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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westmont Manor Hlth & Rhb	512 East Ogden Avenue Westmont, IL 60559

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview, and record review, the facility failed to provide privacy while providing assistance with a shower. This applies to 1 of 1 resident (R15) reviewed for privacy in the sample of 18. The findings include: R15's face sheet showed he is an [AGE] year old male admitted to the facility on [DATE], with diagnoses that includes Obesity, History of Falling, Dependence on Renal Dialysis, and Cerebral infarction. R15's Minimum Data Sheet (MDS) dated [DATE] showed that R15 requires partial/moderate assistance with showering. The same MDS showed that R15 is cognitively intact. On December 11, 2024, at 3:59 PM, while walking down the hall on the way to the nurse's station, surveyor came across a small shower room where R15 was sitting getting assistance with a shower. R15 had no clothing or covering on his body. V31 (Certified Nursing Assistant) had a shower head in her right hand and was holding the door open with her left hand. V31 was spraying water on R15 with the handheld shower head. On December 11, 2024, at 4:07 PM, V2 (Director of Nursing) stated that the staff should not be showering residents with the door open because it is a privacy issue. The facility's Resident Rights Guidelines dated October 2023 showed the following: the resident have the right to be treated with respect and dignity.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48308 Based on interview and record review the facility failed to file and respond to resident grievances in accordance with their policy. This applies to 8 of 8 residents (R9, R10, R14, R15, R23, R49, R56, R61) reviewed for grievances in the sample of 18. The findings include: During the resident interview meeting on December 10, 2024, at 10:05 AM, the consensus of the attendees (R49, R61, R9, R56, R23) was that they were not aware of the facility's grievance process and did not receive feedback from the facility in response to their concerns. V17 (Ombudsman) provided a copy of the facility's grievance form to the resident attendees at the meeting, and the resident attendees stated they had not seen the grievance form before. R61 (Resident Council President) and R49 (Resident Council [NAME] President) both looked closely at the form and stated they had not seen the grievance form before. During the resident meeting, R56 stated she reported to V28 (Social Services/Medical records) during her care plan meeting over the summer, that she was missing clothing items and a phone charger and cord. Review of the grievance forms from February 1 through December 10, 2024, showed there was no grievance for R56's concern regarding missing clothing and a phone charger and cord missing. R56 stated she has not gotten a response from the facility regarding her missing items. During the resident meeting, R49 stated she reported a missing razor, and phone charger to V23 (Social Services) and V1 (Administrator) about 3 months ago. R49 stated she also reported R15's (R49's father) missing coat to V23 and V1 at the same time. Review of the grievance forms from February 1 through December 10, 2024, showed there was no grievance for R49 or R15 filed. R49 stated she has not gotten a response regarding her missing items. Review of the resident council meeting minutes showed concerns were raised, but no grievance form completed, or response provided to the Resident Council. The Resident Council Meeting Minutes dated March 19, 2024, April 16, 2024, May 21, 2024, and June 18, 2024, all showed the Resident Council identified staff using their cell phones while providing care to residents, was a distraction for staff and requested staff not use their cell phones while providing care. V1 provided a document dated September 11, 2024, titled CNA In service. V1 stated that this was the education provided to staff regarding the resident's concern. However, during the resident interview meeting on December 10, 2024, at 10:05 AM, the resident attendees (R49, R61, R9, R56, R23) all agreed staff using cell phones while providing care remains a problem and has never been resolved. On December 9, 2024, at 10:47 AM, R14 stated he does not get his clothing back from the laundry and has told the CNA and Nurses but could not recall the name of who he told, but that the missing clothing items had been going on for weeks. Review of the grievance forms from February 1 through December 10, 2024, showed there was no grievance form filed on behalf of R14. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 10, 2024, at 5:00 PM, R49, R23, and R10 were playing cards in the dining room and asked to speak with the surveyor. R10 stated she had a concern regarding her incontinence care not being provided timely and this was an ongoing problem. R10 stated she had previously told V28, who had been working at the reception desk at the time of her concern. R10 stated V28 told her at the time she would file the grievance form on her behalf regarding incontinence care not being provided timely. Review of the grievance forms from February 1, 2024, through December 10, 2024, showed there was not a grievance form filed on R10's behalf regarding incontinence care. R10 had a grievance filed on her behalf on June 8, 2024, that showed R10 needed more boxes of tissues, and on December 2, 2024, that showed R10's phone charger was missing and replaced. R49, R23 and R10 each stated incontinence care is not being provided timely and it is not being addressed by the facility. The facility's policy titled Grievance dated October 2021, showed General: It is the policy of the facility to allow and encourage residents and their families to express grievances and concerns they may have regarding the facility, services, and staff Responsible Party: All facility staff .Guideline: .1. Posted signage required advising residents and their representatives of their right to voice a grievance. The sign must include: The Grievance Officer's contact information including name, address/phone number, email address; state QIO contact information; State Survey Agency information; State Ombudsman information .2. The resident and representative must have notification that Grievances/concerns may be filed anonymously either in writing or by postings. 3. A response in writing may be requested by the resident or representative . 4. The resident or representative has the right to expect the facility to make prompt efforts to resolve grievances .5. Any staff member in the facility may receive a grievance or complaint from a resident or representative .10. The staff member will submit the grievance form to the appropriate department head/designee for resolution .13. The Administrator will be the designated Grievance Officer and will review the completed form and action taken and do any follow up necessary.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389 Based on observation, interview, and record review, the facility failed to ensure a resident was free from verbal and physical abuse. This applies to 1 of 3 residents (R73) reviewed for abuse allegations in the sample of 18. This failure resulted in R73 feeling traumatized, unsafe, being afraid to sleep, and developing insomnia. The findings include: R73's face sheet showed him to be a [AGE] year old male admitted to the facility on [DATE], with diagnoses that include Necrotizing Fasciitis, Severe sepsis, Pneumonia, Acute respiratory failure, Alcohol Abuse, and Long Term use of antibiotic. R73's Minimum Data Set (MDS) dated [DATE], showed R73 to be cognitively intact. The initial facility reportable dated November 21, 2024, showed the following: While in the hallway a miscommunication occurred between R73 and V12 (CNA/Certified Nursing Assistant), after which R73 began using his cell phone to video V12. Upon noticing this, V12 moved the phone out of view, which led to R73 becoming upset. The facility's final reportable dated November 29, 2024, showed the following: On November 29, 2024, the facility completed a thorough investigation into an incident involving R73 and V12. The investigation was initiated after R73 became upset during an interaction with V12 in the hallway, where V12 moved R73's cell phone out of view after noticing R73 was recording her. R73 reported feeling upset about the interaction but did not express feeling of fear or alleged physical harm. V12 stated that the phone was moved to avoid being recorded, which was perceived as intrusive or unwanted, and emphasized that there was no intent to escalate the situation. Witness interview and resident interviews revealed no concerns about V12's behavior. V12 was suspended pending the outcome of the investigation. The review concluded that V12's actions, while upsetting toward R73, did not constitute abusive behavior. The interaction appears to have resulted from a misunderstanding rather than intentional harm. The facility's investigation report showed no documentation of V14's interview. V14 was the nurse at the nurse's station during the altercation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On December 9, 2024, at 1:57 PM, R73 stated he was verbally abused and physically assaulted by V12 (Certified Nursing Assistant/CNA). R73 stated that he put his call light on and V33 (CNA) answered the light, and he told her he needed his urinal emptied. R73 stated that V33 said she was going to tell his CNA (V12) to empty the urinal. R73 stated that after a few minutes he wheeled himself to the nurse's station and he saw V14 (Registered Nurse), and he asked V14 who his CNA was. R73 stated that V14 stated his CNA was V12 (CNA) and she was in the internet/ room across from the nurse's station. R73 stated he went and asked V12 to empty his urinal and she (V12) told him to do it himself and started cursing at him. R73 stated he was on the phone with someone, and they could hear what was going on and they told him to record it. R73 stated he started recording. R73 stated V14 was sitting at the nurse's station during the altercation. R73 stated he asked V12 again if she was going to empty his urinal and she started screaming and cursing at him and then walked towards him and as she was passing him, she (V12) hit his right hand and arm, and his phone went flying out of his hand. R73 showed the video to the surveyor at 2:00 PM on December 9, 2024. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On December 10, 2024, at 10:43 AM, R73 stated when he asked V12 to empty his urinal and she started yelling and cursing at him, he was shocked that she was acting like that. R73 said at the nurse's station he just asked her, if she could please empty his urinal. R73 became teary eyed, and said he is seeing a therapist because, now he has trust issues. R73 stated that V14 was there and did not say anything or do anything. R73 stated he was thinking of how to escape. R73 stated he went into his room and started thinking about what had just happened and he came back out to speak to the supervisor. It was around shift change and V16 (RN) was at the nurse's station and the girl that assaulted him was still at the nurse's station with V33, and V14. R73 stated they were all talking to each other. R73 stated he then asked to speak to the supervisor and V16 said if you decide to report this, she will have to document what he (R73) did. R73 stated he didn't do anything. R73 stated he never yelled at V12 or anyone. R73 stated then V16 asked if he was sure he wanted to call the police and he said yes. They were all talking at the nurse's station, so he went back to his room. R73 stated then V15 (Nursing Supervisor) and V16 came to his room. V16 asked what happened. R73 stated he told them what happened and V15 stated the administrator would talk to him tomorrow and they left. R73 stated they didn't ask him if he was okay or anything. R73 stated he was thinking that the person that assaulted him is still here and I'm defenseless. R73 stated he felt like there was an intent to keep him from reporting it to the police. R73 stated, he then went back to the nurse's station and asked them to call the police and V16 told him that it would be better if he called from his phone. R73 stated he went back to his room and called the police. R73 stated the police came and interviewed him and the first thing the officer said was that the V12 told the police that R73 singled her out. R73 then started crying with lots of tears rolling down his face at this point and surveyor got him some tissue. R73 stated that V12 told the police that he cornered her in his wheelchair so she swung at him because that was the only way she could get away from him. R73 stated he showed the officer the video and the officer went and got V15 and told V15 what V12 said and what the video showed. R73 said the officer then asked him if he wanted to file Battery charges and he said yes. R73 stated that the officer told V15 it was R73's right to file charges. R73 stated if he had not recorded it, no one would have believed him. R73 stated no one asked him if he was okay that night, they didn't examine him or anything. R73 stated his right hand was stinging after the CNA knocked the phone out of his right hand. R73 stated that he thought it was a little swollen, so he requested an x-ray. R73 stated the next morning the social worker, the administrator and a couple other people came and asked if he was okay. R73 stated he showed V1 (Abuse Coordinator/Administrator) the video of the altercation and V1 asked for a copy of it, but R73 did not give him one. R73 stated he does not feel safe in the facility, and he put in a request to be transferred. R73 stated after the altercation he called around to see what facilities took his insurance. R73 stated he is afraid at night and is watching closely who is here because no one helped him, and they tried to cook up a story about him. R73 was teary eyed and said they could have had me arrested. R73 stated he is suffering from sleep deprivation since this happened, he is sad, and afraid of retribution. R73 was still visibly shaken and stated that it was so abrupt and shocking. On December 10, 2024, at 1:34 PM surveyor went to go review video footage again with another surveyor. R73 stated he fears retribution. R73 stated he felt defenseless when the altercation with V12 happened because I couldn't even run away if I needed to. R73 stated again he doesn't feel safe and started to cry with tears rolling down his face. R73 again stated he started calling numbers that the hospital gave him that accepted his insurance. R73 started crying again and said had he known he needed to involve the facility to help him with the transfer, he would have contacted them sooner. As R73 continued crying he said no one ever asked how he was doing that night. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On December 9, 2024, at 1:57 PM and on December 10, 2024, at 1:34 PM, the video footage of the altercation was reviewed and showed the following: R73 asked V12 if she would empty his urinal. V12 gets very upset and starts yelling at R73 and stated he pissed her off, she is going to leave the urinal and walk the hell out of the facility. V12 continues screaming while leaning in towards the resident that she is not meant to do what he can do for himself. V12 then stated so go do it yourself, whatever the F*** happens let it happen. I'm not going to do it, whatever the F*** happens let it happen as she walks past the resident and enters the nurse's station. The nurse's station has two exits on either side of V12. V12 chooses the one closest to R73 and she walks about 8-10 feet towards the resident and the video continues to show V12's hand coming towards R73's phone, the screen then becomes obscure and V12 continues to scream in the background. Immediately afterwards R73 can be heard saying to someone, you are my witness she just put her hands on me. On December 10, 2024, at 12:05 PM, V1 stated the facility does not have a video of the incident because the video recycles every week. V1 stated he did not view his facility's video footage of the incident that took place at the nurse's station where there is a video camera. V1 stated he did not request a police report of the incident. The Police report dated November 20, 2024, at 11:50 PM, showed that the responding officer interviewed V12, and she stated that she got into an altercation with R73 regarding him demanding services, cornering her in a room, and rudely asked if she was on break. The report goes on to say that V12 stated R73 then started following her in his wheelchair and recording her. V12 said she tried to get away from R73 and hit his phone out of his hand in the process. The report also shows R73 stated he was upset that V12 was not doing her job and V12 started yelling and cursing, when R73 asked her to assist him, so he started recording her (V12). R73 claimed V12 walked up to him and smacked that phone out of his hand. The responding officer incident report also stated that before the physical altercation with R73, V12 nurse had a different exit where she could have avoided R73 altogether. The police report also showed that V12 was arrested on scene on November 21, 2024, at 12:32 AM and was issued a citation to appear in court for battery. On December 10, 2024, at 4:02 PM, V13 (Police Officer) stated he interviewed the alleged CNA perpetrator (V12). The staff was on the CNA's side and stated that R73 and V12 had a verbal altercation the day before. V13 stated that R73 stated that he rang his call light, and another CNA came and said she would get his CNA to dump his urinal. V13 stated that after no one showed, R73 went looking for his CNA and found her in the room across from the nurse's station. V13 stated that R73 said he asked the CNA if she was on her break, then the CNA and got aggressive and said his call light was not illuminated and she started screaming and cursing at him. V13 stated then R73 said he started recording her. The officer stated that the V12 stated R73 was following her around in the wheelchair. V13 stated that the CNA was about 12 feet away according to the video and she initiated and approached R73 and smacked the phone out of his hand. V13 stated V12 hit R73 hard enough to knock the phone from his hand. V13 stated V12 did not have a professional demeanor. V13 stated he found her aggressive in the video. V13 stated V12 was cited for battery. V13 stated that the definition of Battery is making contact however slight with another subject. V13 stated that V12 originally said R73 cornered her and as she was trying to get pass him is when she knocked the phone out of his hand. V13 stated that was not the truth based on the video he viewed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R73's Psychiatry follow up note by V9 (Psychiatric Nurse Practitioner) dated December 2, 2024, showed the following: Patient's mood appears to be up and down, asked to assess resident by staff due to episodes of agitation. Resident guarded on exam and stated he was physically attacked by a staff member and doesn't feel too safe. He thinks he will benefit from talk therapy. Denies prior Psychiatric history and reports insomnia and agrees to start melatonin. On December 10, 2024, at 3:48 PM, V9 stated he went to assess R73 for difficultly sleeping and was surprised that R73 talked about being assaulted. V9 stated that the resident said to him. Wouldn't you be agitated if this happened to you. V9 stated R73 told him he wasn't sleeping deeply at night because he was afraid that he will be attacked by staff. V9 stated he can understand not being able to sleep if he had that concern. V9 stated he recommended V9 be seen by psychologist for therapy. V12's employee statement dated November 20, 2024, stated that she told R73 that he walked all the way from his room just to yell at her over a urinal he could have emptied himself or the last shift should have emptied for him. V12 stated that R73 immediately took out his camera and started recording her and she repeated the same thing to him and pushed the camera away from her face and walked away. V16's nursing note dated November 2, 2024, at 11:55 PM showed the following: while walking up the hall, resident was observed wheeling around the nurse's station screaming at the CNA, He pointed at the nurse on duty and said, Didn't she smack my phone out my hand? the nurse on duty said, I did not see. The resident looked at writer and said. She smacked the phone out of my [hand] and that is assault. The writer asked the CNA to leave the area and she stated, He recorded me! and resident to return to his room so that supervisor could be notified. Immediately all resident's needs were reassigned to the alternate CNA on duty, Resident informed writer and supervisor that he wanted to press charges and called 911. The police arrived and spoke to R73, writer, and all other staff. On December 11, 2024 at 11:59 AM, V14 stated she remembers the altercation with R73 and V12 on 11/20/2024. V14 stated it happened at the nursing station. V14 stated she was at the nurse's station, she heard loud screaming and got up saw them going back and forth. V14 stated she told V12 to lower her voice because people were sleeping. V14 stated R73 was looking around and then found V12 and started talking at the Cybercafe (across from the nurse's station). V14 stated she heard them screaming and told them to calm down. V14 stated that R73 said immediately after it happened that V12 knocked the phone out of his hand. V14 said she did not see it happen. On December 12, 2024, at 12:47 PM, V14 stated that at no point during the altercation with R73 and V12 did she try to remove R73 from the situation. V14 stated they were not close together. V14 stated she did tell V12 to stop screaming at the R73, but V12 was so angry and told V14 that she was not her boss and couldn't tell her what to do. V14 stated she should have documented it but wasn't aware of the facility's protocols because she is agency staff. Progress note dated November 11, 2024, showed that R73 complained of pain to his right hand at a level of 7/10 pain level. Pain medication was given and an x-ray of his right hand and wrist was ordered. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Employee Discipline Form dated November 27, 2024, showed V12 was terminated for violating rule 6 of the SEIU agreement as outlined in the appendix. The violation occurred when the employee knocked the phone out of the hand of a resident, an action that constitutes inappropriate conduct. In addition, resident stated that his phone screen was cracked due to it being knocked out to the floor which violates Service Employee International Union (SEIU) rule #6- Willful destruction or damage of property belonging to facility or persons. This behavior is considered a breach of workplace standards and rules, leading to the employee's termination. The facility's Abuse Prevention Policy showed the following: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods, and services, by staff or mistreatment. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Verbal abuse is the oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389 Based on interview and record review the facility failed to conduct a thorough staff to resident abuse investigation by not reviewing available video footage of the altercation and not requesting the police report of the incident. This applies to 1 of 3 residents (R73) reviewed for abuse allegations in the sample of 18. The findings include: R73's face sheet showed him to be a [AGE] year old male admitted to the facility on [DATE], with diagnoses that include Necrotizing Fasciitis, severe sepsis, Pneumonia, Acute respiratory failure, and Long Term use of antibiotic. R73 Minimum Data Set (MDS) dated [DATE], showed R73 to be cognitively intact. On December 9, 2024, at 1:57 PM, R73 stated he was verbally abused and physically assaulted by V12 (Certified Nursing Assistant). R73 stated that he asked V12 at the nurse's station to empty his urinal and she started cursing at him, and she smacked his phone out of his hand. R73 stated he called the police. According to the facility's Final incident reportable dated November 29, 2024, the allegation of abuse was unsubstantiated as it related to R73. The facility's investigation was absent of any mention of reviewing the facility's or resident's video of the altercation. There was no mention in the investigation of the police report. The investigation report was also absent of any documentation of V14's (Registered Nurse on duty) interview. V14 was the nurse at the nurse's station during the altercation. On December 9, 2024, at 4:30 PM, V1 (Administrator/Abuse Coordinator) stated that he viewed the video of the incident that R73 had recorded. V1 stated he could not tell if V12 struck the resident based on R73's video. That is why he did not substantiate the allegation. On December 10, 2024, at 12:05 PM, V1 stated there is a camera that records at the nursing station where the incident occurred. V1 stated he does not have a video of the incident because the video recycles every week. V1 stated he did not view the facility video footage of the incident that took place at the nurse's station where there is a video camera. V1 stated he did not request a police report of the incident. On December 11, 2024, at 11:15 AM, V1 stated the incident between R73 and V12 occurred at the nurse's station where there is a camera positioned. V1 stated they interview witnesses if there was a witness. V1 stated R73 did not tell him there were any witnesses. Surveyor asked why was V14 not interviewed when she was the nurse on duty, and resident also stated in the video regarding a witness. V1 stated he interviewed V14, but she wouldn't write a statement. V1 stated V14 said she didn't see anything, but she was at the nurse's station. V1 stated he does not always review the facility's video recordings when investigating altercations. Furthermore, R73 had shown V1 the video he had recorded of the incident. V1 stated he did not view the facility's video footage. V1 stated the facility's video footage could have been helpful in giving another view of the incident to make it more clear for him whether or not R73 was hit by V12. (continued on next page)

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	12/12/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The police report related to the incident and dated November 20, 2024, documented that V14 was arrested and cited for battery of R73 on November 21, 2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on observation, interview, and record review, the facility failed to provide assistance to residents requiring help with ADL (Activities of Daily Living) care. This applies to 9 of 9 residents (R7, R13, R22, R34, R35, R42, R63, R71 and R72) reviewed for ADL in the sample of 18. The findings include: 1. R34's EMR (Electronic Medical Record) showed R34 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, contracture unspecified joint, and unspecified sequelae of nontraumatic subarachnoid hemorrhage. R34's MDS (Minimum Data Set) dated October 9, 2024, showed R34 had moderate cognitive impairment. R34 was dependent on staff for showering and required substantial/maximal staff assistance with personal hygiene. R34's care plan showed R34 required assistance with ADL care and the intervention included staff to provide assistance with ADL care. On December 9, 2024, at 11:50 AM, R34 was lying in bed wearing a hospital gown with spots on it, his hair was stringy and sticking up in different directions. There was a foul odor noted and R34 said he wants to get cleaned up and shaved up. On December 10, 2024, at 9:48 AM, R34 was in bed lying on his back wearing the same hospital gown (with spots on it), his hair remains stringy, foul odor noted, skin flaky, whiskers on face. On December 11, 2024, at 8:29 AM, R34's stringy hair was standing up all over his head. foul odor noted, skin flaky, whiskers on face. R34 said no one has offered a shower or bed bath. 2. R63's EMR showed R63 was admitted to the facility on [DATE], with diagnoses that included bilateral osteoarthritis of knees, dementia, acute respiratory failure with hypercapnia, anxiety, and congestive heart failure. R63's MDS dated , November 12, 2024, showed R63 was cognitively intact. R63 was incontinent of both bowel and bladder. R63 required substantial/ maximal assistance with oral care, and personal hygiene (shaving, combing hair, nail care). R63 was dependent on staff for showering/bathing, and toileting. R63's care plan showed R63 is incontinent of bowel and bladder and interventions implemented staff are to check as required for incontinence and clean the perineal area with each incontinence episode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 2:04 PM, R63 was in bed wearing a hospital gown. There was a foul odor noted, R63's hair was disheveled, she had facial hair on chin and upper lip. Her nails were long and jagged. Her fifth digit (little finger) on her left hand was contracted and when she turned her hand over, the nail on that finger was approximately half an inch long. R63 said she is seeing a doctor about her contracted finger and also stated she has asked the staff twice to cut her nails. On December 10, 2024, at 10:07 AM, V4 (CNA/Certified Nurse Assistant) and V5 (Restorative Aide) entered R63's room to provide incontinence care. V5 pulled R63's covers down, and the incontinence brief was saturated and there was liquid stool that had seeped out of the incontinence brief onto R63's gown and bed linen. V4 said she had worked the overnight shift and she had changed R63 this morning at 4:00 AM. V4. There was an area of excoriation noted to R63's bottom and groin area. On December 11, 2024, at 8:58 AM, V11 (CNA) said R63 will get a bed bath or shower that day. V11 said when giving a resident a bed bath or shower, she will place clean linen on the bed, she will wash the resident's hair, apply moisture barrier to bottom, apply lotion to dry skin and feet, and clip fingernails. There was no mention of oral care or putting on clean clothes. 3. R71's EMR showed R71 was admitted to the facility on [DATE], with diagnoses that included adult failure to thrive, unspecified osteoarthritis, rheumatoid arthritis, Alzheimer's disease, and muscle wasting and atrophy. R71's MDS dated [DATE], showed R71 had severe cognitive impairment. R71 required staff's substantial/maximal assistance for toileting, shower/bathing, dressing, and personal hygiene. R71's care plan showed R71 has ADL functional needs related to immobility, due to pain and gout. R71 requires assistance with oral care and staff are to encourage R71 to consume adequate fluid, instruct in proper brushing techniques, monitor adequacy of brushing, obtain dental consult, assist with oral care. On December 9, 2024, at 11:55 AM, R71 was in his wheelchair. R71 had long nose hair, long jagged nails, facial whiskers that extended under his chin and down the front of his neck. R71 was wearing a gray shirt, brown pants, and a red and blue jacket. There were white flakes all over his shirt and a white substance on his pants. On December 10, 2024, at 9:51 AM, R71 was in bed asleep. He was wearing the same clothes as yesterday, he still had long nose hair, long facial hair, and long jagged nails. On December 11, 2024, at 8:31 AM, R71 up in his wheelchair eating breakfast. R71's hair was stringy and standing up all over his head. R71 said he needed a shave and his long nose hairs clipped. R71 was wearing the same clothes for the third day in a row. R71's bed had food crumbs all over and a brown smear about 2 inches wide and 4 inches long on the bottom sheet of his bed. 4. R72's EMR showed R72 was admitted to the facility on [DATE], with diagnoses that included unspecified fracture of humerus, adjustment disorder with anxiety, acquired deformity of musculoskeletal system unspecified, and pain. R72's MDS dated [DATE], showed R72 was cognitively intact. R72 required assistance with showering. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 9, 2024, at 10:53 AM, R72 was in bed and said his pants were missing. R72 said he made the staff aware, and they were looking for his pants. R72 said he wants to be shaved. R72 said the staff has offered to shave him but they never follow up and now he has a beard that he doesn't want. On December 10, 2024, at 9:44 AM, R72, was in bed asleep, wearing the same clothes as yesterday and still with facial hair. On December 11, 2024, at 8:39 AM, R72 was sitting on the side of his bed eating breakfast and wearing same clothes as Monday (December 9, 2024). R72 said he still would like to be shaved. On December 11, 2024, at 9:15 AM, V2 (Interim DON/Director of Nursing and Regional Nurse Consultant) said residents are to be given a shower and/or bed bath twice a week. During shower days and non-shower days, the residents are to be provided with morning care which includes shaving (male/female) wash hair, nail care, wash face and hands, underarms, and perineal area. Staff should also offer and or set up the resident for oral care. Resident clothing should be changed daily and as needed if they have spilled something on them or if they are not clean. If a resident only has one or two outfits, we would first follow up with the family. If there is not any family, we have clothing donations we can check and get the resident more clothing. 29562 5. Face sheet shows R13 is [AGE] years-old who has multiple medical diagnoses which include personal history of traumatic brain injury and unspecified lack of coordination. R13 was on the facility's list of residents who has weight loss concern. R13's MDS (Minimum Data Set) dated November 8, 2024, shows that R13 is alert and oriented, and requires supervision for eating. On December 9, 2024, at 1:17 PM, R13 was sitting in his wheelchair in his bedroom. There was no staff around him to supervise. His lunch tray which was covered and untouched was placed on his overbed rolling table positioned on his left side. When surveyor approached him, R13 said he needed help for someone to cut his food, he said that he has no appetite. R13 was encouraged by surveyor to eat his food. Surveyor had to call a staff to set up his lunch. When the staff sliced the food for him, he started eating. R13's left arm appeared weak, he used his right arm and hand to eat that was unsteady with tremors. 6. R7 is [AGE] years-old who has multiple medical diagnoses which include multiple sclerosis, muscle spasm, and unspecified dementia. R7's MDS dated [DATE], shows that R7 is alert and oriented, and dependent on staff for grooming and hygiene. On December 10, 2024, at 9:48 AM, R7 was resting in bed. R7 was displaying facial hair, uncombed hair, and long dirty fingernails with brown substances underneath nails. V25 and V27 (Both Certified Nursing Assistants/CNA) rendered morning hygiene care to R7. V25 cleaned R7 from the face to the perineum with wet wipes. However, V25 did not comb R7's hair, did not offer to do nail care, and did not offer to shave R7. On December 10, 2024, at 10:11 AM, R7 stated that she wants her hair to be combed, her nails to be clipped and facial hair shaven. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024, at 2:28 PM, V2 (Director of Nursing/DON) stated that staff should provide grooming and hygiene to residents such as shaving, nail care, dressing, toileting, etc. 16746 7. R22 has multiple diagnoses including dementia without behavioral disturbance, based on the face sheet. R22's quarterly MDS (minimum data set) dated October 15, 2024, showed that the resident was cognitively intact and required assistance with personal hygiene. On December 9, 2024, at 10:48 AM, R22 was sitting in his wheelchair inside the unit television room close to the nursing station. R22 was alert, oriented and verbally responsive. R22 had accumulation of long facial hair. R22 stated that he wanted the staff to shave him because he cannot shave himself. On December 10, 2024, at 10:34 AM, R22 was sitting in his wheelchair inside the unit television room close to the nursing station. R22 was alert, oriented and verbally responsive. R22 had accumulation of long facial hair. In the presence of V3 (Nursing Supervisor), R22 stated that he wanted the staff to shave him because he cannot shave himself. V3 agreed that R22's facial hair were long and that R22 needs the assistance of the staff with personal hygiene including shaving of facial hair. R22's active care plan regarding ADL (activities of daily living) functional status initiated on November 6, 2022, showed that the resident need assistance with personal care. 8. R35 had multiple diagnoses including acute on chronic diastolic (congestive) heart failure and muscle wasting and atrophy on multiple sites, based on the face sheet. R35's admission MDS dated [DATE], showed that the resident was cognitively intact. On December 9, 2024, at 11:41 AM, R35 was sitting in her wheelchair inside the therapy room. R35 was alert, oriented and verbally responsive. R35's fingernails were long, jagged with black substances under some of the nails. R35 stated that she wants the staff to trim and clean her fingernails. On December 10, 2024, at 10:37 AM, R35 was sitting in her wheelchair inside her room. R35 was alert, oriented and verbally responsive. R35's fingernails were long, jagged with black substances under some of the nails. In the presence of V3, R35 stated that she wants the staff to trim and clean her fingernails. V3 acknowledged that R35's fingernails were long, jagged and needed cleaning. V3 stated that R35 needs the assistance of the staff with fingernails trimming and cleaning. 9. R42 had multiple diagnoses including Parkinsonism and Tourette's, based on the face sheet. R42's quarterly MDS dated [DATE], showed that the resident was cognitively intact. On December 9, 2024, at 1:51 PM, R42 was sitting in a chair inside the first floor big dining/activity room. R42's fingernails were long, jagged and curving downwards. R42 stated that she wants the staff to assist her with trimming her fingernails. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 10, 2024, at 10:30 AM, R42 was inside her room. R42's fingernails remained long, jagged and curving downwards. In the presence of V3, R42 stated that she wants the staff to assist with trimming her fingernails. According to V3, R42 needed the assistance of the staff to trim her fingernails. R42 had an active care plan initiated on November 13, 2024, that showed that the resident has Parkinson's disease and is at risk for ADL decline. On December 11, 2024, at 10:14 AM, V2 (Director of Nursing) stated that it is part of the facility's nursing care and services to assist all residents needing assistance with ADLs including shaving/removal of unwanted facial hair and nail care. According to V2, all residents needing assistance with ADLs should be assisted by the staff to ensure and maintain the resident's good hygiene and grooming. The facility's activities of daily living policy with effective date of February 2023 showed under purpose, Based on a comprehensive assessment of the resident and consistent with the resident's needs and choices, our facility provides necessary care and services to ensure that a resident's abilities in activities of daily living (ADL) do not diminish unless the circumstances of the individual's clinical condition demonstrates that such decline was unavoidable. The same policy showed in-part under guidelines, In accordance with the comprehensive assessment, together with respect for individual resident needs and choices, our facility provides care and services for the following activities: Hygiene, bathing, dressing, grooming and oral care . Elimination: toileting . Dining: eating including meals and snacks.

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	145338	A. Building B. Wing	12/12/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 29562 Based on observation, interview, and record review, the facility failed to provide a dressing change as needed to a resident with a vascular wound. This applies to 1 of 5 residents (R66) reviewed for wounds in the sample of 18. The findings include: On December 10, 2024, at 4:28 PM, R66 was propelling his wheelchair in the hallway. R66's left leg had a wound dressing which was covered with a tubi-grip that was stained from top to bottom with brown substance. On December 11, 2024, at 9:17 AM, R66 was sitting in his wheelchair in his bedroom, he had the same stained tubi-grip and dressing which was caked with dry brown substance. Upon closer inspection R66's dressing had strong urine odor. On December 11, 2024, at 10:02 AM, V24 (Wound Care Nurse) stated that R66 has a vascular wound on the left leg. His dressing is changed daily and as needed. As needed means to change the dressing if the dressing came off or if the dressing is soiled, this is done to prevent potential infection. On December 11, 2024, at 10:10 AM, V24 rendered wound care to R66. The tubi-grip and dressing was heavily soiled with urine which overflowed to the wound. V24 stated that the leg is granulating but still secreting discharges. V24 cleaned the wound and changed the dressing. R66 was cooperative during the wound care. On December 11, 2024, at 1:48 PM, V2 (Director of Nursing/DON) stated wound dressing should be changed as needed. It's an increased risk of infection when soiled dressing is left in place. R66's wound care plan dated November 10, 2024, shows R66 has venous stasis ulcer to left lower leg. The same care plan showed multiple interventions including, Change resident as needed and ensure skin is dry to prevent further breakdown of skin. If he refuses educate and encourage.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 16746 Based on observation, interview, and record review the facility failed to assess and provide a brace to a resident to prevent further reduction in ROM (range of motion) and to maintain proper positioning. This applies to 1 of 1 resident (R41) reviewed for range of motion in the sample of 18. The findings include: R41 has multiple diagnoses including nontraumatic subarachnoid hemorrhage, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, paraplegia, anorexic brain damage and contracture of the right and left hand, based on the face sheet. R41's quarterly MDS (minimum data set) dated October 14, 2024, showed that the resident was cognitively intact. The MDS showed that R41 had functional limitation in ROM on both sides of his upper and lower extremities. The same MDS showed that R41 required total assistance from the staff with all of his ADLs (activities of daily living). On December 9, 2024, at 11:24 AM, R41 was sitting in his reclined high back wheelchair, inside his room. R41 was alert, verbally responsive and oriented. With the assistance of V8 (Licensed Practical Nurse) resident's left hand, wrist and left fingers were observed contracted without any brace/splint or device in place. R41's right hand was hyperextended, with some right hand fingers contracted. R41 stated that he does not use any brace/splint and/or positioning device on both hands. On December 10, 2024, at 10:26 AM, R41 was in bed, alert, oriented and verbally responsive. R41's left hand, wrist and left fingers were contracted, and his right hand hyperextended with some right hand fingers contracted. In the presence of V3 (Nursing Supervisor), R41 stated that he does not use any brace/splint and/or positioning device on both hands. V3 agreed that R41's left hand, left fingers and some right hand fingers were contracted. V3 was prompted to have the therapy department screen R41 to determine the need for a brace/splint or positioning device on the resident's bilateral hands. R41 agreed to be screened by the therapy department. R41's active care plan initiated on February 23, 2023, showed that the resident has a splint to the left and right hand related to hemiplegia and hemiparesis. The care plan goal target date was until January 20, 2025. The goal was for R41 to tolerate the use of the bilateral hand splints without untoward reaction with application time from 7:00 PM through 7:00 AM. The same care plan showed multiple interventions including application of the splint/brace per physician order and for the staff to apply a soft brace to the left hand and a resting hand splint to the right hand during the night. R41's active physician order as of December 10, 2024, showed no order for the use of a soft brace to the left hand and no order for a resting hand splint to the right hand. On December 11, 2024, at 9:35 AM, R41 was in bed, alert, oriented and verbally responsive. In the presence of V3, R41 was asked if the staff applies a brace/splint on his bilateral hands at night from 7:00 PM through 7:00 AM. R41 responded No. R41 added that no brace and/or splint are applied to his bilateral hands in the morning, afternoon or at night. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's therapy communication form dated December 10, 2024, created by V32 (Occupational Therapist) showed screening of the resident. The screening results showed, [Patient] screened this [morning]. Patient noted to have bilateral distal [upper extremity] contractures and deformities. [Patient] will benefit from bilateral distal [upper extremity] braces for positioning during nighttime to maintain joint integrity. On December 11, 2024, at 9:49 AM, V32 stated that she had screened R41 on December 10, 2024, between 12:15 and 12:30 PM, to determine the need for a brace on both hands. V32 stated that R41's right hand and proximal joints were hyperextended with wrist drop. V32 added that R41's right hand had contracture at the wrist and fingers. According to V32, based on R41's right hand screening she had recommended for the resident to use a brace at night for positioning. V32 stated that R41's left hand, wrist and fingers were contracted but the resident was still able to extend his left fingertips about 5 to 10 degrees. V32 stated that based on R41's left hand screening she had recommended for the resident to use a left hand brace at night for positioning and to prevent further left hand and fingers contracture since the resident is still able to slightly move his left hand and fingers. During the same interview, V32 stated that she will also evaluate R41 to determine the appropriate brace to be applied on both the resident's hands/wrist and fingers. On December 11, 2024, at 10:21 AM, V2 (Director of Nursing) stated that the facility should follow and apply the bilateral hand splint/brace on R41 based on the resident's plan of care to maintain the resident's hand functioning, positioning and to prevent further contractures.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to provide incontinence and catheter care in a manner that would prevent urinary tract infections (UTI). This applies to 4 of 6 residents (R7, R10, R13, R56) reviewed for incontinence and urinary catheter care in the sample of 18. The findings include: 1. Face sheet shows R13 is [AGE] years-old who has multiple medical diagnoses which include personal history of traumatic brain injury, benign prostatic hyperplasia (BPH) without lower urinary tract symptoms, obstructive and reflux uropathy, and unspecified lack of coordination. On December 9, 2024, at 11:20 AM, V25 (Certified Nursing Assistant/CNA) rendered incontinence care to R13 who was wet with urine. V25 wiped R13's groins with wet wipes in a stroke, then she asked R13 to turn on his right side without ensuring that the penile and scrotal area were cleaned. V25 proceeded to remove the soiled incontinence brief and changed it, without wiping/cleaning the rectal and buttocks area. 2. Face sheet shows R10 is [AGE] years-old who has multiple medical diagnoses which include vascular dementia, stage 4 pressure ulcer of the right buttock, and unspecified diarrhea. On December 9, 2024, at 12:40 PM, V25 (CNA) rendered incontinence care to R10 who was wet with urine and had a bowel movement. V25 positioned R10 on her right side to clean the rectal and buttocks area. V25 proceeded to place a new incontinence brief on R10 without cleaning the front perineum. 3. Face sheet shows that R7 is [AGE] years-old who has multiple medical diagnoses which include multiple sclerosis, neuromuscular dysfunction of the bladder, hydronephrosis, and hydroureter. On December 9, 2024, at 10:44 AM, R7 was resting in bed, she had a suprapubic catheter that was leaking from the insertion site as observed with V34 (Nurse). On December 10, 2024, at 9:48 AM, V25 and V27 (Both Certified Nursing Assistants/CNA) rendered hygiene care to R7 which include incontinence care. V25 wiped R7's left groin and outer labia, then she proceeded to clean the back perineum and placed a new incontinence brief. There was an ABD (army battle dressing) pad on R7's abdominal fold which was heavily saturated with urine. V25 changed the ABD pad without cleaning the skin of the abdominal folds and the catheter tube. In addition, V25 did not ensure the labial folds and right groin were cleaned. On December 11, 2024, at 2:25 PM, V2 (Director of Nursing/DON) stated when providing incontinence care, the staff should clean the whole peri-area from front to back to prevent skin breakdown and UTI. R7's suprapubic care plan catheter shows to keep skin clean and dry. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's suprapubic catheter care policy dated September 2005 showed, The purpose of this procedure is to prevent infection of the resident's urinary tract. The policy showed in-part under steps in the procedure, 6. Wash around the catheter site with soap and water. (Note: If the resident has a drainage sponge around the stoma site, remove the sponge before washing with soap and water.) Wash the outer part of the catheter tube with soap and water. 16746 4. R56 has multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, urinary incontinence, chronic kidney disease, based on the face sheet. R56's quarterly MDS dated [DATE], showed that the resident is cognitively intact and required maximum assistance from the staff with most of her ADLs (activities of daily living) including toileting hygiene. The same MDS showed that R56 was frequently incontinent of both bowel and bladder functions. On December 10, 2024, at 2:20 PM, in the presence of V3 (Nursing Supervisor), V10 (Certified Nursing Assistant) provided incontinence care to R56. R56's disposable brief was wet with urine. Using one side of the disposable cloth, V10 wiped R56's left groin area once, then wiped the resident's perineal area (front/middle area) in an up and down stroke once. V10 then folded the same used disposable cloth, wiped R56's right groin area once, then again wiped the resident's perineal area (front/middle area) in an up and down stroke once. V10 did not separate R56's labial folds to ensure that it was cleaned. On December 11, 2024, at 10:17 AM, V2 (Director of Nursing) stated that V10 should have used multiple disposable cloths or at least used the different sides of the disposable cloth to wipe the middle perineal area of R56 after wiping the groin area, to prevent cross contamination and potential infection, during urinary incontinence care. V2 added that V10 should have separated the resident's labial folds during the urinary incontinence care to ensure that the area was thoroughly cleaned and to ensure and maintain perineal hygiene. The facility's incontinence care guideline last revised by the facility in June 2021 showed, Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. The facility policy and procedure regarding perineal care revised in August 2008 showed, The purpose of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. The policy showed in-part that for female residents, b. Wash perineal area, wiping from front to back. (2) Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side, and using downward strokes. The same policy showed in-part that for male residents, b. Wash perineal area starting with urethra and working outward. (3) Continue to wash the perineal area including the penis, scrotum and inner thighs.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on interview, and record review, the facility failed to document the dialysis communication and assessment after dialysis. This applies to 1 of 2 residents (R64) reviewed for dialysis in the sample of 18. The Findings Include: R64 was admitted to the facility on [DATE], with multiple diagnoses including end stage renal disease with dependence on hemodialysis, type 2 diabetes, hemiplegia, and hemiparesis following cerebral infarction and hypotension of hemodialysis. R64's physician order summary showed R64 has an order for in facility hemodialysis 4 days per week and a left arm A-V (Arterial Venous) fistula to the left arm. On December 11, 2024, at 11:30 AM, V18, (Dialysis Registered Nurse) stated after dialysis the facility nurse should assess the fistula for bruit and thrill, check the dressing for bleeding, and check the blood pressure and pulse and assess for any change of condition. V18 stated there is a dialysis communication form that the pre dialysis assessment is documented on by the facility nurse, the dialysis treatment section that the dialysis nurse completes, and the after-dialysis section that the facility staff completes, titled Nursing Home Use Only-Upon Return to the facility Following Dialysis. The dialysis communication form is then scanned into each resident's medical record under the miscellaneous tab. V18 stated that R64 received dialysis treatment on the following dates: November 29, 2024, December 2, 2024, December 4, 2024, December 6, 2024, and December 11, 2024. Review of R64's dialysis communication forms showed there was no information entered into the after-dialysis portion of the form by the facility nurses on the following days: November 25, 26, 27, and 29, 2024, and December 2, and 6, 2024. The record did not show there was an assessment of the resident's dressing after dialysis. The facility's policy titled Post Dialysis Monitoring and Observation with Implanted A-V Shunt Policy dated January 2018 showed .General Information .3. Complete the dialysis communication form with any info request by the Certified Dialysis Facility.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562 Based on observation, interview, and record review, the facility failed to provide meaningful activity to a resident who is bed bound and is diagnosed with dementia. This applies to 1 of 4 residents (R7) reviewed for dementia in the sample of 18. The findings include: Face sheet shows that R7 is [AGE] years-old who has multiple medical diagnoses which include multiple sclerosis, unspecified dementia, unspecified severity with other behavioral disturbance, major depressive disorder, stage 4 pressure ulcer to left and right buttocks, stage 4 pressure ulcer to sacral region, osteomyelitis of vertebra, sacral and sacrococcygeal region, gastrostomy, colostomy, muscle spasm, unspecified pain, major depressive disorder, and anxiety disorder. Minimum Data Set (MDS) dated [DATE], showed R7 is alert and oriented and totally dependent on staff for activities of daily living care. From December 9 through December 10, 2024, there were multiple observations of R7 screaming repeatedly for a nurse to come. On December 9, 2024, at 1:07 PM, V34 (Nurse) stated that it was R7's behavior to yell for staff because she wants someone to sit with her inside the bedroom. On December 10, 2024, at 11:05 AM, R7 was yelling for a nurse. Staff would come and asked R7 what she needed, and they would give it to her like water, coffee, and repositioning. However, the moment that staff step out of the bedroom, R7 would start yelling again for staff to come. It was also observed during care that R7 was calm and cooperative with staff. But when staff left her to assist other residents, she started yelling again. Surveyor asked R7 if she wanted to get up from bed to join the group activities, R7 refused and said she prefers to stay in bed. On December 10, 2024 at 11:21 AM, there were three CNAs (V11, V25, and V27) sitting at the nurses' station talking while R7 was yelling for staff. When surveyor approached V29 (Nurse) who was also at the nurses' station to ask how they manage R7's behavior, V29 said that R7 was prescribed Depakote three times a day for her behavior. R7 continued to yell for a nurse, however V11, V25, and V27 remained at the nurses' station without checking on what R7 needed. At 1:40 PM on December 10, 2024, R7 was observed yelling for a nurse, but nobody came in to check. On December 11, 2024, at 11:14 AM, V23 (Social Service Director) stated R7 has behavior like yelling for the nurse. Any staff members should respond to R7's calling. The facility does one to one activity for R7. It does not matter how many times a resident calls, the staff have to respond to the resident and offer activity. On December 11, 2024, at 11:36 AM, V30 (Activity Director) stated R7 has a yelling behavior. They provide a daily pop in visit, they give a daily newsletter, and R7 loves chatting with the staff. R7 doesn't like getting up for activities. She likes to talk. They ensure that she has snacks. As far as activity participation, they don't have anything for her. Prior to hospitalization she likes to participate in nail care activity. V30 added, maybe she could talk R7 into participating in the nail activity. V30 also said that R7 likes watching TV, which is one of her activities. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It was observed from December 9 through December 11, 2024, that R7's TV was on, even when she was yelling out for a staff. On December 11, 2024, at 11:52 AM, when asked if R7 wanted to watch what she was watching she said no and she wants to watch another program. Surveyor asked where her TV (television) remote control was, R7 stated she does not know. Surveyor looked for it and found it on top of the window stool, which was beyond R7's reached. On December 11, 2024, at 11:52 AM, R7 stated nobody comes in to interact with her except when they give her incontinence care and medication. Nobody comes to sit down and have real interaction with her. They don't give her newsletter because they know she doesn't like reading. Nobody came in that morning for a pop-in visit. V30 presented a copy of R7's activity log for December 2024. It showed that they did a current event news (daily newsletter), pop-in visit, and activity cart, which R7 said that it did not happen. On December 11, 2024, at 2:27 PM, V2 (Director of Nursing/DON) stated that staff should provide meaningful activities for a resident for quality of life. R7's has multiple care plans addressing her psychosocial well-being and behavior. Care plan dated October 4, 2024, shows R7 has limited social interactions with her peers due to limited independent mobility. The same care plan shows Staff to provide resident opportunities to interact with peers through activities or through 1:1 visit. Care plan regarding behavioral symptoms dated March 4, 2021, with a target date of January 20, 2025, shows, resident displays behavioral symptoms not directed towards others as evidenced by; resident frequently calling out into the hallway for the nurse instead of utilizing her call light for assistance. The same care plan shows interventions which include, anticipate resident's needs to decrease verbal behavioral symptoms, and provide diversional activities to reduce behavioral symptoms. Facility's undated activities policy shows, It is the policy of this facility to provide an activity program to the residents which is appropriate to their needs and interest and capacity to participate and benefit. Activities are designed to stimulate physical and mental capabilities to obtain the optimal social, physical, and emotional state. Individual resident activities will be planned in accordance with any limitations set by the attending physician. The same policy shows in-part under standards that, 6. Activity programming shall include but not limited to: b. Activities specifically suited for residents unable to leave their rooms. j. Individual programs provided on a one-to-one basis. In addition, it also shows, 7. Programming will be designed to meet, in accordance with the comprehensive assessments, the interests and the physical, mental and psychosocial well-being of each resident. There was no evidence of activity assessment or documentation showing that meaningful activities were being provided for R7.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48308 Based on interview and record review the facility failed to provide bedtime snacks in accordance with their menu. This applies to 5 of 5 (R9, R23, R49, R56, R61) residents who attended the resident counsel meeting and expressed their concerns regarding the availability of bedtime snacks in the sample of 18. The findings include: On December 10, 2024, at 10:05 AM, during the resident meeting, when asked about the availability of bedtime snacks, R49 (Resident Council [NAME] President) stated they are only served peanut butter sandwiches every night and not all the residents get to have one. R61 (Resident Council President) agreed and stated the staff do not pass out the snacks and only the residents who can get to the nurses' station are able to get the sandwich. R49 resides on the first floor and stated the staff do not pass out the snacks. R61 resides on the second floor. R49 and R61 also stated the peanut butter sandwiches that are served are stale. R9, R23 and R56 all agreed that the bedtime snacks are not passed out by staff, not available to all residents who want them, and only peanut butter sandwiches are served. On December 11, 2024, V1 (Administrator) provided a menu titled ECC NCS Snacks and Always Available Menu Regular page 3 of 4. The Menu listed each day Sunday through Saturday, and identified food items always available for starters, lunch, dinner, and PM snacks. The PM snack always available menu listed the following items: sugar free fruited gelatin, peanut butter and jelly sandwich, oatmeal raisin cookie, graham cracker, fruited yogurt, applesauce, and assorted beverages as snack items available for residents each day. On December 11, 2024, at 1:20 PM, V20 (Food Service Supervisor) stated the only bedtime snack that is prepared daily are peanut butter and jelly sandwiches. No beverage was identified as being served. V20 stated he is not sure how many sandwiches are prepared to be served daily. The facility roster dated December 9, 2024, showed census of 74 residents in the facility. V20 reviewed the available stock in the kitchen for each snack item listed on the always available menu and found there was no gelatin mix or prepared fruited gelatin available, no fruited yogurt available, no oatmeal raisin cookies available, no graham crackers available, and no prepared applesauce available to be served as snack to the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43389 Based on observation, interview, and record review the facility failed to monitor refrigerator temperatures, failed to label and date potentially hazardous food items, and failed to store food to prevent cross contamination of food items. The facility also failed to ensure dietary staff use facial hair covers while in the kitchen. This failure affects all residents receiving food from the kitchen. The findings include: The facility roster dated December 9, 2024, showed census of 74 residents in the facility. The diet type report dated December 9, 2024, showed 71 residents receive food from the facility's kitchen. On December 9, 2024, at 9:27 AM during the initial tour of the kitchen with V20 (Dietary Manager) the reach in refrigerator #1 had milk and cheeses in it and no thermometer in the refrigerator. The thermometer that is a part of the refrigerator was not functional. V20 stated that staff checks temperatures and records these temperatures in a logbook. The logbook of the refrigerator temperatures for December 5 through December 9, 2024, were reviewed and noted to be blank. V20 stated he did not check the temperature of the refrigerator today. V20 was also observed with a mustache and beard and V20 was not wearing a beard covering during this tour. In the walk-in refrigerator, a tray of partially covered shredded pork was in the walk-in refrigerator, with a date of 12/13/2024. The label did not identify the food item. V20 confirmed that the food item should be completely covered to prevent contamination. In the walk-in freezer there was a large aluminum pan of what V20 described as pork chops. The pork chops had cellophane plastic on top of them that was not completely sealed all around. The pork chops had frost around them, and a thick layer of ice on the top of about half of the pork chops. The ice was about 1.5 inches thick in some places. There was no date on the pork chops. V20 stated that the fan is dripping on the pork chops and stated that the facility is in the process of fixing the fan. V20 stated he will throw the pork chops away today. On December 11, 2024, at 9:20 AM with V20, observed the pork chops that were not labeled and almost completely covered in a thick layer of ice still in the freezer, in the same spot they were on 12/9/2024 and 12/10/24 (below the leaking fan.) V20 then took them and threw them in the garbage. V20 was not wearing a beard covering. On December 9, 2024, at 10:34 AM, V20 was not wearing a beard covering while preparing the pureed diet. On December 9, 2024, at 12:06 PM, V20 was not wearing a beard covering while slicing a pork loin. On December 9, 2024, at 12:35 PM, V20 started plating the resident's food without wearing a beard covering. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On December 12, 2024, at 3:08 PM, V21 (Cook) and V22 (Dietary Aide) were in the kitchen and stated that staff should cover the hair on their head and face when in the kitchen. The facility's Culinary Services Inventory, Purchasing and Storage Policies stated the following: Check meat, fish, and poultry for signs of freezer-burn and refreezing. Assure that all packaging of food is clean and unbroken. All food products must be stored in their original container, except when opened or processed; then, they may be stored in a covered container. n. all products should be clearly dated as they are removed from the original container to maintain First-in-First out (FIFO) rotation. 4b. Dairy Products: check temperature, it should be 40 degrees Fahrenheit or below. All opened foods should be kept in containers that prevent contamination. Such containers should be clearly labeled with the common name of the food. Frozen storage 3. Frozen foods should be wrapped or otherwise containerized in a manner that prevents oxidation (freezer-burn). The facility's Team Member Health and Personal Hygiene policy dated June 2024 showed the following: all mustaches and beards must have a beard covering.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview, and record review, the facility failed to implement transmission-based precautions as required, failed to perform hand hygiene during provision of care, failed to change gloves during incontinence care and placed soiled linen on the floor. This applies to 7 of 7 residents (R7, R10, R13, R40, R54, R56, R63) reviewed for infection control in the sample of 18. The findings include: 1. R63's EMR (Electronic Medical Record) showed R63 was admitted to the facility on [DATE], with diagnoses that included bilateral osteoarthritis of knees, dementia, acute respiratory failure with hypercapnia, anxiety, and congestive heart failure. R63's MDS dated , November 12, 2024, showed R63 was cognitively intact. R63 was incontinent of both bowel and bladder. R63 required substantial/ maximal assistance with oral care, and personal hygiene (shaving, combing hair, nail care.) R63 was dependent on staff for showering/bathing, and toileting. R63's EMR showed R63 experienced loose stools while receiving antibiotic on December 10, 2024. R63 was also being treated for pneumonia. R63 was in a semiprivate room with a roommate and not on any transmission-based precautions. On December 11, 2024, at 11:23 AM, V2 (DON) and V3 (IP nurse) were reviewing the infection control report. V2 read out loud the CDC (Center for Disease Control) guidelines for transmission-based precautions. V2 stated since R63 has symptoms of diarrhea with suspicion of C-difficile infection, R63 should have contact precautions implemented. 2. R10's EMR showed R10 was admitted to the facility on [DATE], with multiple diagnoses including dementia, chronic diastolic congestive heart failure, generalized anxiety disorder, and pressure ulcer stage 4. R10 was listed on the infection control report as having a bacterial wound infection with new or increased purulent drainage. R10 was not identified as being on any transmission-based precautions. On December 11, 2024, at 11:23 AM, V2 (DON) and V3 (IP nurse) were reviewing the infection control report. V2 read out loud the CDC (Center for Disease Control) guidelines for transmission-based precautions for draining wounds. V2 and V3 stated R10 should be on contact transmission-based precautions based on R10's symptoms of the draining wound. 3. R40's EMR showed R40 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis, acquired absence left leg below the knee, chronic obstructive pulmonary disease, neuromuscular dysfunction of the bladder with indwelling catheter, acquired absence of the right leg below the knee and unspecified asthma. R40's physician order summary showed R40 had an order for Levofloxacin 500 mg (Milligrams) for pneumonia and Robitussin cough syrup both orders initiated on December 10, 2024. R40 was listed on the infection report as having a bacterial infection for pneumonia. R40 was exhibiting symptoms of a cough according to the physician progress note of December 10, 2024. R40 was not in any transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024, at 11:23 AM, V2 (DON) and V3 (IP nurse) were reviewing the infection control report. V2 read out loud the CDC (Center for Disease Control) guidelines for pneumonia. V2 stated R40 should be in contact droplet transmission-based precautions for cough related to pneumonia. The facility's policy titled Isolation categories for Transmission based Precautions dated January 20, 2024, showed .1. Transmission based precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection .Contact Precautions .for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. 41855 4. R63's EMR showed R63 was admitted to the facility on [DATE], with diagnoses that included bilateral osteoarthritis of knees, dementia, acute respiratory failure with hypercapnia, anxiety, and congestive heart failure. R63's MDS dated , November 12, 2024, showed R63 was cognitively intact. R63 was incontinent of both bowel and bladder. R63 required substantial/ maximal assistance with oral care, and personal hygiene (shaving, combing hair, nail care). R63 was dependent on staff for showering/bathing, and toileting. R63's care plan showed R63 is incontinent of bowel and bladder and interventions implemented staff are to check as required for incontinence and clean the perineal area with each incontinence episode. On December 10, 2024, at 10:07 AM, V4 (CNA/Certified Nurse Assistant), V5 (Restorative Aide), and V6 (CNA) entered R63's room with supplies to provide incontinence care. All three CNAs applied gloves without performing hand hygiene first. V5 was noted to double glove. V5 pulled down the covers and lifted up R63's gown, the brief was saturated with urine and liquid stool had leaked out of the brief in the front, back, and on the sides. There was stool on her inner legs and on the cloth pad under her and also on the bottom bed sheet. V5 used a couple of disposable wipes and cleaned the groin area and then cleaned down the middle with the same wipe. V5 repeated this many times until R63 was cleaned. With the same gloves, V5 assisted R63 to turn onto her right side away from her and towards V4. There was a large amount of liquid stool and mucous noted. V5 cleaned R63 from front to back and then pushed the soiled linen under R63. While wearing the same gloves, V5 placed the new clean linen under R63, and helped her turn onto her back and over onto her left side facing V5 with V4's assistance. V4 used the wipes and cleaned R63 from front to back. V4 pulled out the soiled linen and placed it into a plastic bag that was on the end of the bed. V6 CNA tied up the linen bag and placed it on the floor near the door. With the same gloves, V4 pulled out the clean linen from under R63, and helped turn R63 onto her back and she pulled the incontinence brief up between R63's legs. The staff did not perform hand hygiene before care or during care. Gloves were removed as they left the room and V4 showed surveyor where they went into another hallway to wash their hands. (continued on next page)

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westmont Manor Hlth & Rhb	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024, at 9:15 AM, V2 (Interim DON/Director of Nursing) said hand hygiene should be performed before putting on gloves and before starting care. The gloves should be removed after cleaning an area and before moving to the next area. Hand hygiene should be performed after removing the gloves and before putting on new gloves. Staff should not touch the clean linen or the resident with the same gloves they had cleaned a soiled area with. Once care is done and resident is comfortable, gloves should be removed, and hand hygiene performed before leaving the room. V2 also said dirty linen in a bag should never be placed on the floor. 29562 5. On December 9, 2024, at 11:20 AM, V25 (Certified Nursing Assistant/CNA) rendered incontinence care to R13 who was wet with urine. V25 wiped R13's groins, removed R13's soiled incontinence brief and replaced with a clean one, and pulled R13's pants back in place while wearing the same soiled gloves. 6. R10 was on Enhance Barrier Precaution due to stage 4 pressure ulcer on right buttock. On December 9, 2024, at 12:40 PM, V25 (CNA) rendered incontinence care to R10 who was wet with urine and had a bowel movement. V25 cleaned R10's rectum and buttocks and placed a new incontinence brief and helped reposition R10. V25 then removed her gloves and washed her hands and proceeded to assist R10 to get dressed. However, V25 did not wear full PPE (personal protective equipment) such as the gown. 7. On December 10, 2024, at 9:48 AM, V25 and V27 (Both CNAs) rendered hygiene and incontinence care to R7. V27 emptied the colostomy bag, changed her gloves and helped reposition R7 during care without hand hygiene in between tasks. V25 cleaned R7 from the face to the perineum, assisted to reposition R7, and placed a new incontinence brief and clean linen while wearing the same soiled gloves all throughout the care. 8. On December 11, 2024, at 8:41 AM, V26 (CNA) rendered incontinence care to R54 who was wet with urine. V26 assisted R54 in getting dressed. V26 assisted R54 to sit up at the edge of the bed, put R54's shoes on, and set up her breakfast tray, while wearing the same soiled gloves. On December 11, 2024, at 2:22 PM, V2 (Director of Nursing/DON) stated that staff should perform hand hygiene and change their gloves in between tasks to prevent cross contamination and prevent spread of infection. 16746 9. On December 10, 2024, at 2:20 PM, in the presence of V3 (Nursing Supervisor), V10 (Certified Nursing Assistant) provided incontinence care to R56. After the incontinence care procedure, V10 applied barrier cream on R56's perineum and buttocks, applied a new disposable brief, fixed the resident's hospital gown, placed a pillow under R56's legs, covered the resident with a blanket. V10 then used the bed remote to elevate the head of R56's bed, while using the same soiled gloves that she used to provide incontinence care to the resident. While outside of R56's room, in the presence of V3, V10 acknowledged that she did not remove her soiled gloves after providing incontinence care to R56. V10 also acknowledged that she used the soiled gloves to complete the clean task for R56. (continued on next page)

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	145338	A. Building B. Wing	12/12/2024

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Westmont Manor Hlth & Rhb	512 East Ogden Avenue Westmont, IL 60559

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2024, at 10:17 AM, V2 (Director of Nursing) stated that the staff should remove their gloves and perform hand hygiene, either hand washing or use of the hand sanitizer after providing incontinence care to a resident because the procedure is considered a dirty task. The staff then should apply a new pair of gloves before performing a clean task such as applying a barrier cream to a resident and before touching and/or manipulating resident's personal stuff (brief, blanket, pillow) and equipment (bed remote control) to prevent cross contamination and infection. The facility's handwashing/hand hygiene policy dated March 2020 showed, It is the policy of the facility to assure staff practice recognized handwashing/hand hygiene procedures as a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids. The policy showed in-part under specifications that, 4. When hands are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: . g. before moving from a contaminated body site to a clean body site during resident care; h. before and after putting on and upon removal of PPE (Personal Protective Equipment), including gloves; i. after contact with a resident's intact skin; . l. after contact with potentially infectious material; m. after removing gloves.