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
	IL6004964	A. BUILDING: ________ B. WING ________	05/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOLIET TERRACE NURSING CENTER	2230 MCDONOUGH JOLIET, IL 60436

(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 Licensure Survey for Subpart S: SMI	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: Section 300.625 (b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. Based on record review and interviews the facility failed to obtain background information on one(1) resident (R24) out of 5 reviewed for background information in the sample of 20. The findings include: The facility's Identified Offender Policy and Procedure, dated 2011, showed "...this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. R24's Identified Offender Reporting Form showed he was admitted to the facility on January 13, 2017. The Illinois State Police Stated Level Criminal Background Check dated January 8, 2017 showed R24's results were pending. R24 had additional Illinois State Police State level Criminal Background Checks dated February 6, 2017 and February 13, 2017, which continued to	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

show the findings as pending. There was no evidence that the facility staff followed up to get the finial results of R24's criminal background check form the state police. The facility did not do a risk assessment screen until May 18, 2017.

Z2 (works in the Identified Offendants for IDPH,was interviewed by phone on May 18, 2017 at 2:39 PM.) Z2 said the facility had 3 days to submit a request for a background check. Z2 stated if a facility did not get the background check findings within 30 days, the facility should call weekly to get the results.

E11 is the director of psychosocial program and responsible for identified offender program. E11 said, "R24's information was sent to the state police before I came here." E11 stated the results of R24's background are still pending. E11 said she did not know when was the last time someone checked on the status of R24's background check, but she had not contacted the state police. E11 stated she did not do finger prints until R24's background check was done.

(B)

Section 300.3240

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

Based on interview, observation and record review the facility failed to ensure a resident was free from staff abuse. This applies to 1 of 12 residents (R20) in the sample of 12.

The findings include:

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The facility's Incident Report form dated April 24, 2017 showed R20 had multiple medical diagnoses to including Unspecified Bipolar Disorder, Major Depressive Disorder and Anxiety Disorder.

April 26, 2017 at 9:46 AM Z1 (R20's friend) stated that R20 repeatedly told him (Z1) that (R20) is being mentally harassed, and that at times staff treatment was borderline to physical abused. Z1 reported R20 stated the staff treatment by the staff due to his ethnicity. Z1 stated that R20 refused to tell him details or elaborate on the staff's harassing and abusive behavior.

April 26, 2017 at 3:20 PM R20 gave the following statement:

R20 was smoking in the facility's designated smoking area when he heard E5 (Dietary Staff) telling E15 (CNA) that R20 should not cause any problem on the night shift, otherwise R20 should take his (R20) "m...f.... ass" back to Mexico. R20 added he (R20) already felt depressed and had so many personal and emotional issues that to hear that from a staff was really upsetting.

R20 reported there was another incident, during night shift when he was having severe anxiety. R20 stated he asked E7 (Nurse) for his anti-anxiety medication. R20 stated E7 told him that his next dose of anti-anxiety medication was not due yet. R20 stated that E7 then tried to slam the medication room door in R20's face, but R2 placed his right foot to block the door from closing. R20 stated E7 then pushed the door and called security. R20 banged his fist against the door because he was very anxious and frustrated. R20 stated E8 (Receptionist) came to intervene and told R20 that if he did not stop, he

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(E8) would "body slam" R20.

R20 was unable to re-call exact date of when this second incident, but stated it happened a few days ago.

R20's Nursing Behavior Note dated April 22, 2017 documented the incident:
R20 came into the nurses' station to ask for PRN (as needed) medication. E19 (Nurse) told R20 to wait for scheduled time of the medication. While walking away R20 turned to the next nurse (E7) and talked profanity. R20 came back a few minutes later and demanded to staff to give him (R20) the medications because R20 could not wait.
E19 called physician for PRN medication order that R20 wanted but while waiting for physician to call back R20 became very agitated started banging nurses' station's windows and door. Psycho-social staff and security were called. R20 was not able to control self. Physician and E1 (Director of Nursing) were notified of R20's behavior. E19 was able to give PRN medication as ordered by physician. R20 called 911. Two police officers came but left after R20 calmed down and returned to his room.

Facility's Roster dated April 26, 2017 showed: R20 was the only Hispanic resident in the facility at that time. Another resident of Hispanic ethnicity was not in the facility during the survey.

On April 26, 2017 at 10:40 AM E2 (PRSC) stated that the majority of the facility's residents are black and white, and that there were 2 Hispanics and at least 1 Asian. E2 stated he had not seen any employee verbally harassing or abusing a resident. E2 added he would sometimes see residents getting into verbal altercations and

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S9999	Continued From page 4 would insult each other with their ethnic background, but never from staff.	S9999		