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 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT MANOR HLTH & RHB	512 EAST OGDEN AVENUE 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation # 2272408/IL145117	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b)5) 300.1210 c) 300.1210d)6) 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide safety measures for a resident while being turned/repositioned during provision of care. This failure resulted in R1 sustaining a laceration to the left side of his forehead, a subdural hematoma, and intensive care monitoring. This applies to 1 of 4 (R1) residents reviewed for falls with injury in the sample of 4. The findings include: R1's EMR (Electronic Medical Record) shows R1 was admitted to the facility on March 2, 2022, with diagnoses including cerebral infarction (stroke) with hemiplegia and hemiparesis (paralysis) affecting the left side, diabetes, dilated cardiomyopathy, chronic kidney disease, and depression. R1's MDS (Minimum Data Set) dated March 16, 2022, shows R1 had severe cognitive impairment. R1 required extensive assistance of two staff for bed mobility, extensive assistance of one staff for personal hygiene, totally dependent on one staff for toilet use, and totally dependent on two staff for transfers. R1's care plan dated March 15, 2022, shows R1	S9999		

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S9999	Continued From page 2 is at risk for falling related to difficulty walking, muscle weakness, hemiplegia, lack of coordination and decreased endurance. Interventions dated March 15, 2022, include keep bed in lowest position with brakes locked, keep call light within reach at all times, and keep personal items and frequently used items within reach. Interventions dated March 24 include floor mats to side of bed. V3's (RN, Registered Nurse) Nursing Progress Note dated March 24, 2022, at 7:32 AM shows while CNA was changing R1's incontinence brief, R1 rolled out of bed and fell on the floor in the prone position. R1 hit his forehead and got a laceration with bleeding. 911 was called and R1 was sent to hospital for evaluation and treatment. V12's (LPN, Licensed Practical Nurse) Nursing Progress Note dated March 24, 2022, at 3:38 PM shows R1 was admitted to hospital with intracranial bleed. On March 28, 2022, at 1:15 PM, R1 was lying in bed with the top of the mattress approximately two and half to three feet off the floor. R1 had a healing laceration on his left forehead. R1's bed was not in the lowest position as possible per the fall intervention in R1's care plan. On March 29, 2022, at 9:35 AM, R1 was lying in bed with the top of the mattress approximately two and a half to three feet off the floor. R1's bed was not in lowest position as per the fall intervention in his care plan. On March 29, 2022, at 11:26 AM, V4 (CNA) stated he provides care with two staff. V4 also stated he has provided care to R1 by himself but can tell when R1 is having a bad day and he	S9999		

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S9999	Continued From page 3 knows to have another staff help him on those days because he can get "squirmy" in the bed. On March 29, 2022 at 1:39 PM, V8 (Director of Rehab) stated when turning a resident to their side in the bed, the staff should first pull the resident closer to them, that means further away from the side of bed the resident will be turned towards, so if they are turning the resident to their left side, the staff needs to pull the resident over to the right side of bed before turning the resident to their left side. Furthermore, the staff should bend the top leg and place one hand on hip/waist area and the other hand on the upper back and ease them onto their side. On March 29, 2022, at 2:21 PM, V9 (CNA/Certified Nursing Assistant) stated on the morning of March 24, 2022, he was turning R1 onto R1's left side. V9 also stated R1 was positioned in the middle of the bed prior to V9 rolling R1 onto his side. R1 was rolled onto his left side and while V9 was gathering the soiled linens behind R1, R1 grabbed the side of the bed with his right hand and rolled off the bed onto the floor. V9 stated at the time of the fall there were no side rails on the bed or fall mats on the floor. V9 noted that R1 was bleeding from his face, he notified the nurse and 911 was called. R1 was sent to the local hospital and admitted. On March 29, 2022, at 3:08 PM, V10 (Physician) stated the facility made her aware of R1's fall which resulted in a new subdural hematoma. V10 also stated that when R1 was admitted to this facility, R1 refused to be placed on anticoagulants due to a previous fall which he had that resulted in a brain bleed. V10 said if R1 had been on an anticoagulant at the time of this incident, the outcome could have been much worse.	S9999		

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S9999	Continued From page 4 R1's hospital records dated March 24, 2022, shows R1 had multiple comorbidities including left hemiplegia. R1 presented to the ED (Emergency Department) after he [R1] fell out of bed while staff was logrolling him to change his clothes. R1 had a diagnosis of subdural hematoma. The hospital records also included a CT (Computerized Tomography) scan of R1's head with results of a recent left subdural hematoma. V11's (Emergency Room Physician) provider note shows R1's head laceration was closed with liquid skin adhesive. V11's note also included given the high probability of imminent or life-threatening deterioration of R1's condition without intervention, R1 was assessed by V11 and a nurse. During R1's stay in the Emergency Room, V11 spent considerable time at R1's bedside performing serial re-evaluations of R1's vital signs and clinical status because of the recognized potential threat to life or limb in this condition. Clinical management of R1 involved high complexity decision making to assess, manipulate, and support vital organ system failure. The hospital record also shows R1 was admitted to the intensive care unit and had a neurosurgery consultation. (A)	S9999		