STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145338	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Rehab and Nursing Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision for a resident (R2) to prevent a fall. This resulted in R2 obtaining a fracture to her right clavicle. This applies to 1 of 3 residents reviewed for safety and supervision in the sample of 6.The findings include:R2's electronic face sheet dated 4/26/26 showed R2 has diagnoses including but not limited to chronic obstructive pulmonary disease, type 2 diabetes, heart failure, depression, muscle wasting and atrophy, and osteoporosis.R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment.R2's care plan dated 10/14/25 showed, (R2) is at risk for falls related to general weakness, overestimates abilities, poor coordination, unsteady gait, use of narcotics, decreased safety awareness, impulsiveness with attempts to stand or self-transfer without assistance from staff despite repeated direction/education .Interventions: observe frequently and place in supervised area when out of bed, toilet and lay down promptly after meals.R2's nursing progress notes dated 3/19/26 showed, I was doing my rounds heard resident calling for help, observed on the floor in front of her wheelchair laying on her right side. She then verbalized that she was trying to fix her shoes and fell forward and hit her head and right shoulder. Slowly repositioned her in supine (face up) position, noted a bump on her right temple, ice pack applied, vital signs taken, and neurological check initiated. Complains of pain on her right shoulder, immobilized. Assisted back in bed with 2 staff assist and she was able to help stand and transfer.R2's nursing progress notes dated 3/19/26 showed, Resident returned back to facility via ambulance. Per report received from emergency room nurse, x-ray to right shoulder shows fracture to right clavicle. Resident is to wear sling to right arm as much as possible. Resident able to move fingers to her right hand, denies pain and discomfort .R2's local hospital records dated 3/19/26 showed, Diagnosis: traumatic closed fracture of distal clavicle with minimal displacement, closed head injury.On 4/26/26 at 12:24PM, V2 (Director of Nursing) stated, (V8-Certified Nursing Assistant-CNA) just got (R2) off the toilet and she requested to stay in her room to watch tv and she bent down to fix her shoe and fell forward out of the wheelchair. (R2's) fall prevention measures in place right now are to keep her in high supervision areas when she is awake. We also put her where a tv is at too so that she can watch it, (non-slip pad) in her wheelchair, and try to keep her in activities. Her room would not be a supervised area because there are not always staff members in the hall by her room. If she wheels herself to her room, we redirect her to come back out. At the time of her fall, it was what she was comfortable with, so we were abiding by her requests at the time. If we don't do what they ask, then we aren't abiding by her rights. I think there is a tv in the dining room and maybe one in the area across from the nurse's station that we could have tried to get her to watch. She is alert and oriented with forgetfulness so needs a lot of reminders not to get up on her own.On 4/26/26 at 12:26PM, V5 (Registered Nurse) stated, (R2) was in the bathroom before she fell, the aide took her to the bathroom and when she came out of the bathroom, she wanted to stay in her room, so we left her in her room. She does that from time to time. I was passing by her room, and I saw her on the floor. She told me she was trying to fix her shoes, and they were slip on shoes. She must have had poor trunk control and fell forward on her right side. She fractured her clavicle. She (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	didn't want to go to the hospital, but we convinced her to do it because she was on a blood thinner and she needed to be checked out. Monitoring is a big thing for her fall prevention measures. From time to time, she slides down in the wheelchair. We usually put her by the nurse's station, and we are constantly monitoring her and reminding her to sit back. I do rounds 4-5x/shift. Sometimes she sits in her room by herself and watches tv and plays on her cell phone. On 4/26/26 at 12:52PM, V6 and V7 (CNA's) stated, We try to keep (R2) in activities but she likes to be in her room in her wheelchair. We put movies on in the dining room to try to keep her in there. She can be in her room by herself if she wants to be. She requests to be in here on her own and watch movies and plays on her phone. We try to encourage her not to so that we can keep an eye on her but at the end of the day it's her choice if she wants to be in her room.On 4/27/26 at 11:18AM, V8 (CNA) stated, The day (R2) fell I was the aide taking care of her. It was sometime after lunch and I put her on the toilet and when she was done she asked me if she could stay in her room to watch tv. I left the room and she was up in her wheelchair. I'm not sure what time it was. After she had her fall they told me she needed to be out in the hallway so we could watch her but that it's her right to be in her room if she wants to be. I don't really know about the care specifics with the residents. I only work there PRN (as needed) so I think I can look in the computer if I need to know something but I'm not sure if it's updated or not. I would think whatever I needed to know would be given to me in our shift report from the previous shift.R2's nursing progress notes and care plan showed no documentation related to R2's preference to stay in her room nor was there documentation of R2's power of attorney or family having discussions with the facility regarding alternative fall prevention measures.The facility's policy titled, Safety and Supervision of Residents revised 3/2025 showed, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .3. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. 4. Implementing interventions to reduce accident risks and hazards, while maintaining resident rights, may include the following: a. communicating specific interventions to all relevant staff. b. assigning responsibility for carrying out interventions. c. providing training, as necessary. d. ensuring that interventions are implemented; and e. documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently. b. evaluating the effectiveness of interventions. c. modifying or replacing interventions as needed; and d. evaluating the effectiveness of new or revised interventions .2. Resident supervision is a core component of the system's approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment .