

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/04/2024
NAME OF PROVIDER OR SUPPLIER  Westmont Manor Hlth & Rhb		STREET ADDRESS, CITY, STATE, ZIP CODE  512 East Ogden Avenue Westmont, IL 60559	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to perform skin assessments in order to prevent pressure injuries from developing for 1 of 5 residents (R2) reviewed for pressure in the sample of 6. This failure resulted in R2 developing a facility acquired pressure injury that was not identified until it was a Stage 3.</p> <p>The findings include:</p> <p>On 9/3/24 at 11:50 AM, R2 was dressed and sitting bedside in his room. R2 had a low air loss mattress on his bed. R2 said he has a pelvic fracture in two places which causes him some pain. R2 said he is able to walk with a walker, move in bed, and takes himself to the bathroom. R2 said he got the low air loss mattress when they found a sore on his bottom. R2 said he didn't have any sores when he came in.</p> <p>R2's Progress Noted dated 8/6/24 shows R2 was admitted to the facility from the hospital, is alert and oriented to person, place, time, and situation, and is able to make his needs known. The same note shows No open areas, skin is intact.</p> <p>R2's Progress Note dated 8/8/24 shows R2's skin is intact.</p> <p>R2's Progress Note dated 8/9/24 shows skin intact. There are no progress notes regarding R2's skin until 8/18/24 when R2 was found with a Stage 3 pressure injury to his sacral area.</p> <p>R2's Wound Management Detail Report dated 8/18/24 shows R2 was found to have an in house acquired Stage 3 pressure injury sacrum area measuring 1 x 1 cm with serous drainage.</p> <p>R2's Wound MD Progress Note dated 8/29/24 shows R2 has a Stage 3 pressure injury to coccyx, measuring 1.5 x 0.3 x 0.1 cm with scant serous exudate.</p> <p>On 9/4/24 at 10:40 AM, V11 Nurse Practitioner said R2 is alert and uses a walker with minimal assistance. V11 said she was notified of R2's pressure injury on his sacrum when it was found at a stage 3. V11 said pressure injuries should be found before they are a Stage 3 and staff should be doing skin assessments during care.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 9/4/24 at 11:20 AM, V10 Wound Licensed Nurse Practitioner said R2 was admitted when she was on vacation. V10 said when she returned from vacation, she did a skin assessment on all of the new residents and found a Stage 3 pressure injury on R2's bottom. V10 said she notified V11 and got treatment orders and put pressure reducing interventions in place. V10 said Certified Nursing Assistants (CNA) look at skin daily during care and then on shower days the CNA is supposed to call the nurse into the shower room to do a full skin assessment. V10 said the nurse signs off on the shower sheet that a skin assessment was done and then if there were new openings the nurse would call the NP and get orders, let her know of the wound, and notify the Director of Nursing. V10 said R2 is alert and able to turn and reposition himself but had pain from his fractures and needed reminders to reposition.</p> <p>R2's Bath and Skin Report Sheet for August 2024 shows R2 received a shower on 8/8/24, refused on 8/12/24, and received a shower on 8/15/24, and then on 8/18/24. This Report has initials in the Nurse Signature column for all showers. The shower on 8/15/24 is completed in pencil and has a check mark on the open area column and an x on the sacral area on the body diagram.</p> <p>On 9/4/24 at 12:55 PM, V10 reviewed R2's Bath and Skin Report with this surveyor. V10 said R2's shower on 8/8/24 and 8/15/24 have an x and a check mark in the open area column but the body diagram has no marking on 8/8/24 only on 8/15/24 where there is an x on the sacral area. V10 said the nurse initialed both showers but she was unable to decipher who the initials were. V10 said if the CNA found an open area they are supposed to tell the nurse. V10 reviewed the staff schedule for 8/15/24 and could not determine who the initials were for the nurse or the CNA and said it could have been agency. V10 said the CNA probably didn't tell the nurse and the nurse didn't actually do the skin assessment and just signed off on the form.</p> <p>On 9/4/24 at 1:10 PM, V4 Registered Nurse said she did work on 8/15/24 but that was not her signature on the shower sheet. V4 said she was not told of R2 having a wound until V10 found it on 8/18/24. V4 said the nurse is supposed to go into the shower room and look at the resident's skin and then sign the shower form.</p> <p>On 9/4/24 at 1:15 PM, R2 said that no one said anything to him about an open area on his bottom during his showers and the nurses didn't come in during his showers to look at his skin. R2 said the nurse came into his room, did a skin check and found the sore on his bottom.</p> <p>The facility's undated Pressure Ulcer and Wound Prevention/Management Program shows Resident's skin will be inspected during daily bathing, dressing, showering, and incontinency care with special attention to bony prominences by CNA and staff nurses.</p>		