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 _____	C 09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT NURSING AND REHAB CENTER	**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) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 309 SS=G	Complaint Investigation #1172747 / IL 54407 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to quantitatively assess R3's pain before and after administering pain medication, and failed to follow the physician's order for administrating pain medication. This is for 1 resident (R3) in the sample of 3. These failures resulted in R3 experiencing unnecessary severe pain and discomfort. The findings include: R3 is a severely cognitively impaired resident who was re-admitted to the facility on 9/9/11 with multiple diagnoses including an impacted fracture of the left femur according to the Minimum Data Sets (MDS) dated of 9/21/11. R3 did not exhibit any Behavior Symptoms or Rejection of Care behaviors between 9/14 - 9/21/11 according to the MDS (Section E Behavior). R3 was re-admitted with physician orders for Norco 10 mg/325 mg every 4 hours PRN (as needed) for pain according to the Physician's Order Sheet	F 309		9/27/11

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

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F 309	Continued From page 1 (POS) dated 9/9/11. On 9/14/11 R3's Norco order was changed from PRN to 'give' every 4 hours according to the physician's order dated 9/14/11 in the POS. R3 was having "severe pain" in the left thigh and knee related to a non-healing impacted fracture according to the Z1's (Physician) progress note dated 9/14/11 in the medical record. The facility failed to change the order, and failed to administer the Norco every 4 hours, according to documentation on the Controlled Drug Disposition Form and Medication Administration Record (MAR) for September 2011. The controlled Drug Disposition Form shows that R3 received Norco as follows: 9/14/11 - 3 doses; 9/15 - 0 doses; 9/16 - 1 dose; 9/17 - 1 dose; 9/18 - 2 doses; 9/19 - 5 doses; 9/20 - 3 doses; 9/21 - 3 doses. Additionally, there were no quantitative pain assessments documented prior to giving the Norco, and no quantitative assessment of the effectiveness of pain relief after giving the Norco according to review of notes in the electronic medical record, the hard copy medical chart, and the MAR. R3's "Alteration in Comfort" care plan documents, "RESIDENT WILL HAVE EFFECTIVE RESULTS 30 MIN. AFTER PAIN MED IS GIVEN" and to assess the effectiveness of pain medication. During an interview with E2 (Director of Nursing) on 9/22/11 at 4:30 PM, E2 stated that the nurses document pain assessments in the MAR every shift, but not before and after administering pain medications. The MAR shows "0" for every shift, everyday, between 9/14 - 9/22/11 in the pain scale assessment column, indicating that R3 has no pain. However, this is in contradiction to Z1's Physician notes dated 9/14/11 and 9/22/11 which describe R3 to be in pain, and to the observations made of R3 on 9/22/11 (see below).	F 309		

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F 309	Continued From page 2 During an interview with Z2 (Medical Director) on 9/26/11 at 4:30 PM, Z2 stated that he would expect the nurses to do a quantitative assessment of a residents pain prior to giving pain medication. Z2 also stated that it was his expectation that nursing staff would do a quantitative re-assess 30 minutes after giving pain medication to determine its effectiveness. Z1 (R3's Physician) was interviewed by telephone on 9/26/11. Z1 said that R3 would be in "so much pain" if he didn't get pain medication every 4 hours. Z1 said that, for this reason, she changed the order for Norco from PRN to every 4 hours around the clock. Z1 said that R3's impacted fracture would cause severe pain. Z1 said that she increased R3's pain medication to every 4 hours around the clock because when she saw him on 9/14/11 he was in "an unbelievable amount of pain." Z1 explained that she wanted to maintain a steady, controlled pain medication level in R3 because once he is having severe pain it requires much more pain medication to treat it. Additionally, Z1 stated that R3 is not able to ask for pain medication. On 9/22/11 at 1:20 PM R3 was in his room in bed. R3 was grimacing as he was holding on to the trapeze bar with his right hand trying to pull himself up. R3 said that his back hurt a little and his leg hurt a lot. R3 repeatedly asked "please help me, please help me." E4 (Wound Nurse) was summoned from the hallway. E4 and her assistant repositioned R3. E4 then left the room and returned a couple minutes later. E4 stated that she informed R3's nurse that R3 was in pain. At 1:30 PM no staff had re-entered R3's room to	F 309		

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F 309	Continued From page 3 assess his pain. At 1:30 PM E5 (R3's Nurse) was sitting at the nurses station. At this point R3 began yelling out "HELP ME, HELP ME." On 9/22/11 at 1:35 PM E5 stated that she gave R3 his Norco at 1:00 PM for his 2:00 PM scheduled medication. E5 said that R3 gets Norco every 4 hours and that he also received a dose at 6:00 AM and 10:00 AM that day. However, the Controlled Substance Disposition Form shows that R3's last dose (prior to 1:00 PM on 9/22) was given on 9/21/11 at 10:00 PM. The Disposition Form shows that on 9/21/11 "10" pills were left after the 10:00 PM dose was given. The documentation on the Form further shows that "9" medications were left after the 1:00 PM dose was given on 9/22/11, indicating that no doses were given between 9/21/11 at 10:00 PM and 9/22/11 at 1:00 PM.	F 309		
F9999	FINAL OBSERVATIONS Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d) 300.1620a) 300.3240a) 300.7020b)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or	F9999		

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F9999	Continued From page 4 the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and	F9999		

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F9999	Continued From page 5 emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 300.7020 Assessment and Care Planning b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the	F9999		

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F9999	Continued From page 6 resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident 6) The care plan shall be implemented and followed by staff who care for the resident. Based on observation, interview and record review the facility failed to quantitatively assess R3's pain before and after administering pain medication, and failed to follow the physician's order for administrating pain medication. This is for 1 resident (R3) in the sample of 3. These failures resulted in R3 experiencing unnecessary severe pain and discomfort. The findings include: R3 is a severely cognitively impaired resident who was re-admitted to the facility on 9/9/11 with multiple diagnoses including an impacted fracture of the left femur according to the Minimum Data Sets (MDS) dated of 9/21/11. R3 did not exhibit any Behavior Symptoms or Rejection of Care behaviors between 9/14 - 9/21/11 according to the MDS (Section E Behavior). R3 was re-admitted with physician orders for Norco 10 mg/325 mg every 4 hours PRN (as needed) for pain according to the Physician's Order Sheet (POS) dated 9/9/11. On 9/14/11 R3's Norco order was changed from PRN to 'give' every 4 hours according to the physician's order dated 9/14/11 in the POS. R3 was having "severe pain" in the left thigh and knee related to a non-healing impacted fracture according to the Z1's (Physician) progress note dated 9/14/11 in the	F9999		

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F9999	Continued From page 7	F9999		

medical record. The facility failed to change the order, and failed to administer the Norco every 4 hours, according to documentation on the Controlled Drug Disposition Form and Medication Administration Record (MAR) for September 2011. The controlled Drug Disposition Form shows that R3 received Norco as follows: 9/14/11 - 3 doses; 9/15 - 0 doses; 9/16 - 1 dose; 9/17 - 1 dose; 9/18 - 2 doses; 9/19 - 5 doses; 9/20 - 3 doses; 9/21 - 3 doses. Additionally, there were no quantitative pain assessments documented prior to giving the Norco, and no quantitative assessment of the effectiveness of pain relief after giving the Norco according to review of notes in the electronic medical record, the hard copy medical chart, and the MAR. R3's "Alteration in Comfort" care plan documents, "RESIDENT WILL HAVE EFFECTIVE RESULTS 30 MIN. AFTER PAIN MED IS GIVEN" and to assess the effectiveness of pain medication. During an interview with E2 (Director of Nursing) on 9/22/11 at 4:30 PM, E2 stated that the nurses document pain assessments in the MAR every shift, but not before and after administering pain medications. The MAR shows "0" for every shift, everyday, between 9/14 - 9/22/11 in the pain scale assessment column, indicating that R3 has no pain. However, this is in contradiction to Z1's Physician notes dated 9/14/11 and 9/22/11 which describe R3 to be in pain, and to the observations made of R3 on 9/22/11 (see below).

During an interview with Z2 (Medical Director) on 9/26/11 at 4:30 PM, Z2 stated that he would expect the nurses to do a quantitative assessment of a residents pain prior to giving pain medication. Z2 also stated that it was his expectation that nursing staff would do a

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F9999	Continued From page 8	F9999		

quantitative re-assess 30 minutes after giving pain medication to determine its effectiveness.

Z1 (R3's Physician) was interviewed by telephone on 9/26/11. Z1 said that R3 would be in "so much pain" if he didn't get pain medication every 4 hours. Z1 said that, for this reason, she changed the order for Norco from PRN to every 4 hours around the clock. Z1 said that R3's impacted fracture would cause severe pain. Z1 said that she increased R3's pain medication to every 4 hours around the clock because when she saw him on 9/14/11 he was in "an unbelievable amount of pain." Z1 explained that she wanted to maintain a steady, controlled pain medication level in R3 because once he is having severe pain it requires much more pain medication to treat it. Additionally, Z1 stated that R3 is not able to ask for pain medication.

On 9/22/11 at 1:20 PM R3 was in his room in bed. R3 was grimacing as he was holding on to the trapeze bar with his right hand trying to pull himself up. R3 said that his back hurt a little and his leg hurt a lot. R3 repeatedly asked "please help me, please help me." E4 (Wound Nurse) was summoned from the hallway. E4 and her assistant repositioned R3. E4 then left the room and returned a couple minutes later. E4 stated that she informed R3's nurse that R3 was in pain. At 1:30 PM no staff had re-entered R3's room to assess his pain. At 1:30 PM E5 (R3's Nurse) was sitting at the nurses station. At this point R3 began yelling out "HELP ME, HELP ME."

On 9/22/11 at 1:35 PM E5 stated that she gave R3 his Norco at 1:00 PM for his 2:00 PM scheduled medication. E5 said that R3 gets

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F9999	Continued From page 9 Norco every 4 hours and that he also received a dose at 6:00 AM and 10:00 AM that day. However, the Controlled Substance Disposition Form shows that R3's last dose (prior to 1:00 PM on 9/22) was given on 9/21/11 at 10:00 PM. The Disposition Form shows that on 9/21/11 "10" pills were left after the 10:00 PM dose was given. The documentation on the Form further shows that "9" medications were left after the 1:00 PM dose was given on 9/22/11, indicating that no doses were given between 9/21/11 at 10:00 PM and 9/22/11 at 1:00 PM. (B)	F9999		