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 03/07/2013

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 309	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 impression of "Subcapital Fracture of Right Hip." Hospital Operative Report dated 11/2/12 showed R3 had to have surgical intervention for repair of the right femoral neck fracture.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a)	F9999		

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F9999	Continued From page 3 300.1210b) 300.3240a) 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 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	F9999		

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F9999	Continued From page 4 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	F9999		

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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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F9999	Continued From page 6 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 impression of "Subcapital Fracture of Right Hip." Hospital Operative Report dated 11/2/12 showed R3 had to have surgical intervention for repair of the right femoral neck fracture. (B)	F9999		