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
	IL6015192	A. BUILDING: _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(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
S 000	Initial Comments Complaint Survey Investigation # 1917171/ IL 116180	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.1120a) Section 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. The REQUIREMENT was not met as evidence by: Based on interview and record review the facility failed to provide pain management for a resident after a fall. R1's Admission Record dated October 10, 2018 (facility old computer system) showed R1 admitted to the facility with a diagnosis of unspecified dementia without behavioral disturbance. R1's Physician Orders dated June 15, 2019 showed R1 was admitted into hospice services. R1's Resident notes dated September 15, 2019 at 2:45 PM, R1 had a witnessed fall, resident was assessed, and "was noticed moaning upon standing".	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	A. BUILDING: _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(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	Continued From page 1	S9999		

On October 1, 2019 at 9:30 AM, V14 Certified Nursing Assistant (CNA) stated he was with V5 Licensed Practical Nurse (LPN) talking in the office. V14 stated he heard someone yell "fall", and went to check. V14 stated R1 was on the floor attempting to get up by herself. R1 would try to move, yell out, and then lay back down. V14 stated R1 grimaced and yelled like she was in pain. V14 stated V5 looked at R1, and after V5 was finished we had to lift R1 into a wheelchair. R1 yelled in pain when we got her up, but seemed fine when she was sitting in the wheelchair. V14 stated before the fall R1 would use a walker and walk around the unit. After the fall, R1 could not stand so she was placed in a wheelchair to move her on the unit.

On October 1, 2019 at 12:00 PM, V5 stated R1's initial assessment was done right after her fall. We had to lift R1 from the floor and put her in a wheelchair. When R1 was moved from the floor, she yelled, and "I knew something was wrong." R1 moaned in pain which is why the physician was called. V5 stated R1 was not able to tell you where her pain was. R1 had dementia, was confused, and you had to use visual cues to know she was in pain or not. V5 stated another pain assessment was performed during the shift. V5 stated Tylenol was given for pain. V5 stated she was not informed about any other pain concerns after R1 was up in the wheelchair.

On October 1, 2019 at 8:20 AM, V9 (CNA) stated after dinner she attempted to get R1 up from the wheelchair. V9 stated when R1 went to get up, she "locked up", said "ouch", and sat back down not wanting to stand. The nurse (V5) told me earlier she had a fall. V9 stated "I did not say anything about (R1) not getting up from the chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	A. BUILDING: _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(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	Continued From page 2	S9999		

I was told (R1) had x-rays ordered, and the nurse knew about it."

R1's Resident Notes dated September 15, 2019 at 3:08 showed physician ordered a stat right hip and right ankle x-ray which were completed on September 16, 2019 at 12:45 AM (9.5 hours later).

R1's X-ray report dated September 16, 2019 showed R1 to have a right femur fracture (femoral neck).

On October 1, 2019 at 1:15 PM, V16 (LPN) stated R1 had her x-ray done around 12:30 AM (September 16th). R1 needed two people to help with positioning R1 for the x-ray. She would "grimace, scream, and reach for her right hip" when she was turned or repositioned. V16 stated "I assisted with the aides when (R1) needed to be turned. We repositioned (R1) three or four times during the night. (R1) only had pain when she was moved, but I wanted to make sure the repositioning was easy on her."

R1's Hospice Nursing Notes dated September 16, 2019 showed R1 being uncomfortable with pain, occasional moan or groan, frowns, and tense with moderate pain.

On October 1, 2019 at 9:30 AM, V7 (Hospice Nurse) stated after assessing R1 on Monday (September 16th) a pain patch was ordered help manage R1's pain.

On September 30, 2019 at 10:45 AM, V3 (LPN) stated R1 needed to receive pain medication (Morphine) prior to the aides repositioning R1 on Monday (September 16th) morning. R1 did not tolerate being turned in bed very well. R1 would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015192	A. BUILDING: _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SR LVG POPLAR CREEK	2150 WEST GOLF ROAD HOFFMAN ESTATES, IL 60194

(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	Continued From page 3	S9999		

moan and shout if you touched her right hip or turned her.

R1's Physician Order Sheet dated September 2019 showed an order for Morphine 20 milligrams per milliliter (mg/ml). Give 0.5 ml (10mg) by mouth every 1 hour as needed for pain with a start date of August 22, 2019.

R1's Medication Administration Record for September 2019 showed R1 received Acetaminophen on September 15, 2019 at 4:58 PM for general pain with an unknown outcome. R1's first dose of morphine for right hip pain was given at 10:49 AM approximately 19 hours after R1 fall.

The facility's Acute Change of Condition Policy dated March 28, 2017 showed "it is the policy of this community to assist all resident during periods of acute/temporary illness and/or change in condition ....Oversight of residents shall be increased to accommodate the care needs of the resident."

(B)