

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Bria of Geneva		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 East State Street Geneva, IL 60134	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45906 Based on observation, interview, and record review, the facility failed to provide secure wheelchair transportation in facility van/bus for a resident. This applies to 1 resident (R1) reviewed for safe facility van transportation in a sample of 9. The findings include: R1's Face sheet shows diagnoses of morbid sever obesity, abnormalities of gait and mobility, generalized muscle weakness, history of falling, lack of coordination, and peripheral vascular disease. R1's MDS (Minimum Data Set) dated 6/10/24 shows her cognition is intact and she uses a wheelchair. R1's MAR (Medication Administration Record) shows she took PRN (as needed) doses of Tylenol on 7/11/24 at 2224 and again on 7/20/24. On 7/23/24 at 1:50 PM, V7 (Activity Director) said when she was driving the van on 7/11/24, a car drove out in front of her and she braked hard and R1 fell out of her wheelchair. V7 said she parked the van and went back to assess R1, who was sitting on the floor in front of her wheelchair with her left leg extended against the wall of the bus and her right leg extended under the wheelchair of R6, who was sitting right in front of R1. V7 said R1 told her that she was okay but that her feet were hurting. V7 said the other residents on the bus at the time of R1's fall were R6, R7, R8, and R9. On 7/23/24 at 10:48 AM, R1 said she fell out of her wheelchair while being transported in the facility van by V7 (Activity Director) on 7/11/24. R1 said she fell because the seatbelt did not work in the van. R1 said ever since the fall she has had pain in her left foot that she has taken Tylenol for and put ice on to help with the pain. On 7/24/24 at 3:25 PM R1 said she did not have lap belt on when she fell , and she could not recall if she had shoulder belt on. On 7/25/24 at 10:01 AM R1 said it is the facility staff's responsibility to hook everybody in right on the bus and don't cut any corners thinking they're not going to have an accident. On 7/23/24 at 3:10 PM, R7 said on 7/11/24 when he and R1 were on the bus together he recalled hearing V7 (Activity Director) and V13 (Activity Aide) talking and trying to latch R1's seatbelt and having difficulty. R7 said V7 and V13 knew that R1's seatbelt was not latching correctly when they left the facility to go to museum. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 12:28 PM, V7 (Activity Director) demonstrated for surveyor on the facility van/bus how she latched R1's seatbelt on 7/11/24 when R1 fell out of her wheelchair. V7 showed surveyor that she fastened the shoulder belt (attached on opposite end to the wall of the van) to the notch on the center of the lap belt by the red button/release, then she attached one side of the lap belt to the notch on the floor of the bus. V7 said the other side of the lap belt was left hanging and was not attached to anything; it was not a three point restraint. V7 said she thought only the shoulder belt was needed. V7 said every time she has taken residents anywhere in the van, she has only restrained the front wheelchair passenger with the 1 piece shoulder belt and the rear wheelchair passenger with a 2 piece shoulder belt attached to lap belt (but only used as a two point shoulder restraint). On 7/24/24 at 2:06 PM, V1 (Administrator) said after R1's fall on 7/11/24 in the van, V7 demonstrated to him how she fastened R1's seatbelt. V1 said V7 did not use the lap belt correctly, it was used as a shoulder belt and there was no additional lap belt used across R1's lap. V1 said after R1's fall, he assumed it was caused by user error and that was why V1 instructed V11 (Maintenance Director) to inservice V7 again how to correctly fasten seatbelt for wheelchair residents. V1 said I did not come away from it with the faith that V7 was using the equipment correctly. On 7/24/24 at 12:25 PM, V11 (Maintenance Director) demonstrated for surveyor in the facility van that V7 told him the lap belt would not latch, so she removed the lap belt piece and used just the shoulder belt to restrain R1. On 7/25/24 at 3:03 PM, V15 (Hospital Liaison) said she has driven the van and she was inserviced on the correct way to secure a wheelchair resident in the facility van. V15 said she has since then inserviced V16 and V17 (CNA Leads) who also transport wheelchair bound residents on the facility bus. V15 said the correct way to secure a wheelchair resident is to first put the lap belt around the resident's waist, under the wheelchair arms and attach both sides of the lap belt to the notches on the floor behind the wheelchair. V15 said that belt then gets adjusted to make sure it is taut. V15 said after the lap belt is on, the shoulder belt gets pulled across the resident's chest from the wall and attached to the notch on the center of the lap belt. V15 said then the shoulder belt is adjusted to make sure it is taut. V15 said after that is done, you take the wheelchair and wiggle it back and forth to make sure the wheelchair and resident are secure. V15 said both the lap belt and shoulder belt need to be used to properly secure a wheelchair resident because that is best practice. The facility provided restraint User Instructions copyright 2014 state, .SECURE PASSENGER 1. Attach Lap Belts- .feed belts through openings in seat backs and bottoms, and/or armrests to ensure proper belt fit around occupant. A. On the aisle side, attach belt .to rear tie down pin connector .b. On the window side, attach belt .to rear tie down pin connector .2. Attach Shoulder Belt- Extend shoulder belt over passenger's shoulder and across upper torso, and fasten pin connector onto lap belt. 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort. WARNINGS: .Wheelchair Securement System should be used as shown in these instructions .IMPORTANT SAFEGUARDS AND WARNINGS .Compliant Shoulder and Pelvic Belt Restraint must go across occupant's shoulder and pelvis (lap), and not be worn twisted or held away from the occupant's body by wheelchair components. We recommend using both a pelvic and shoulder belt together and not individually since it will compromise the performance of the system .		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to provide resident wheelchairs in safe, operating condition. This applies to 2 residents (R1 and R5) reviewed for safe equipment in a sample of 9. The findings include: 1. R5's Face Sheet shows he was recently admitted to the facility on [DATE]. On 7/23/24 at 10:21 AM, R5 showed surveyor that the wheelchair brake on his left wheel was loose and when in locked position the left wheel could still move. R5 said the wheelchair he was using was provided by the facility. 2. On 7/23/24 at 10:48 AM, R1 demonstrated for surveyor locking her wheelchair on both wheels and she was still able to move forwards and backwards while brakes were in lock position. R1 showed surveyor that her right wheel brake handle was also loose. On 7/25/24 at 1:57 PM, V11 (Maintenance Director) said a wheelchair wash was done in either June or July in the facility parking lot when maintenance is provided to wheelchairs in need. V11 said he could not recall if R1 was there and they did not document any maintenance that was done on the wheelchairs that day. On 7/25/24 at 3:32 PM, V11 said the facility did not have a policy that pertained to maintenance of wheelchairs.		