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	IL6000335	A. BUILDING: _____ B. WING _____	C 10/27/2021

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WESTMONT MANOR HLTH & RHB	512 EAST OGDEN AVENUE WESTMONT, IL 60559

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S 000	Initial Comments Complaint Investigation: 2177804/IL139451	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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.	S9999		

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S9999	Continued From page 2 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their policy and care plan interventions to ensure residents at high fall risk were being monitored. This failure resulted in R1 having an unwitnessed fall, sustaining a fracture requiring hospitalization and surgical intervention. This applies to 3 of 4 residents (R1, R3, and R4) reviewed for falls in a sample of 10.	S9999		

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S9999	Continued From page 3	S9999		

The findings include:

1. According to the Electronic Health Record (EHR) R1 had diagnoses including diabetes, peripheral vascular disease, hypertension, gastroesophageal reflux disease, hyperlipidemia, osteoporosis, cerebrovascular accident, osteoarthritis, dementia, depression, encephalopathy, dysphagia, weakness, reduced mobility, assistance with personal care, and history of falling.

The Minimum Data Set (MDS) dated 08/05/2021 showed R1 needed extensive assistance of one person for bed mobility, dressing, eating, and toilet use; and needed extensive assistance of two people for transfers. The MDS showed R1's cognition was moderately impaired. The admission MDS dated 05/19/2021 showed R1 did not have any falls prior to admission.

A Care Plan showed R1 had dementia and confusion; had an actual fall and is at high risk for falling related to dementia, weakness, difficulty walking, stroke, lack of coordination with interventions including being in a supervised area at all times while up (09/01/2021), toileted early morning, after each meal, before bed, and check for incontinence every two hours.

The EHR event log showed R1 had a history of previous falls in the facility:
a fall on 05/24/2021 at 1:50 PM, R1's roommate had called for staff. R1 was observed lying on the floor, right side of the bed with R1's head against the wall heater vent;
a fall on 08/10/2021 at 2:35 PM with a laceration to forehead. R1 had stood up from the wheelchair while being wheeled back to room by V5 (RN); and

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S9999	Continued From page 4 a fall on 08/31/2021 at 9:00 AM R1 was found on the floor in the dining room. On 10/25/2021 at 3:29 PM, V4 (Registered Nurse/RN) said R1 was a fall risk, sometimes sitting at the nurse's station so someone was always watching. V4 had heard about R1's fall and thought V5 (RN).the nurse taking care of R1, had been on break when R1 fell. V4 thought R1 often would lean forward when sitting in the wheelchair and that was why R1 was kept at the nurse's station. R1 was alert and oriented to person and place. V4 said she never saw R1 walk and doubted R1 was able to walk. V4 said R1 did have a low bed with fall mats on either side of the bed. A Nursing Progress Note dated 10/19/2021 at 2:20 PM showed (V5, RN) was in the dining room and heard a thud sound towards the nurses station. When V5 responded, R1 was lying on left side, next to the wheelchair, and had a bump on the left forehead. A body check was done, ice was applied to R1's forehead, vital signs were taken and R1 was assisted back in the chair with the assistance of two people. R1 had complained of pain on forehead and the left hip. R1 had verbalized wanting to go to the bathroom and had gotten up without assistance. On 10/26/2021 at 12:07 PM, V5 (RN) said he was on a break in the dining room near the nurse's station sometime after 2:00 PM. It was around shift change for the Certified Nursing Assistants (CNAs). R1 had been sitting in a wheelchair near the nurse's station. V5 had heard a noise and when he came out of the dining room, R1 was lying on left side on the floor. V5 said R1 did not call out for help and there was no staff in the vicinity. V5 said since it was near the end of the	S9999		

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shift, possibly the CNAs were making rounds on other residents. V5 said the CNAs who had been working the day shift were V6 (Restorative CNA) and another CNA. V5 said he had to go find V6 to help get R1 up off the floor. V5 said when he was on break, there wasn't another nurse to cover the residents for him. V5 said R1's fall was unwitnessed. R1 initially was grimacing, had a large bump on the left forehead, and said "wants to go." V5 said R1 was always saying that R1 wanted to go home. R1 was alert but very forgetful. At 3:00 PM when asked about the care plan showing R1 should be in a supervised area due to being a high fall risk, V5 said R1 was "placed at the nurse's station to be supervised to the best of our ability." V5 said sometimes, if the CNA would need to answer a call light, it would take them away from the nurse's station. V5 (RN) thought V6 (CNA) knew he was on break. The CNAs change shifts at 2:00 PM and V5 couldn't recall seeing the evening shift CNAs coming on duty yet, at the time.

On 10/26/2021 at 12:32 PM, V6 (Restorative CNA) said R1 was a fall risk because R1 "tried to get up a lot." R1 would try to stand and take steps but R1 did not meet the requirements to be walked. V6 said R1 had been taken to the toilet approximately 1:30 PM with V6 and another CNA. When R1 had fallen, it was toward the end of V6's shift and V6 was down at the other end of the hallway, getting ready to leave. V6 said she was walking down the hallway when V5 (RN) came to get V6 (CNA) because R1 had fallen. V6 (CNA) did not know where any other CNAs were. V6 said R1 way lying on the ground, near the nurse's station, on the left side. V6 (CNA) said sometimes the CNAs give report to the oncoming CNAs sometimes they don't. V6 said sometimes there are CNAs who may come to work 15

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S9999	Continued From page 6 minutes late. On 10/26/2021 at 3:48 PM, V2 (Director of Nursing/DON) said if a resident was a high fall risk, they should be placed in a high volume area where they can be observed. V2 said the interim nurses station area in the middle of the hallways, someone was always right there. V2 said it was near her office and the activities take place in the dining room near there. V2 said R1 fell near the nurse's station, near the end of the hallway, on another unit. V2 said the staff was monitoring her, a CNA would have been watching R1. V2 said if the CNA or nurse had to go somewhere else, they should have brought R1 to the activity area to be monitored since there was an activity going on. V2 was unsure if the evening shift CNAs were there. V2 said she had passed R1 around 2:00 PM and R1 was sitting by the nurse's station humming. On 10/27/2021 at 9:52 AM, V8 (Nurse Practitioner/NP) said R1 was confused due to dementia, sometimes R1 had agitation,would try to get up out of bed or the wheelchair, and try to walk. V8 said the nursing homes have standard fall precautions which would include having a call light within the resident's reach, padding on the floor on both sides of the bed, sometimes a bed and chair alarm, and lock the wheels on the wheelchairs. V8 said the residents who were at a high fall risk should be closely monitored. V8 said the staff should have kept a close eye on her. On 10/27/2021 at 5:09 PM, V9 (Occupational Therapist) said she had passed R1 in the hallway and had exchanged brief pleasantries asking how was doing. V9 could not recall the exact time but thought it had been around 2:30 PM. V9 was not sitting at the nurse's station but was working with	S9999		

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another resident at the time and had passed by to get something from the supply closet. The encounter lasting less than 30 seconds. V9 said she had previously worked with R1 for therapy. V9 said R1 was able to stand up, needed extensive assistance with toilet use, and needed a lot of cues including safety cues for proper hand placement. According to V9, R1 was rather impulsive at times, would reach for the wrong grab bar, not push up on the wheelchair arm rests, or not lock the brakes of the wheelchair.

On 10/25/2021 at 12:46 PM, this writer was looking for any nursing staff for 10 minutes to assist a resident who requested crackers, V3 (Housekeeper) said she had worked in the facility for three and a half months and often nursing staff cannot be found very easily. V3 said it takes awhile to find someone on the nursing staff to help the residents.

A Magnetic Resonance Imaging (MRI) dated 10/20/2021 showed a nondisplaced proximal left femoral fracture involving the subcapital region and extending into the intertrochanteric region.

A Hospital Orthopedic Consultation note dated 10/21/2021 at 9:44 AM from V11 (MD Orthopedic Surgeon) showed R1 had a nondisplaced left femoral neck fracture with a plan for left hip percutaneous screw fixation surgery the same evening.

On 10/27/2021 at 1:38 PM, V11 (Orthopedic Surgeon MD) said R1's fracture was a result of the fall. V11 said R1 was admitted with altered mental status from a subarachnoid hemorrhage and was admitted to the intensive care unit for observation. A MRI scan showed R1 had a fracture.

(A)