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
	IL6004899	A. BUILDING: ______ B. WING ______	C 05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENNINGS TERRACE	275 SOUTH LASALLE AURORA, IL 60505

(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 Investigation 2273588/IL146679	S 000		
S9999	Final Observations Complaint Investigation 2273588/IL146679 Statement of Licensure Violations: 300.690b) 300.690c) 300.1210b) 300.1210d)6) Section 300.690 Incidents and Accidents b)The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

Section 300.1210 General Requirements for Nursing and Personal Care
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 regulations were not met as evidenced by:

Based on interview and record review, the facility failed to prevent an injury for 1 of 3 residents reviewed for falls and injuries. As a result of this failure, R1 sustained a rib fracture, and L2 spine fracture.

Findings include:

R1 is an 81-year-old Spanish-speaking male

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S9999	Continued From page 2 admitted on 4/4/22 having severely impaired cognitive functioning with a Brief Interview for Mental Status (BIMS) score of 03. R1 was admitted with an admitting diagnosis, including Dementia. Record review on clinical progress note dated 4/15/22 document that R1 was repeatedly tried to leave the facility during the night by opening the emergency door and sounding an alarm. R1 was aggressive and became more annoyed and angry when staff tried to redirect. R1 became extremely combative towards staff and was swinging on staff. The facility called 911 and transferred R1 to a local hospital. On 5/5/22 at 6:40 PM, V4 (R1's Daughter) stated, "On 4/16/22, I visited (R1), and he was walking around and had no complaints of pain. On 4/17/22, I didn't visit. When I visited on 4/18/22 at 8 AM he was complaining of rib and back pain. He was in severe pain, and he said he had a fall while the staff was scuffling him to bring him back to his room the previous day." On 5/7/22 at 12:40 PM V8 (Agency CNA for R1 on 4/16/22 Night shift) stated, "On 4/16/22 night shift, R1 was so violent. We were afraid as he was tall and was swinging his arms. We followed him trying to redirect him back. He moved to the sheltered side. We carried him back to his room by having the male CNA grab both arms, I held his one leg, and the other female CNA held his other leg. I don't know their names. He had a fall that happened in the hallway while we tried bringing him back, and he didn't report any pain at that time. On 5/7/22 at 11:40 AM, V2 stated (Director of Nursing), "We don't know R1 had fallen. I would	S9999		

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have notified of any unusual incidents. As I was not notified of any unusual incidents, I don't think any restraint use or fall during the 4/16/22 night shift." A record review of the fallen log and clinical progress note indicates any fall that happened to R1 during his two-week stay. On 5/6/22 at 11:00 AM, V1 (Administrator) stated, "We use restraint appropriately, but nothing recently. We never use any restraint on R1. "

Record review on hospital record dated 4/18/22 documents that R1 was admitted with complaints of rib pain and may have been injured during a scuffle at the nursing home when the patient was combative as per EMS (Emergency Medical Service).

Record review on hospital X-ray of the right rib dated 4/18/22 document a nondisplaced fracture of 10th right rib. CT (Computerized Tomography) of the chest/abdomen/pelvis dated 4/19/22 documents acute L2 compression fracture. MRI (Magnetic Resonance Imaging) of the lumbar spine dated 4/20/22 documents acute L2 (lumbar vertebra) fracture and suspected L3 fracture.

On 5/10/22 at 9:40 AM, V9 (R1's attending physician) stated, "I can't remember if they called me on 4/16/22 when R1 was being combative and trying to escape from the facility during the night shift. R1 might have had a fall causing his rib and L2 fractures."

On 5/6/22 at 11:00 AM, V1 (Administrator) stated, "residents should be monitored from fall/injury."

(A)