

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5550 South Shore Drive Chicago, IL 60637	
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	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 interviews and record reviews, the facility failed to assess one [R1] resident risk of an accident, identify, implement interventions measures to reduce the hazards or risk as much as possible consistent with R1's needs, goals, care plans and current professional standards of practice to reduce the risk of an accident out of four residents reviewed. These failures resulted in R1 sustaining a right elbow dislocation with mildly displaced fracture of the tip of the coronoid and olecranon process from an unknown origin. Findings Include R1's clinical record indicates the following in part. R1 is a ninety-five-year-old admitted [DATE] with the following medical diagnosis of dementia with mood disturbance, major depression disorder, anxiety disorder, Alzheimer's disorder, dislocation of right ulnohumeral joint, subsequent encounter, essential hypertension, overactive bladder, and chronic kidney disease. R1's face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status Score indicates R1 is cognitively impaired, care plans, medication administration record, treatment administration record, and progress notes were reviewed. R1's hospital notes documented in part: (Page #13) R1 arrived at the hospital at 7:11AM. admission 7/11/26, discharged on 7/13/26. Diagnosis: Right elbow dislocation with mildly displaced fracture of the tip of the coronoid and olecranon process. Dementia with behavioral disturbances. R1's, minimum data set [MDS] in part: R1 is dependent on toileting hygiene, bathing, dressing, personal hygiene, rolling left and right, sitting to lying, and transferring. Nursing staff does all the effort. R1 makes no effort to complete the task. R1's Care Plans reviewed, behavioral care plan and interventions were not documented. Elbow dislocation and interventions were not documented. Reviewed completed care plan with V1 [Administrator], V2 [Director of Nursing] and V15 [MDS Coordinator] all said there was no care plan for behaviors nor R1's dislocated elbow documented. R1's Progress Notes documented in part: V11 [Licensed Practical Nurse] 7/10/26 at 3:55PM Health Status Note Text: Writer called to R1's room by V8 [Certified Nurse Assistant] made writer aware that R1 right arm was swollen. R1 was observed lying in bed, R1 assessed and writer observed right elbow. R1's right elbow red, swollen, warm and painful to touch. Writer administered PRN dose of Tylenol and right arm elevated, NP paged and returned call, orders given for STAT x-ray of right elbow. V2 [Director of Nursing] and family made aware. V15 [Licensed Practical Nurse] 7/10/26 at 10:39 PM Health Status Note Text: Writer received a report regarding R1 X-Ray. R1 has dislocation on the right elbow. V15 [Licensed Practical Nurse] 7/11/26 at 6:04 AM Clinical Note: R1 was sent out to the hospital. Writer notify the V2 [Director of Nursing], V1 [Administration] and family. V11 [Licensed Practical Nurse] 7/13/26 at 6:22PM, admission Summary R1 returned from the hospital. R1 with splint to right arm, no weight bearing until follow up appointment. 7/29/26 and 7/30/26, observed R1 resting in bed with right arm in sling. Call light and personal items in reach. On 7/29/26 at 10:40AM, R1 stated, I am okay. A witch (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	hurt my arm, I don't remember. I am hungry for lunch. On 7/31/26 at 10:57AM, V7 [Certified Nurse Assistant] stated, I worked at the facility for three years. I worked on 7/9/26 night shift from 11PM to 7AM, I was assigned to R1 that night shift. R1 is alert and oriented x1 and confused. R1 is usually woke all night watching television. R1is combative, calls you out of your name, saying she hopes I die, holding her hands like claws, scratching, biting, spitting, and kept talking about the devil. R1 is able to roll from side to side and hold on the side bars on the bed. On 7/9/26, I checked R1 every two hours and she was dry. R1 did not urinate, did not have a bowel movement. I did not have to change her under brief all night for the entire shift. I did not report that R1 did not have any output. I usually chart on my residents every shift, but I have not had access to chart for over two months, V1 [Administrator] was made aware, and the administration has not done anything about it. I did not change R1's night gown, it was clean.[Surveyor asked how could R1 hold on the to side bar and her right hand is contracted] V7 stated, V7 stated, I did not know R1's right arm was contracted. I took care of her at night so did not know. I was suspended one day pending investigation due to R1's injury. In the past I was suspended two more times for abuse allegations. On 7/30/26 at 11:38 AM, V8 [Certified Nurse Assistant] stated, I started working here in May 2026. I am familiar with R1. R1 is alert and oriented x1 and confused most of the time. Usually during ADL/incontinence care R1 becomes combative. R1 yells out she wants to kill you, hitting, and scratching with the left arm. Since I started working here in May, R1 has not been able to move her left arm. R1's left arm is contracted. I worked on 7/10/26 day shift from 7AM to 3PM. R1 was assigned to me on my set of residents to care for. I made rounds and R1 was resting in bed with a clean gown on and I checked her front of the under brief and R1 was dry. I checked on R1 around 9:30 AM, during breakfast. I assisted R1 with her meal and she was still clean and dry. After lunch around 2PM, R1's gown was dirty from eating lunch and she was wet and needed to be changed. While performing care, I asked V4 [Certified Nurse Assistant] for assistance. R1 is a two-person assist while performing ADL/incontinent care, due to not being able to move well and her combative behaviors. V4 and I entered R1's room I explained to R1 that we were going to change her under brief and gown. I went to remove R1's gown and R1 began to yell out, no! My arm is broken. I gently lifted up her sleeve, and R1's right arm by the elbow was swollen big as two soft balls, hard and dark red. I immediately got the nurse. The nurse assessed her and the three of us got R1 cleaned up and her gown changed. R1 did not complain about any pain, until I went to remove her night gown. I knew R1's right arm was contracted. When I first started working here, the nurse told me to be careful of her right arm because it was fractured in January. When R1 becomes combative, I stop and talk to R1 to distract her and one of us will hold her hand and talk about different things while the other aide cleans R1. On 7/30/26 at 11:45AM, V4 [Certified Nurse Assistant] stated, I worked night shift on 7/9/26 11PM-7AM, continued to work into 7/10/26, 7AM to 3PM. On 7/9/26 night shift I did not have R1's room, she was not my resident to attend to. R1 was on V7's assignment. I did not see R1 during the night shift on 7/9/26. It was only V7 and I was working as certified nurse assistant. It always takes two nurse assistants to change R1, because she is confused and combative. R1 always needs multiple changes during the night due to her overactive bladder disorder. R1 is woken all night long eating snacks and drinking water. On 7/9/26, V7 did not ask me for assistance to clean R1, I had no contact with R1 that night. On 7/30/26 at 2:38 PM, V5 [Agency Registered Nurse] stated, I worked 7/9/26 night shift from 7PM to 7AM. I was R1's nurse. I did not receive any reports from V7 [Certified Nurse Assistant] that anything was wrong with R1's elbow. When I made rounds R1 was at her usual baseline. I worked several times with R1, and she requires two persons assist, due to R1 being combative. That night V7 did not ask me for assistance to clean R1. On 7/30/26 at 1:18PM, V11 [Licensed Practical Nurse] stated, I worked on 7/10/26 day (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	shift 7AM to 7PM. I was R1's nurse. V4 [Certified Nurse Assistant] was R1's nurse assistant. Around 2PM, V4 came to get me and said R1's right elbow was swollen. I went immediately and assessed R1. I observed R1's right elbow. R1's elbow was swollen a lot, red, warm and hard to touch. R1 was yelling out saying 'my arm is broken'. I gave R1 pain medication and notified R1's nurse practitioner, Director of Nursing and R1's family. The nurse practitioner ordered a STAT Xray of R1's arm. The mobile Xray service came and took R1's X Rays but by the time the results came in, I was gone. On 7/30/26 at 3:44PM, V15 [Licensed Practical Nurse] stated, I worked on 7/10/26 from 7PM to 7AM, I was R1's nurse. I received a report of R1's elbow. R1's Xray results came around 11PM. R1 was sent to the hospital shortly after that, maybe around 1AM. I was busy helping the agency nurse and then I sent R1 to the hospital, I don't remember what time it was. I did notify the physician, director of nursing and administrator.[R1's hospital documented in part: (Page #13) R1 arrived at the hospital at 7:11AM.] On 7/30/26 at 11:25 AM, V12 [Medical Director] stated, I am familiar with R1. I made wound rounds the wound physician and I assessed with R1 skin assessment. On 7/9/26, early afternoon, I assessed a skin rash on R1's back. There was no swelling or discoloration to R1's right arm elbow area. R1 was being combative, grabbing and hitting, I crossed R1's arms in front of her chest and I wrapped her torso with a sheet. We were able to roll R1 gently over to her side for the assessment. During the assessment, there were no signs of pain or distress and no evidence that R1 had an injury at that time. I am positive R1 was not abused. When R1 was in the hospital emergency department, R1 had the type of dislocation they used to call the injury a nursemaids' elbow known as a pulled elbow injury. I think it was an incident that someone pulled R1's arm and did not know it was contracted. I cannot say for certain, that's what happened, because I was not there. On 7/30/26 at 3:50 PM, V2 [Director of Nursing] stated, On 7/10/26, I was called to R1's room around 1PM and I saw R1's right arm was swollen and tender to touch. R1 could not explain what happened. I was notified of R1's results on 7/11/26 early morning I don't remember the time. R1 sustained a right elbow dislocation. V1 [Administration] was made aware and started the investigation. R1 does have combative behaviors. The nursing staff should always give R1 time to calm down and there is always two nursing staff during care due to her behaviors. [Surveyor and V2 reviewed R1's complete care plan together]. V2 stated, There is no care plan for R1's combative behaviors. There is no care plan regarding R1's elbow dislocation. The team comes up with the interventions, and the MDS coordinator is responsible for placing them in the resident's care plan. There should have been a care plan for R1's combative behaviors and interventions, and for the dislocated elbow. I have not in-serviced staff about R1's incident. On 7/30/26 at 4:35PM, V1 [Administrator] stated, On 7/10/26, I was made aware that R1's elbow was swollen and was getting a Xray. On 7/10/26 around 11PM, R1's X Ray results came in. On 7/11/26 R1 was sent to the hospital early that morning. I don't know what happened to R1's elbow. I could not rule out abuse nor say it was abuse. The medical director and wound care physician assessed R1 on 7/9/26 during the day shift, and there was no swelling to R1's arm. The injury occurred between 7/9/26 day shift to 7/10/26 around 2PM. I interviewed all the staff and residents and could not identify any concerns. V7 was suspended one day and brought back to work. I had no evidence that any particular staff did any harm to R1. I know R1 did not fall out of bed, she is not mobile in and cannot roll or get up with assistance. I do not recall care plans for R1's behaviors or her dislocated elbow. The care plans are in place to hopefully prevent and minimize recurring incidents by placing in interventions. To allow staff to have a resource document staff can review to understand what to do for the residents. I did not come to any conclusion about what happened to R1's elbow. I have not in-served staff regarding R1's incident. Policy in part: Injury of Unknown Origin Policy Any injury observed on a resident for which the cause cannot be immediately determined shall (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	be treated as an injury of Unknown Origin until an investigation is determined otherwise. The facility will promptly assess the resident, provide necessary treatment, investigate the circumstances, notify appropriate individuals, and implement interventions to prevent recurrence. Such as bruises, swelling, fractures, and unexplained pain or tenderness. Procedures: Care Plan: Review contributing factors, update the care plan, implement interventions to reduce the risk of future injury. Educate staff regarding any identified concerns.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their Injury of Unknown Origin Policy and report an injury of unknown origin within two hours of the incident to IDPH [Illinois Department of Public Health] for one [R1] out of four residents reviewed. Findings Include R1's clinical record indicates the following in part. R1 is a ninety-five-year-old admitted [DATE] with the following medical diagnosis of dementia with mood disturbance, major depression disorder, anxiety disorder, Alzheimer's disorder dislocation of right ulnohumeral joint, subsequent encounter, essential hypertension, overactive bladder, and chronic kidney disease. R1's face-sheet, medical diagnosis, physician order sheets, minimum data set [MDS] Brief Interview Mental Status Score Indicates R1 is cognitively impaired, care plans, medication administration record, treatment administration record, and progress notes. R1's hospital notes documented in part:(Page #13) R1 arrived at the hospital at 7:11AM. admission 7/11/26, discharged on 7/13/26.Diagnosis: Right elbow dislocation with mildly displaced fracture of the tip of the coronoid and olecranon process. Dementia with behavioral disturbances. On 7/30/26 at 1:18PM, V11 [Licensed Practical Nurse] stated, I worked on 7/10/26 day shift 7AM to 7PM. I was R1's nurse. V4 [Certified Nurse Assistant] was R1's nurse assistant. Around 2PM, V4 came to get me and said R1's right elbow was swollen. I went immediately and assessed R1. I observed R1's right elbow. R1's elbow was swollen a lot, red, warm and hard to touch. R1 was yelling out saying 'my arm is broken'. I gave R1 pain medication and notified R1's nurse practitioner, Director of Nursing and R1's family. The nurse practitioner ordered a STAT Xray of R1's arm. The mobile Xray service came and took R1's X Rays but by the time the results came in, I was gone. On 7/30/26 at 3:44PM, V15 [Licensed Practical Nurse] stated, I worked on 7/10/26 from 7PM to 7AM, I was R1's nurse. I received a report of R1's elbow. R1's Xray results came around 11PM. R1 was sent to the hospital shortly after that, maybe around 1AM. I was busy helping the agency nurse and then I sent R1 to the hospital, I don't remember what time it was. I did notify the physician, director of nursing and administrator.[R1's hospital note documented in part: (Page #13) R1 arrived at the hospital at 7:11AM.] On 7/10/26 at 4:35PM, V1 [Administrator] stated, On 7/10/26, I was made aware that R1's elbow was swollen and was getting a Xray. On 7/10/26 around 11PM, R1's X Ray results came in. On 7/11/26 R1 was sent to the hospital early that morning. I sent the initial IDPH report on 7/11/26 at 8:08 AM. According to the facility's policy on injury from unknown origin, I should have sent the report on 7/10/26 due to the swelling from an unknown source. Policy in part:Injury of Unknown Origin PolicyTo ensure all injuries of unknown origin are promptly identified, assessed, investigated, documented, and reported in accordance with facility policy and applicable to federal and state regulations to protect the health, safety, and rights of residents. Any injury observed on a resident for which the cause cannot be immediately determined shall be treated as an injury of Unknown Origin until an investigation is determined otherwise. The facility will promptly assess the resident, provide necessary treatment, investigate the circumstances, notify appropriate individuals, and implement interventions to prevent recurrence. Such as bruises, swelling, fractures, and unexplained pain or tenderness. Abuse policy:Immediately report any reasonable suspicion of a crime committed against a resident of the facility to the state survey agency in fulfillment of the statutory directive. Immediately means not later than two hours after the allegation is made if the events that cause the allegation result in serious bodily injury.		