Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6016265	A. BUILDING: _____ B. WING _____	C 12/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLYMOUTH PLACE	315 NORTH LA GRANGE ROAD LA GRANGE PARK, IL 60526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Complaint Investigations: 1596709/IL82028 STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/23/15

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S9999	Continued From page 1 injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to assess and treat a new complaint of worsening and uncontrolled pain for 1 of 3 residents (R1) reviewed for pain control in the sample of 7. This failure caused R1 to have "excruciating" pain in the left arm for over 3 hours, rating the new and worsening pain 10 out	S9999		

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S9999	Continued From page 2 of 10, and causing R1 to cry due to the severe uncontrolled pain. Findings include: Closed record documents R1 was admitted to the facility on 11/25/15 with the diagnoses of left upper arm fracture, left side rib fractures, and multiple fractures of the pelvis. Hospital discharge medications include Norco 5-325 milligrams (mg) 1 tablet every 4 hours as needed and a Lidoderm patch, both for pain. Pain Evaluation 11/25/15 R1 has pain in the left shoulder rated 6 out of 10, no non verbal signs such as crying, moaning, or groaning. Orthopedic consult 11/21/15 the fracture is treated nonsurgically with a splint, sling, immobilization, and non-weight bearing status. Pain assessment 11/25/15 R1 scores the pain as 6 out of 10. Pain vital signs sheet 11/25/15 through 11/28/15 R1 has reported pain scores ranging from 0 to 8 out of 10. November Medication Administration Record documents R1 only received pain medication twice in the 3 days prior to the increased left arm pain. Norco 5-325 mg 1 tablet on 11/25/15 at 10:33pm and was effective, 11/27/15 at 12:44pm and was effective, and on 11/28/15 at 3:42pm and the results are "ongoing". Progress Note signed 11/29/15 at 11:20am R1 requested stronger pain medication after receiving 1 pain pill and a second pain pill was given as ordered (no time documented). Progress Note signed 11/29/15 at 8:23am R1 has "excruciating pain to the LUE (left upper extremity)" as a result of being transferred from the wheelchair to the bed by nurses aides, R1 was crying and insisted on being transferred to the hospital. Transfer form 11/29/15 documents the hospital	S9999		

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S9999	Continued From page 3	S9999		

was called and given report on R1 on 11/28/15 at 10:43pm.
Emergency Room left arm x-ray report 11/29/15 R1 has a displaced communited fracture of the left humerus.
The following interviews took place on 12/9/15:
At 1pm, E3(Nurse Aide) stated R1 was already in bed when she answered the call light before dinner (between 4-5pm). R1 told E3 he was in a lot of pain, his shoulder hurt. E3 did not notify the nurse.
At 2pm, Z3(Agency Nurse Aide) stated she saw R1 around 3:20pm on 11/28/15 sitting up in the wheelchair next to the bed. R1 complained of pain in the left arm.
At 3:30pm, E8(Nurse) stated Z4(Family) told her on 11/28/15 around 7pm that nurse aides transferred R1 into bed "roughly". R1 wanted more pain medications but it was too soon, and was insisting on getting intravenous (IV) pain medications. E8 stated R1 reported pain in the left arm 10 out of 10 every time it was assessed, but pain medication was not due until 10pm. E8 paged the doctor once, did not hear back, and transferred R1 to the hospital anyway on 11/28/15 around 10:30pm. E8 stated R1's pain did not improve because no interventions were implemented. R1 kept changing the story of who hurt his arm and all R1 wanted was IV pain medicine.
At 4pm, E2(Director of Nursing) stated a resident's pain is what they report it as to the nurse.
At 4:05pm, E7(Nurse) stated R1 was sitting in the wheelchair in the room, complaining about a lot of pain in the left arm. E7 stated one pain pill was given around 3:45pm and another around 6pm when R1 still complained of left arm pain rating 8 out of 10.
On 12/10/15 at 2:05pm, by phone, Z5(Physician)

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S9999	Continued From page 4 stated if he was called when R1's pain was unrelieved after the change in medication, Z5 would have asked if something happened that would cause R1's left arm pain to worsen and no longer be controlled as with the previous pain medication. Z5 stated x-rays could have been ordered or R1 could have been sent out sooner for pain management. If R1 said someone pulled his broken arm, a worsening fracture would cause uncontrolled pain. On 12/14/15 at 9:55am, by phone, Z7(Orthopedic Physician) stated R1's left arm fracture was worse, requiring surgery. While any amount of pressure could cause the fracture to become displaced, R1's newly displaced left arm fracture caused the severe and uncontrolled pain. Change in Condition Notification policy - In the event of a significant change, the attending physician is notified. In the event of an emergency situation and the attending physician is unavailable, the Medical Director is notified. Pain Assessment and Management policy - Pain is defined as "whatever the client says it is." Clients are assessed for pain upon admission, re-admission, if a change in condition, quarterly, and after a fall. (B)	S9999		