DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMI							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145405		B. WING			C 03/07/2013		
NAME OF PROVIDER OR SUPPLIER WESTMONT NURSING AND REHAB CENTER				6	REET ADDRESS, CITY, STATE, ZIP CODE 501 SOUTH CASS VESTMONT, IL 60559		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 Review of the 72 hour nursing documentation showed nursing documentation was not done per facility policy or per instructions by E2. Nursing documentation showed there was 2 shifts that did not document at all on R3 during the 72 hour post fall (10/29/12 11:00 p.m - 7:00 a.m. and 10/30/12 - 3:00 p.m. to 11:00 p.m.). Three nurses notes were signed very late. The nurses note entry dated 10/28/12 - 3:52 a.m. was signed on 11/6/12 (9 days after R3's fall). The nurses note dated 10/29/12 - 2:28 p.m. was signed 11/5/12 (7 days after R3's fall), and the nurses note dated 10/30/12 2:45 p.m. was dated 10/31/12 (1 day after being written). None of the nurses notes showed R3 had been assessed and/or examined for bruising, redness, swelling, or range of motion. On 10/31/12 at 8:00 a.m. nursing documentation showed R3 still remained in the wheel chair. Ten O'clock documentation for the same day showed R3 had facial grimacing and complained of pain upon movement of the right lower extremity. Upon nursing examination of R3's right hip a 4.8 cm x 5.2 cm greenish/purple bruise was noted. R3 was sent to a nearby hospital where he was admitted with a diagnoses which included Acute Right Hip Fracture, Hospital x-ray of R3's right hip dated 10/31/12 showed R3 had to have surgical intervention for repair of the right femoral neck fracture. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a)			309			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/10/2013 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145405			B. WING			C 03/07/2013	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTMONT NURSING AND REHAB CENTER					6501 SOUTH CASS WESTMONT, IL 60559		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From page 3 300.1210b) 300.3240a)		F99	99	9		
	Section 300.610 Resident Care Policies						
	procedures, govern the facility which sh Resident Care Polic least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th	have written policies and ing all services provided by all be formulated by a cy Committee consisting of at tor, the advisory physician or y committee and hursing and other services in olicies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a					
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care					
	and services to atta practicable physical well-being of the re- each resident's com plan. Adequate and care and personal of	provide the necessary care in or maintain the highest l, mental, and psychological sident, in accordance with prehensive resident care properly supervised nursing care shall be provided to each total nursing and personal esident.					
	Section 300.3240 A	buse and Neglect					
	a) An owner, licens	ee, administrator, employee or					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 145405 B. WING 03/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 SOUTH CASS WESTMONT NURSING AND REHAB CENTER WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 4 F9999 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview the facility failed to assess and monitor 1 resident (R3) per facility policy after a fall. As a result of this failure R3 remained in the facility for 3 days after the fall before x-rays were taken. The x-rays revealed a fractured hip which required hospitalization for surgical repair. This is for 1 of 3 residents reviewed for falls. (R3) The findings include: 1. Review of R3's closed record admission face sheet showed R3 was admitted to the facility for Respite Care on 10/27/12. R3's admission diagnoses included Alzheimer's Disease and Hypertension. Nursing note documentation dated 10/27/12 at 1:05 p.m. showed R3 was ambulatory upon admission to the facility. Interviews with E2 (Director of Nurses) on 2/27/13 at 12:15 p.m. and E3 (Restorative Coor/Occupational Rehab Aide) on 2/28/13 at 1:00 p.m. verified that R3 was ambulatory on admission to the facility. Nursing note documentation dated 10/28/12 at 2:06 a.m. and Fall Occurrence report documentation dated 10/28/12 at 2:00 a.m. showed R3 was confused, pacing, and wandering. R3 was placed at the nurses staion, was observed ambulating from chair to chair, and attempted to sit on the floor and fell. Nursing

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 145405 B. WING 03/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 SOUTH CASS WESTMONT NURSING AND REHAB CENTER WESTMONT, IL 60559 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 5 F9999 documentation showed an assessment was done on R3 at this time with no noted injury. Nursing documentation the same day (10/28/12) at 2:43 p.m. showed "R3 is calm today sitting in his wheel chair ... " On 2/27/13 at 12:15 p.m. E2 (Director of Nurses) stated R3 was placed in a wheel chair on the same day of his fall even though he was not injured. E2 stated, "R3 was put in a wheel chair due to his cognition. He was so confused." As mentioned above, R3 was admitted with a diagnosis of Alzheimer's Disease. Review of restorative intervention post fall for R3 included, "Wheel chair with alarm." Review of the facility's policy on documentation post falls showed, "All residents who had a fall incident will be monitored every shift for the next 72 hours and documented on..." Further interview with E2 on 2/28/12 at 12:15 p.m. noted E2 to say, "After a resident falls the nurses are supposed to assess/examine the resident for any further injury, pain, swelling, etc... and document this information on the resident on every shift for the next 72 hours. Review of the 72 hour nursing documentation showed nursing documentation was not done per facility policy or per instructions by E2. Nursing documentation showed there was 2 shifts that did not document at all on R3 during the 72 hour post fall (10/29/12 11:00 p.m - 7:00 a.m. and 10/30/12 - 3:00 p.m. to 11:00 p.m.). Three nurses notes were signed very late. The nurses note entry dated 10/28/12 - 3:52 a.m. was signed on 11/6/12 (9 days after R3's fall). The nurses note dated

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	145405		B. WING			C 03/07/2013		
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
WESTMO	ONT NURSING AND F	REHAB CENTER			501 SOUTH CASS VESTMONT, IL 60559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F9999	after R3's fall), and 10/30/12 2:45 p.m. after being written). showed R3 had bee for bruising, redness motion. On 10/31/12 at 8:00 showed R3 still rem O'clock documenta R3 had facial grima upon movement of Upon nursing exam cm x 5.2 cm greeni R3 was sent to a ne admitted with a diag Right Hip Fracture, dated 10/31/12 sho Fracture of Right H dated 11/2/12 show	nge 6 h. was signed 11/5/12 (7 days the nurses note dated was dated 10/31/12 (1 day . None of the nurses notes en assessed and/or examined as, swelling, or range of 0 a.m. nursing documentation hained in the wheel chair. Ten tion for the same day showed acing and complained of pain the right lower extremity. hination of R3's right hip a 4.8 sh/purple bruise was noted. earby hospital where he was gnoses which included Acute Hospital x-ray of R3's right hip wed impression of "Subcapital ip." Hospital Operative Report ved R3 had to have surgical air of the right femoral neck	F9	999				

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Facility ID: IL6009930

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