Service Manager) to review the preparation process, the coffee was observed at dinner on 12/3/25, and a food committee was held on 12/4/25. The form also shows dietary staff were retrained on proper preparation of coffee. On 12/6/25 at 8:29 AM with V8 (Licensed Practical Nurse) during breakfast service, coffee being served to residents at breakfast from the coffee cart was sampled. V8 looked at the coffee and stated, That's rough. Dark. Thicker than I have ever seen. Looks like sludge. On 12/6/25 at 8L55 AM, R2 stated the coffee served at the facility smelled rancid, nasty and burnt and she would not drink the coffee served. On 12/6/25 at 9:01 AM, R6 stated in the past week when they were served coffee, the coffee tasted horrible and you could not drink it if it were served. On 12/6/25 at 9:14 AM, R10 stated it was difficult to get coffee served at the facility and when it was served it tasted poor. On 12/6/25 at 8:57 AM, R13 stated the coffee at the facility did not taste good. On 12/6/25 at 9:37 AM after breakfast on the second floor, V17 (Dietary Aide) poured a sample of coffee from a coffee pot in the hallway used to serve coffee to residents. The color of the coffee was very light and translucent. On 12/6/25 with V1 (Administrator) in the kitchen, there were several packages of instant coffee sitting on the counter next to the coffee brewing machine. V27 (Dietary Aide) and V28 (Food Service Director) stated he used the instant coffee sitting on the counter to brew the coffee that morning for breakfast. On 12/6/25 at 10:09 AM, V1 (Administrator) stated after reports of poor coffee on 12/3/25, V1 stated she sampled the coffee and it did not smell or taste good. V1 stated the day prior the facility bought instant coffee and used the instant coffee from the store to brew the coffee. Facility policy Palatability and Nutritive Value, reviewed 3/9/23, shows, Food will be prepared, held, and served in a manner that preserves nutritive value and palatability.