### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

145307

**Multiple Construction
A. Building:**

**B. Wing:**

**Completion Date:**

07/26/2013

**Name of Provider or Supplier:**

GROVE OF LA GRANGE PARK

**Street Address, City, State, Zip Code:**

701 NORTH LAGRANGE ROAD
LA GRANGE PARK, IL 60526

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<tr>
<th>ID</th>
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**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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**Deficiency F 465**

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During the General Observation of the facility 7/25/13, (E3) Maintenance Supervisor at 11:00 am the HVAC units for R58, R12, R14, R47, R59, R78, R48, R60 and R8 are dented, dirty, sharp edges exposed to residents. The units are missing knobs and controls.

R17, a third floor resident, was observed with the bed placed directly against the HVAC unit. The front part of the unit was protruding against the bed. Sharp edges are noted on the sides and front of the unit. There is duct tape attempting to hold the unit together. The tape is cracked and not secure.

From record review of R17's care plans and interview with family, R17 requires assistance with activities of daily living (ADL). R17 has a history of seizures and wears an helmet.

Interview with E3 on 7/25/13, E3 states all the HVAC units are going to be replaced. E3 said he has only replaced two units.

**Licensure Violations:**

- 300.610a)
- 300.1210a)
- 300.1210b)
- 300.1210d(3)
- 300.1220b(2)(3)
- 300.3240a)
<table>
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<tr>
<th>ID</th>
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<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<td>(X2) MULTIPLE CONSTRUCTION</td>
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| B. WING | 07/26/2013 |

| (X3) DATE SURVEY COMPLETED | 145307 |

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Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as
Continued From page 31 applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical
F9999 Continued From page 32
functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on record review, interview and observation the facility failed to develop, implement, monitor, modify and care plan for pain management interventions for two residents (R11 and R6) who were exhibiting and verbalizing
Continued From page 33

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
## Statement of Deficiencies and Plan of Correction

### (X1) Provider/Supplier/CLIA Identification Number:

145307

### (X2) Multiple Construction

A. Building __________________________

B. Wing ____________________________

### (X3) Date Survey Completed

07/26/2013

### (X4) ID Prefix Tag

### (X5) Completion Date

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<td>Continued From page 34 of pain to her shoulder and hips. On 7/24/13 at 12:20pm, E5 (nurse's aide) entered R11's room to feed her lunch. E5 stated R11 is unable to feed herself because of her pain and hand contractures. E5 proceeded to raise R11's head using the bed control. As she did, R11 pleaded for E5 to stop because it was hurting her hips even though E5 did not even raise R11's head to a 45 degree angle. E5 stated that (E5) has fed R11 her meals for the past year and that every movement we do for her (R11) is painful. Prior to having dressing change to her wounds on 7/24/13 at 1:30pm, R11 stated &quot;This is going to hurt. My skin even hurts. When anyone bumps me it hurts and then I yell. It's miserable. I try to be pleasant so people will come around. They don't like it when I yell. It makes them nervous and afraid and then they don't want to take care of me. They think I'm mean and I don't need to yell but I do. It relieves the pain a little.&quot; R11 stated E6 (wound and restorative nurse) had recently told her if she yells out during the treatment they will have to stop the procedure. E6 entered the room to perform the wound treatments and when asked why she (E6) thinks R11 yells during care, E6 stated it is because R11 anticipates pain even before anyone touches her and that R11 has rheumatoid arthritis and receives Vicodin every 8 hours and Tylenol in between. Upon review of the current MAR (medication administration record) for July/2013, it shows R11 has been administered Tylenol 2 tabs, one time during the month of July on 7/24/13, shortly before the dressing change was being observed. When asked if any other interventions to manage R11's pain have been attempted including non-pharmacological measures, E6 stated, &quot;No, but we are open for suggestions.&quot; Review of...</td>
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R11’s pain flow sheet located in the MAR book was totally blank. This form is for documenting pain intensity, pain statements, action taken, side effects and results of medication, including effects on physical or social function. Review of Pain Screening Form with quarterly assessments dated 10/10/12, 11/13/12, 12/20/12, 2/2/13 and 5/2/13 are inaccurate: #4 shows R11 assessed for effectiveness of pain meds to be effective and #8 shows no observations of pain for R11. It is unclear how this could be accurate as multiple direct care staff stated (as referenced above) R11 is in pain most of the time and even screams out in pain. The total score is 5, with the instructions stating "Score 5 or greater indicates comprehensive assessment needed." A Comprehensive Pain Assessment form was located in the medical record but was totally blank. E2 (Director of Nursing) states there had not been a comprehensive pain assessment completed for R11.

Review of R11’s pain care plan is not specific or individualized to R11’s pain issues. E4 (MDS/care plan) on interview stated on 7/25/13 at 10:30am, R11 did not trigger for pain on the MDS and therefore she (E4) does not write a specific and individualized pain care plan.

2. R6 was observed on 7/23/13 at 12:45 PM to be lying in bed with her lunch on the table positioned over her. R6 was observed to be in a bariatric bed and states she does not get up for meals usually because she is too tired. After further discussion, R6 stated during interview she does not like to get up at all because it is too painful for her and that she would like to take an axe and chop off her left leg at times, from her hip to her toes. R6 then asked if surveyor could get a pillow for under her left knee.

R6 was observed to be transferred via total body
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R6 has been refusing to get up for at least the past several weeks, saying that everything hurts, especially her left leg and hip. E12 (nurse’s aide) stated, on 7/25/13 at 10:10am, R6 complains of pain to her left leg and hip when ADL’s are performed while R6 remains in bed.

E6 (wound and restorative nurse) stated she was not aware R6 verbalized pain as one of the reasons given for refusing to get out of bed. Review of Pain Screening Form with dated 12/20/12, 3/18/13 and 6/11/13 are inaccurate: #4 shows R6 assessed for effectiveness of pain meds to be effective and #5 shows no frequency of pain for R6. It is unclear how this could be accurate as multiple direct care staff stated (as referenced above) R6 experiences pain with movement.

R6’s care plan dated 6/11/3 states R6 yells out in pain during transfers but offers no specific interventions or measurable goals. E4 (MDS/care plan ) stated on 7/25/13 at 10:30am that R6 did not trigger for pain on the MDS and therefore she (E4) does not write a specific and individualized pain care plan.

E1 (Administrator) and E2 (Director of Nursing) stated on 7/24/13 at 3:15pm the facility does not have pain protocols or policy and procedures to guide and educate staff in the proper evaluation and management of pain.
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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED**

PRINTED: 12/30/2013