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 _____	03/30/2023

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

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensue Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safety while transporting a resident in a wheelchair. R18 was transported by staff without legs rests attached to the wheelchair and fell forward when R18 placed her feet down. This resulted in R18 requiring sutures and an emergency room visit. The facility also failed to ensure proper techniques were utilized for R15 and R49 during transfers. This applies to 3 of 4 residents (R15, R18, R49) reviewed for falls and supervision in the sample of 20. The findings include: 1. R18's EMR (Electronic Medical Record) included that R18 is a 91 year old female with	S9999		

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S9999	Continued From page 2 diagnoses of Alzheimer's disease with late onset, unsteadiness on feet, difficulty in walking, not elsewhere classified, unspecified abnormalities of gait and mobility, muscle weakness (generalized), bilateral primary osteoarthritis of knee, paranoid personality disorder, other specified anxiety disorders, atherosclerotic heart disease of native coronary artery without angina pectoris. R18's MDS (Minimum Data Set) dated 3/15/2023 showed that R18 was moderately impaired in cognition and required extensive assistance of one person physical assist for locomotion on and off unit. R18's nursing care plan revised 2/3/2023 included that R18 has been observed wandering in wheelchair when confused and/or disoriented but is easily redirected. Interventions included to distract R18 from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, identify pattern of wandering and intervene as appropriate, provide structured activities, inquire if R18 needs to be toileted or in pain. Incident Note dated 3/26/22 18:52 included as follows: [R18] was being wheeled in wheelchair by staff and tipped forward falling to the floor. [R18] bumped to right side of forehead causing a laceration above the right eye. Area covered. Medical Doctor notified orders to send 911 ER/Emergency Room for evaluation. Facility nurses' notes 'Transfer to Hospital Summary' dated 3/26/2023 19:12 included as follows: 911 in facility and R18 transferred to ER. R18 remains alert and verbal at the time of transfer. Bleeding controlled. Report given to RN/Registered Nurse at hospital. POA (Power of Attorney) and supervisors aware.	S9999		

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S9999	Continued From page 3 On 03/27/23 at 10:33 AM, R18 was lying in bed with a bandage wrapped around her head above her eye and R18 was noted to have bruising and swelling under her right eye. R18 remarked "They had to sew my head up at the hospital last night. I fell here. Everybody was with me. I don't know how many people. I want to rest now and don't want to talk anymore." On 03/28/23 at 08:59 AM, R18 was propped up in bed eating breakfast and had a dressing on the right side of forehead. Regarding the fall incident of 3/26/23, R18 stated "I was in my wheelchair outside the room, and they started pushing me. There were 3-4 people around. I think it was outside in the hallway. When I fell it was very hard on the floor and there was nothing soft about it." On 03/28/23 at 10:26 AM, V13 (Certified Nursing Assistant) stated that she saw R18 ambulating by wheelchair down the opposite hallway of where R18's room was. V13 added that R18 has periods of confusion from time to time and tends to wander the hallway. V13 stated that she noted that R18 was more confused than usual that evening. V13 continued "she said she doesn't want to go to the bathroom. She doesn't have a footrest on wheelchair as she can propel herself with her feet. I told her that I was going to take her back to her room and to lift her feet up. As I started to wheel her down the hallway to her room, she suddenly put her feet down that caused her to fall forward. She fell on the carpet and hit her forehead and there was some bleeding. There was a housekeeper close by and I told her to go get the nurse. It was the change of shift around 7:00 PM and V12 RN (Registered Nurse) was with the night nurse who was taking over."	S9999		

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S9999	Continued From page 4 On 03/28/23 at 1:35 PM, V12 stated "I was standing down the hallway and V13 was attempting to wheel R18 to her room. R18 is independent and able to propel to move her wheelchair. R18 put her feet down and when she fell, she had a laceration above her right eye. I evaluated her and there was bleeding to her forehead and wrapped it and put an ice pack. She was sent out by calling 911." Hospital discharge papers dated 3/27/23 included for resident to follow up with the primary care doctor for further evaluation of head injury and removal of two sutures in 5-7 days for laceration to forehead. On 03/29/23 at 09:24 AM, V2 (Director of Nursing) stated that he did not report R18's injury to IDPH (Illinois Department of Public Health). V2 added that if there are sutures, it is reportable. V2 stated that R18 did not have sutures as the report he got from nursing is to apply antibiotic and keep open to air. V2 stated that R18 was sent to the ER as she was on anticoagulants and had a risk for blood clots. When V2 was notified by surveyor that the ER report showed that R18 received two sutures, V2 stated that he was not aware of the same and will have to verify the same. On 03/29/23 at 10:57 AM and 11:07 AM, V2 stated that after further investigation it was verified that R18 had received sutures to the forehead. V2 stated that if there was an injury, he should have received a call from nursing after the incident and that he did not receive the same. V2 stated that he is going to submit a late reportable. V2 added that R18 has cognitive impairment, and this indicates that R18 is not capable to comply with direction to put feet up. V2 stated that based	S9999		

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S9999	Continued From page 5 on root cause analysis for best intent for R18's safety, is to use a leg rest during transfer. Initial and Final Notification of Incident of 3/26/23 included that assessment was completed on 3/29/23 and revealed that R18 right eyebrow was swollen and red and had two sutures for the laceration to forehead with steri strips applied. Assessment for fall included that R18 will benefit from leg rest during wheelchair transport due to inability to elevate feet during transfer or notify staff of rest periods needed. 2. The electronic medical record (EMR) shows that R15 is 90 years-old who has multiple medical diagnoses to include dementia, muscle weakness and abnormality of gait and mobility, and unspecified fracture of the upper end of the right humerus, subsequent encounter for fracture with routine healing. Minimum Data Sheet (MDS) dated 3/20/23 shows that R15 is cognitively impaired and requires extensive assistance when being transferred. On 3/28/23 at 11:17 AM, V22 and V23 (Both Certified Nursing Assistants/CNA) transferred R15 from wheelchair to toilet via sit to stand. While being transferred, R15's knees were bent 45 degrees, like in a squat position, his hands were holding on to the bar handle of the sit to stand while his upper torso and armpits were hanging in the sling. R15's feet did not bear weight during transfer. R15's fall risk assessment dated 2/18/22 shows that R15 is moderately at risk for fall. 3. The electronic medical record (EMR) shows that R49 is 75 years-old who has multiple medical diagnoses which include dementia, cognitive communication deficit, and need for assistance	S9999		

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S9999	Continued From page 6 with personal care. MDS dated 2/27/23 shows that R49 requires extensive assistance for transfer. On 3/29/23 at 10:44 AM, V18 (CNA) brought R49 to the bathroom with a wheelchair for toileting. V18 did not use a gait belt to assist R49, instead, she (V18) assisted R49 to stand by pulling up his waistband. R49 stood up unsteadily, then V18 proceeded to clean his back peri-area for incontinence care. On 3/29/23 at 2:49 PM, V2 (Director of Nursing/DON) stated that a resident on a sit to stand can have flexion in the knees but needs to be able to maintain standing balance and must be able to bear weight. V2 added, when transferring a resident who can stand and pivot, the staff must use a gait belt. This is for safety and proper body mechanics. R49's fall risk assessment dated 2/21/23 shows that R49 is a high risk for fall. (B)	S9999		