

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

JENNINGS TERRACE

0010371

Facility Name

I.D. Number

275 SOUTH LASALLE AURORA, IL 60505

Address

Date of Survey: 2/3/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

- 300.1210a) The facility must 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 assessment and plan of care.
300.1210a)5) 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.
300.1210b)6)

All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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 are not met:

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300.1210a) Based on observation, closed record review, a 10/17/03 Coroner's Report, and staff interview
300.1210a)5) the facility failed to:
300.1210b)6)
(Cont-d.)

1. Ensure staff use appropriate equipment to prevent accidents;
 2. Ensure staff follow residents' plan of care;
 3. Ensure staff follow the facility's policies and procedures in the use of mechanical lifting devices; for R1 who on 9/3/2002 sustained a fracture to the left humerus during a transfer.
- And, on 8/30/03, when R1 fell backward from the sling of a mechanical lift during a transfer and sustained a left convexity sub dural hematoma.

Examples include:

R1, was admitted to the facility 1/21/2000 with multiple diagnoses of which included a status post cerebral vascular accident with left hemiparesis, generalized osteoarthritis, osteoporosis and seizure disorder.

During the interview with E1 on 1/29/04, and the review of the facility's incident report and investigation report dated September 5, 2002 documents: R1 who was being cared for by E5, a part-time Certified Nurses Assistant (CNA), on September 3, 2002, at approximately 11:10 a.m. R1 had a shower and was clothed awaiting transfer from the shower chair to a wheelchair. The report indicates the sling from the mechanical lift had been put under /around R1. R1's left and right arms were lifted up and her hands were put into the grasp position. R1 held onto lift at this time the lift was slightly elevated. R1 then let go of her right side and the CNA heard a "pop." R1 was put in the down position and E5 called for help. R1 began complaining of left shoulder pain. A portable left shoulder and left clavicle x-ray was conducted. The x-ray report dated 9/4/02 documents, AOblique fracture at proximal aspect of the left humerus with bony fragment in fairly good position and alignment. No evidence of dislocation of the left shoulder. No evidence of acute or recent fracture of the left clavicle.® A review of R1's plan of care dated 2/15/02, indicated R1 required two assistants' with lift from bed to chair. The facility's investigation indicates that R1 was transferred with one assist on 9/4/02. From the facility's investigation it was indicated that the facility had not identified R1 as a resident authorized to use the sit-to-stand lift due to R1's hemiparesis. E5 was in-serviced on all residents' transfers. The facility, family and resident care committee mutually determined an appropriate action toward E5 was: E5 to provide 1-1 care to R1 until the fracture is healed as a reminder of the incident.

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- 300.1210a) A review of the facility's incident report and incident investigation dated August 30, 2003 at approximately 6:30 p.m. the report documents: E4 was using the facility's mechanical lift to put R1 in bed. R1 raised her arm and moved her arm outside of the sling. R1's body shifted
- 300.1210a)5) and R1 fell backward from the sling striking her head on the floor. A large amount of blood was noted on the floor. E6 documents unable to determine exact location of bleeding. Pressure was applied until paramedics arrived. R1 was air lifted to the hospital with diagnosis head trauma , sub dural hematoma, sub arachnoid hemorrhage. R1 was returned to the facility 9/4/03. A Hospice evaluation was conducted on 9/8/03. R1 expired on 9/9/03. The autopsy reports of 9/9/03 list immediate cause of death for R1 as bronchopneumonia as a complication of a closed head injuries due to a fall.
- 300.1210b)6) (Cont-d.)

During the survey conducted 11/18/03 the surveyor observed the use of the sit to stand and a lift mechanical device during patient care of R2 and R3 and staff demonstration with E3. The mechanical lifts were noted to be in working order and the sling accessory's were in working condition. A review of the facility's incident reports for the last 3-month and administrative staff interview indicates no other incidents of this nature were identified.

A review of R1's clinical record and plan of care revealed R1 had physician orders for the use of a mechanical lift with a sling. The plan of care continues to indicate R1 requires total care of staff and the use of a two-person transfer. An interview with E2 on 11/18/03 indicates from the facility's investigation. E4 was to have two persons to conduct the transfer. A gait belt was not used during the transfer and the correct sling was not used during the transfer.

A review of the facility's investigation it was determined that E4 had used a toileting sling instead of the four point sling used for regular transfers. E4 was suspended 9/16/03 "due to incident."

(A)

Jennings Terrace Aviol.JKR.cp