NO. 0938-0391) DATE SURVEY COMPLETED 07/26/2013
07/26/2013
(X5) COMPLETION DATE

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		145307	B. WING			07/:	26/2013
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GROVE	OF LA GRANGE PAR	к			01 NORTH LAGRANGE ROAD A GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ıge 30	F99	999			
	Section 300.610 Re	esident Care Policies					
	procedures, govern the facility which sh Resident Care Polic least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th	Ill have written policies and hing all services provided by hall be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in ty and shall be reviewed at his committee, as evidenced by dated minutes of such a					
	 Nursing and Person a) Comprehent facility, with the part the resident's guard applicable, must de comprehensive carr includes measurable meet the resident's and psychosocial meet resident's comprehe allow the resident to practicable level of provide for discharg restrictive setting base needs. The assess the active participation 	General Requirements for nal Care hsive Resident Care Plan. A tricipation of the resident and dian or representative, as evelop and implement a re plan for each resident that ble objectives and timetables to a medical, nursing, and mental heeds that are identified in the bensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as					

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		HAND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		145307	B. WING	≩		07/	26/2013
NAME OF F	PROVIDER OR SUPPLIER	•		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GROVE	OF LA GRANGE PAR	к			701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F9999	Continued From para applicable. (Section b) The facility is care and services to practicable physica well-being of the reseach resident's complan. Adequate and care and personal of resident to meet the care needs of the remeasures shall incl following procedures d) Pursuant to nursing care shall in following and shall is seven-day-a-week and the seven-day-a-week and the seven-day-a-week and by nursing stresident's medical eva made by nursing stresident's medical resident's medical resident's medical resident's medical eva made by nursing stresident's medical resident's medical resident's medical resident's medical resident's medical for the medical eva made by nursing stresident's medical resident's medical	age 31 h 3-202.2a of the Act) shall provide the necessary to attain or maintain the highest l, mental, and psychological isident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative lude, at a minimum, the es: o subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis: bservations of changes in a h, including mental and , as a means for analyzing and equired and the need for aluation and treatment shall be taff and recorded in the record. Supervision of Nursing hall supervise and oversee the the facility, including: the comprehensive residents' needs, which	1	9999	DEFICIENCY)		
		efined conditions and medical					

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		HAND HUMAN SERVICES				FORM	: 12/30/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		145307	B. WING	÷		07/	26/2013
NAME OF I	PROVIDER OR SUPPLIER	•		1	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GROVE	OF LA GRANGE PAR	к			701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	functional status, sei impairments, nutriti psychosocial status condition, activities potential, cognitive 3) Developing plan for each reside comprehensive ass and goals to be acc and personal care a Personnel, represe nursing, activities, o modalities as are o be involved in the p plan. The plan shar reviewed and modi needed as indicate The plan shall be re- months. Section 300.3240 A a) An owner, licens agent of a facility sh resident. (Section 2 These Regulations by: Based on record re- observation the fac- implement, monitor management interv	ensory and physical ional status and requirements, s, discharge potential, dental potential, rehabilitation status, and drug therapy. an up-to-date resident care ent based on the resident's sessment, individual needs complished, physician's orders, and nursing needs. enting other services such as dietary, and such other ordered by the physician, shall preparation of the resident care all be in writing and shall be fied in keeping with the care d by the resident's condition. eviewed at least every three	F99	999			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 145307 B. WING 07/26/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 701 NORTH LAGRANGE ROAD **GROVE OF LA GRANGE PARK** LA GRANGE PARK, IL 60526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 33 F9999 signs of pain. The facility also failed to have pain management protocols to guide and educate staff in the proper evaluation and management of pain. This failure resulted in R11 experiencing severe levels of pain (8/10) and recurrent insomnia and R6 not getting out of bed due to fear of experiencing pain. The findings include: Review of most recent full MDS (minimum data set) dated 5/2/13 shows that R11 is 75 years old and requires extensive physical assist with all activities of daily living. R11 was observed to be lying in bed on her right side in a fetal position 7/23/13 at 10:15 am. Both hands were clenched closed and all fingers curled and deformed. R11 stated during interview that she was having a lot of pain in the right shoulder that she was laying on and also in her hips. R11 stated the pain is very unpleasant and she often cannot help it when she screams out in pain when staff attempt to move her because she knows it is going to hurt. R11 states she hates to get out of bed because the pain is so bad and she only gets up once or twice a week now. R11 stated that her pain is usually around 8 on a scale of 10, with 10 being the worst. R11 said her pain keeps her up at night. When asked what measures are taken to manage her pain, R11 stated she takes 1 Vicodin every 8 hours and is afraid of becoming addicted. R11 said the Vicodin does not do much for her and she has been thinking of trying pot, having heard that it can be very effective for some types of pain. During the entire interview, R11 was observed to be grimacing and making small adjustments to her positioning in an attempt to relieve the areas

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	145307			÷		07/2	26/2013
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GROVE OF LA GRANGE PARK					701 NORTH LAGRANGE ROAD -A GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	R11's room to feed unable to feed hers hand contractures. head using the bed pleaded for E5 to si hips even though E head to a 45 degree has fed R11 her me " every movement of Prior to having dress 7/24/13 at 1:30pm, hurt. My skin even I me it hurts and ther be pleasant so peo don't like it when I y and afraid and then of me. They think I'y yell but I do. It reliev R11 stated E6 (wou recently told her if si treatment they will I entered the room to treatments and whe R11 yells during ca anticipates pain eve and that R11 has rh receives Vicodin ev between. Upon review of the administration reco R11 has been adm time during the mor before the dressing When asked if any R11's pain have be non-pharmacologic	-		999			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	145307		B. WING	≩		07 /;	26/2013
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GROVE OF LA GRANGE PARK					701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	R11's pain flow she was totally blank. T pain intensity, pain effects and results effects on physical Review of Pain Scru assessments dated 2/2/13 and 5/2/13 a assessed for effect effective and #8 she for R11. It is unclea as multiple direct ca above) R11 is in pain screams out in pain instructions stating comprehensive Pai located in the media blank. E2 (Director not been a compreficed completed for R11. Review of R11's pai individualized to R1 plan) on interview s R11 did not trigger therefore she (E4) o individualized pain o 2. R6 was observed lying in bed with he over her. R6 was of bed and states she usually because sh discussion, R6 state not like to get up at her and that she wo chop off her left leg toes. R6 then asked for under her left km	eet located in the MAR book his form is for documenting statements, action taken, side of medication, including or social function. eening Form with quarterly d 10/10/12, 11/13/12, 12/20/12, are inaccurate: #4 shows R11 tiveness of pain meds to be ows no observations of pain ar how this could be accurate are staff stated (as referenced ain most of the time and even h. The total score is 5, with the " Score 5 or greater indicates sessment needed. " A tin Assessment form was cal record but was totally of Nursing) states there had hensive pain assessment at a staff on the MDS and does not write a specific or 1's pain issues. E4 (MDS/care stated on 7/25/13 at 10:30am, for pain on the MDS and does not write a specific and care plan. d on 7/23/13 at 12:45 PM to be r lunch on the table positioned bserved to be in a bariatric e does not get up for meals the is too tired. After further ed during interview she does call because it is too painful for puld like to take an axe and pat times, from her hip to her d if surveyor could get a pillow		999			

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			I AND HUMAN SERVICES				FORM	12/30/2013 APPROVED 0938-0391
I	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY PLETED
			145307	B. WING			07/:	26/2013
1	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GROVE OF LA GRANGE PARK					01 NORTH LAGRANGE ROAD A GRANGE PARK, IL 60526			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	F9999	7/26/13 at 1:50pm. of pain as she was her left leg and kne touched or moved. E8 (nurse's aide) st R6 has been refusin past several weeks especially her left le stated, on 7/25/13 a complains of pain to ADL's are performe E6 (wound and res not aware R6 verba reasons given for re Review of Pain Scru 12/20/12, 3/18/13 a shows R6 assessed meds to be effective of pain for R6. It is a accurate as multiple referenced above) I movement. R6's care plan date pain during transfer interventions or me (MDS/care plan) st that R6 did not trigg therefore she (E4) o individualized pain o E1 (Administrator) a stated on 7/24/13 a have pain protocols	bresent along with E2 on R6 yelled and displayed signs being transferred, complaining e were painful when being rated, on 7/24/13 at 12:20pm, ing to get up for at least the , saying that everything hurts, eg and hip. E12 (nurse's aide) at 10:10am, that R6 o her left leg and hip when ed while R6 remains in bed. torative nurse) stated she was alized pain as one of the efusing to get out of bed. eening Form with dated and 6/11/13 are inaccurate: #4 d for effectiveness of pain e and #5 shows no frequency unclear how this could be e direct care staff stated (as R6 experiences pain with ed 6/11/3 states R6 yells out in rs but offers no specific asurable goals. E4 tated on 7/25/13 at 10:30am ger for pain on the MDS and does not write a specific and care plan. and E2 (Director of Nursing) t 3:15pm the facility does not s or policy and procedures to staff in the proper evaluation	F9	999			

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		HAND HUMAN SERVICES			FORM	: 12/30/2013 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		145307	B. WING		07/	26/2013
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
GROVE	OF LA GRANGE PAR	κ		701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

Facility ID: IL6003057