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 _____	12/12/2019

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
S9999	Final Observations Statement of Licensure Violations: 1 of 3 Violations 330.780 b) c) Section 330.780 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. 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 330.785, 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 summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement was not met as evidenced by: Based on record review and interview the facility failed to investigate and notify the State Surveying Agency of an injury of unknown origin.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

This applies to 1 of 3 residents (R302) reviewed for incidents and accidents in a sample of 4.

Findings include:

The Face Sheet documents R302 is 83 years old with diagnoses including hypothyroidism, major depressive disorder, hypertension, cardiac arrhythmia and hyperlipidemia.

The progress notes dated 12/2/19 at 10:05 AM reads: R302 has a bruise to left top orbital and rather large bruises to bilateral (both) knees. Left knee and calf larger than right. She rates pain 7/10. Skin tear to left knee. Vital Signs 169/102 (blood pressure), 84 (Heart Rate). She is also rarely coming out of her room.

The Skin Issue Detail Report documents R302 complained of sharp pain and has a reddened wound with granulation tissue. There's bruising to both knees and the left orbital area. The left leg is swollen.

On 12/11/19 at 3:22 PM, V16 (Director of Nursing/Shelter) stated R302 is high risk for falls. V16 stated on 12/2/19 she went to R302's room and noticed bruising above R302's left eye, on both knees and a skin tear to the left knee. V16 stated she was the one who first noticed the injuries. V16 also stated she did not know how R302 got the bruising as there was no investigation conducted. According to V16, the bruises were purple, and the facility also did not report the injuries to the State Surveying Agency. V16 stated the policy is to report injuries of unknow origin to the State Surveying Agency within 24 hours.

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S9999	Continued From page 2 The facility's policy titled "Abuse Prohibition" reads: Identification and Injuries of Unknown Origin- 1). Injuries of unknown source, including, but not limited to significant bruises, fractures, dislocation, lacerations, abrasions, contusions, lumps and/or severe swelling shall be reported immediately to the charge nurse, the Director of Nurses and the Administrator. 5). The facility shall notify IDPH (Illinois Department of Public Health) of any injury of unknown source, which has or is likely to have, an effect on the health, safety, or welfare of a resident. Notification shall be made by a phone call to the Regional Office within 24 hours of discovery. 6). The Administrator shall assure that IDPH is notified of the injury of unknow source. (AW) 330.2230 a)5) 330.2230c) 330.2230a)5) Laundry Services Soiled linen shall be handled, transported and in a manor that protects facility, residents and personnel' 330.2230c) c) Laundry service for resident's personal clothing	S9999		

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S9999	Continued From page 3 shall be handled, and transported in a manner that will not allow contamination by soiled laundry. This regulation is not met as evidenced by: Based on observation, interview and record review the facility failed to transport soiled laundry in a sanitary manor. This affects all the residents. Findings include: On 12/11/2019 the residents had placed their bags of soiled laundry out side their doors. V11 (laundry personal) grabbed five or six of the bags by their strings and pulled them down the hallway to the stairway to the basement laundry. The bags were thrown down the stairwell to the basement floor. V11 stated the residents put their laundry bags out on Tuesday night and we take them to the laundry Wednesday morning. The facility laundry procedure did not state how the bags of soiled linen would be transported to the laundry. (AW) 330.4240a) 330.4240 a) Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	S9999		

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S9999	Continued From page 4	S9999		

resident. (Section 2-107 of the Act) (A, B)

This requirement is not met as evidenced by:

Based on observation, interview and record review the facility failed to prevent verbal and mental abuse.

This applies to 1 of 4 residents (R303) reviewed for abuse in a sample of 4.

Findings include:

The Face Sheet documents R303 is 72 years old and has diagnoses including: Osteoarthritis, heart disease, chronic pain, rheumatoid arthritis, hypertension, major depressive disorder, intervertebral disc degeneration, and chronic kidney disease.

The Investigation Report to the State Surveying Agency dated 9/3/19 documents V15 (Registered Nurse) made inappropriate comments to R303.

Written statement by V16 (Director of Nursing/Shelter) reads: Friday (9/30/19) R303 was complaining of colitis. V15 informed R303 to come to the nursing station to get medication. The statement documents V15 informed R303 she had two options: 1) come to the nursing station to receive medication, or 2) V15 will document in R303's medical record that she refused medication.

The Progress Notes by V15 reads:
8/30/19- 8:35 AM, Resident reminded to come down to get medication. She is refusing because it is a long walk and she fears she will have diarrhea on the way. She was informed that she was well enough to go out with family, she is well

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enough to walk for meds. She was informed this was part of her moving here and if she can't, she will be moved to skilled side of the facility. She still refused, this writer will bring everything to her, but this will be temporary.

On 12/11/19 at 3:12 PM, R303 was sitting in the chair in her room. Both of R303's legs were reddened and swollen. The left more than right. R303 stated "they make me walk to the nursing station to take medication." R303 stated there's times she's not up to walking as the station is far from her room. R303 also stated she requested not to walk but staff stated it's not up for discussion. R303 did not name the employee.

On 12/12/19 at 11:30 AM, V16 stated nurses cannot withhold medication. If the resident can't walk, we should take the medication. Nurses should not refuse to administer medication. V16 added R303 gets edema (swelling) and does not do well with long distance ambulation. V16 also stated it is not acceptable for staff to threaten to document residents refuse medication because they can't walk to the nursing station. V16 stated you don't speak to residents that way. She spoke in a derogatory manner. It's considered threatening. V16 ended by stating V15 threatened to move R303 to the skilled nursing unit if she didn't come get her medication.

The policy titled "Abuse Prohibition" reads:

1). All residents have the right to be free form verbal, sexual, physical, mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property and exploitation. This includes but is not limited to freedom from corporal punishment, and involuntary seclusion and physical or chemical restraints not required to

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S9999	Continued From page 6 treat residents' symptoms. 8). Mental Abuse- includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by an employee or agent. 15). Verbal Abuse means the use by an employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to a resident or within this or her hearing or seeing distance, regardless of the resident's age, ability to comprehend or disability. (77 Ill. Administration Code Section 300.330). (B)	S9999		