STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000335	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE OF WESTMONT	512 EAST OGDEN AVENUE WESTMONT, IL 60559

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S 000	Initial Comments Investigation of complaint number 1771305/IL92247. STATEMENT OF LICENSURE VIOLATIONS:	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 2-107 of the Act)

These regualtions are not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent an avoidable accident by ensuring that metal food cart was safely transported to residents unit.

This applies to one of three residents (R1) reviewed for injury.

This failure resulted in R1 sustaining multiple toe

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S9999	Continued From page 2	S9999		

fractures and a toe amputation after being run over by the food cart while being pushed by the dietary staff.

The findings include:

R1, a 95 year old with diagnoses that included but not limited to muscle weakness, chronic atrial fibrillation, anemia, hypertension, chronic kidney disease, carcinoma of the bladder and age related osteoporosis.

On March 6, 2017 at 12:15 P.M., R1 was sitting in her wheelchair. R1 was in the dining room. R1 has bilateral leg rests attached to the wheelchair. R1 was wearing a pair of socks and a post-operative pair of shoes. R1 was pleasant and responds coherently. R1 stated "I was sitting in my wheelchair, either in the hallway or dining room, when the cart run over my toes. Whoever was pushing the cart was not looking."

On March 6, 2017 at 3:50 P.M., with R1's permission, and together with E4 (Registered Nurse/Unit Manager), R1's feet was checked. R1's left 3rd toe was amputated. There was a scant amount of dark brownish substance around the incision site of the amputated toe. E4 stated that the amputation was a part of the injury that R1 sustained when the metal food cart hit her toes while the cart was being pushed by E8 (Food Service Director). E4 added that this incident happened on February 13, 2017. E4 also added that R1 also had sustained fractures of the 3rd and 2nd toes of the left foot and the 5th toe of the right foot.

The nurse's notes dated February 13, 2017 at 10:20 A.M. showed that the dietary cart was being pushed while R1 was sitting in her

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S9999	Continued From page 3	S9999		

wheelchair in the hallway by the nursing station. The nurse's notes also showed that after the cart reached the nursing station, the nurse (E3) was summoned to check R1's feet. The nurse's assessment showed that R1 had sustained a deep cut of just below the nail and beyond the 3rd toe of the left foot. The notes also showed that Z1 (Nurse Practitioner) was asked to see R1. R1 was then sent to hospital.

Z1's progress notes dated February 13, 2017 showed that "(R1) was sitting in the hallway when the food cart ran over her left 3rd toe. (R1) is in moderate to severe pain, left 3rd toe has a deep laceration with the toe nail totally removable."

The facility's incident investigation dated February 13, 2017 showed that E8 (Food Service Director) was pushing the food cart and when he took a turn, it was a blind spot corner where R1 was sitting. The investigation also showed that E9 (Respiratory Therapist) made a statement that E8 was pushing the cart "slightly faster than he should but not racing."

On March 6, 2017 at 2:00 P.M., E3 (Licensed Practical Nurse) stated that on February 13, 2017 around 10:00 A.M., R1 was sitting in her wheelchair. R1 was in the hallway next to the wall and was facing the nursing station (Intermediate station). E3 also stated that at the time of incident, E3 was of the same vicinity with R1. E3 was facing the Intermediate nursing station and was at hallway (west side). During this time, E3 added that she saw a "heavy metal food cart" being pushed by someone from behind. E3 added that the food cart was being pushed too fast. Further added by E3 that she cannot see the person pushing the cart because it was being pushed from behind and the person was not

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S9999	Continued From page 4	S9999		

looking the pathway. The food cart came from the north dining room coming towards the intermediate nursing station hallway. As E3 added, it was only when the cart had passed her that she saw the person pushing it and it was E8 (Food Service Director). E3 also stated that there was a short turn at the nurse's station hallway and where R1 was at. E3 also added that the hallway was narrow and the food cart was big. As E3 further stated, it was a blind spot for E8 when he turned the food cart to the left around the nurse's station and R1 was at the right side of the cart. E3 also added that it did not help either because E8 had continued to push the cart too fast when he made the turn. E3 also added that after E8 turned the cart to the front of the nursing station, E3 was summoned to check R1's foot. E3 stated that R1 had non-skid socks on and feet were on the floor. Once the socks were removed, E3 saw R1's left 3rd toe was deeply cut and barely attached to a piece of skin. E3 further stated that this incident could have been avoided, if E8 was not careless, way too fast of pushing the food cart in a narrow hallway and was not cautious of a clear pathway.

During the interview, E3 showed the place of the incident. At the time of incident, R1 was next to the wall facing the intermediate nursing station. There was a short turn/corner from the west hallway towards the front hallway of the nurse's station where R1 was located at. E8 had to make a left turn, leaving R1 on the right side of the cart during the turn.

On March 6, 2017 at 2:30 P.M., E2 (Director of Nursing) provided dimension of the metal food cart and the distance of R1's location in a wheelchair to the nurse's station. The distance of the wheelchair to the nursing station counter was

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S9999	Continued From page 5	S9999		

47 inches. The food metal cart was 52 and 1/2 inches in width, height was 62 inches and the depth was 34 inches. This makes an approximate 5 and 1/2 inches space between R1 and the food cart for E8 to maneuver. The metal food cart also weighs 362 pounds.

On March 7, 2017 at 10:15 P.M., E5 (Certified Nurse Assistant) stated that on February 13, 2017, R1 had breakfast, was assisted to the toilet and then placed on her usual spot which was next to the wall, hallway and front of the intermediate nursing station. E5 also added that R1 wears the non-skid socks all the time as R1's preference, no wheelchair leg rests since R1 was able to propel her wheelchair. E5 also added that after the food cart incident, R1 was assisted with propelling wheelchair due to the foot injury.

On March 7, 2017 at 10:30 A.M., E6 (Certified Nurse Assistant) stated that on February 13, 2017 around 10:00 A.M., R1 was heard screaming of pain. E6 added that he immediately came out of the resident room 223 (which was a nearby room to the place of incident location). E6 further stated that he saw E8 holding R1's foot and E6 was asked to call the nurse. E6 also stated that he saw blood coming from R1's left foot. E6 further stated that few seconds prior to the incident, E6 saw E8 in the hallway pushing the food cart from behind. E6 also added that while E8 was pushing the cart, "(E8) was moving so quick like he was in a hurry." E6 further added that he had seen in the past how E8 pushed the cart which was in the same manner that he did when the incident happened. E6 also added that the food cart was safer to pull than push because the person who is handling the cart has more control of the cart and can visualize if the pathway was clear. E6 further added that R1 is alert and oriented times three

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S9999	Continued From page 6	S9999		

but forgetful at times. As E6 added, R1 can propel her wheelchair, however due to the foot injury, staff helps R1 with locomotion.

On March 6, 2017 at 3:05 P.M., Z1 (Nurse Practitioner) stated that she assessed R1 immediately after R1's feet was ran over by the food cart. Z1 stated that R1's left 3rd toe was "flayed, deeply cut and barely attached to a piece of skin." Z1 also stated that the amputation of the third toe could not be avoided because the bone of the left 3rd toe was already "severed." Z1 further stated that R1 was sent to the hospital precipitated by this incident.

The hospital report dated February 13, 2017 showed that R1 had an avulsion fracture of the distal phalanx of the left 3rd toe. There was also a fracture of at the distal phalanx of the 2nd left toe. The hospital surgical report dated February 14, 2017 showed that R1's pre-operative diagnosis was left 3rd toe traumatic avulsion with exposed tendon. The report further showed that R1 had "traumatic amputation of the left third toe extending from the distal toe at the level of DIP (distal interphalangeal) to the plantar toe at the level of the PIP (proximal interphalangeal) joint medially, with exposed tendon." R1 had undergone surgery of the left 3rd toe due to the traumatic amputation related to the incident.

On March 6, 2016 at 4:00 P.M., E1 (Administrator) stated that E8 was terminated from work related to the incident that occurred with R1's foot. E1 also stated that the facility has no policy regarding safe transfer of the food cart. However, as E1 added, the staff should be aware of surroundings making sure the pathway was clear when transporting the food cart.

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S9999	Continued From page 7	S9999		

E8's personnel file showed that he was terminated due to the incident that occurred on February 13, 2017 "that resulted to serious injury to a patient requiring a surgery." The file also showed that E8 had violated work rules that included but not limited to ..." 2. Comply with all health and safety rules, including rules prohibiting unsafe conduct or unsafe acts that jeopardize the health and safety of self or others or result in serious injury.

On March 7, 2017 at 12:50 P.M., E7 (Registered Dietician/Interim Food Service Director) stated that the facility has no policy regarding safe transport of the food cart. E7 also stated that the "appropriate way to transport the food cart should be pull the cart versus pushing, to be aware of surroundings and to pull slowly. Pulling gives the individual more visual field and has more control of the cart which was much needed when making turns. When pulling the food cart, the person pulling it should be facing and looking toward the direction they are heading or going. The safe practice should be pull not push. This incident could have been avoided if the food cart was transported appropriately as described."

The nurse's note showed R1 returned to the facility on February 18, 2017. On February 20, 2017, R1 complaint of right foot pain. On February 24, 2017, R1 went for a follow up orthopedic appointment. The progress notes for the follow up appointment showed that R1 had the following diagnoses: "1. Right 5th metatarsal fracture 2. Left 3rd toe amputation 3. Left 2nd distal phalanx fracture."

On March 7, 2017 at 11:35 A.M., E4 stated that she had verified with the orthopedic clinic and had confirmed that the 5th metatarsal fracture of the

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S9999	Continued From page 8 right foot was an acute fracture that was sustained from the food cart incident. (A)	S9999		