STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008338	A. BUILDING: _____ B. WING _____	C 11/29/2023

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SALEM VILLAGE NURSING & REHAB	1314 ROWELL AVENUE JOLIET, IL 60433

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S 000	Initial Comments Complaint Investigations 2379668/IL166895 and 2379711/IL166942	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1220 b)3) 300.3210 t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect R2 from physical abuse from R1, and failed to review and revise a resident's plan of care after R1 exhibited physically and verbally aggressive behaviors. R1	S9999		

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S9999	Continued From page 2 assaulted R2 on November 17, 2023, in the 6th floor laundry/vending area of the unit. R2 collapsed became unresponsive and expired a short time later. R1 was arrested and charged by the local police with murder for the death of R2. This applies to 1 of 3 (R2) reviewed for physical abuse from a total sample of 15. Findings include the following: R1 is a 71-year-old male first admitted to the facility on August 18, 2022, with the following diagnoses: Diabetes, Delusional Disorder, Anemia, Anxiety Disorder, Hypertension, and Coronary Artery Disease. R1 was assessed by the MDS (Minimum Data Set) assessment of September 29, 2023, to be cognitively intact with delusions. R1 moved about the facility in his wheelchair and needed only oversight with ADL (Activities of Daily Living) activities. R1 routinely received psychological services from V10 (Advanced Practice Nurse Psychology). V10 documented on November 9, 2023, R1 was "currently as baseline. Staff denies any concerns at present" and "Currently stable. Will continue present management. No further concerns.". R1's care, plan dated August 22, 2023, documents interventions for behavioral symptoms that include verbal and physical aggression, refusal of treatments, and delusions. R2 was a 61-year-old male re-admitted to the facility on November 12, 2023, after treatment for a cardiac issue. R2's diagnosis included the following: Diabetes, Heart Disease, Hypertension, Obsessive-Compulsive Behavior, Depression, Sleep Apnea, Obesity, and Anxiety Disorder. R2's MDS Assessment of October 30,	S9999		

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S9999	Continued From page 3 2023, describes R2 as cognitively intact and able to perform his own ADL activities with minimal assistance. R2 was also noted to use a walker for mobility throughout the facility. R2 also had routine psychological services from V10 for his anxiety and depression. On October 12, 2023, V10 described R2 as, "Stable" and "Will continue to monitor patients progress.". The facility submitted an incident report to the Department on November 18, 2023, at 1:17AM, concerning a resident-to-resident altercation that resulted in a resident's death. This incident involved R1 and R2. R2 expired at the facility, and R1 was removed from the facility by local law enforcement. V2 (DON-Director of Nursing) stated during interview of November 19, 2023, around 9:00PM, R1 and R2 were involved in a disagreement in the facility laundry/vending room on the 6th floor. V6 (Nurse Aide), V5 (Licensed Practical Nurse/LPN) and V7 (Registered Nurse/RN-Supervisor Nurse) were on the unit. V5 was completing medication pass, V7 was making rounds, and V6 was in the nursing station area. V2 stated he was told the disagreement started in the laundry area and went from a verbal disagreement to a fight. R2 was hit by R1 and became unresponsive and 911 was called. Facility staff started CPR (Cardiopulmonary Resuscitation) and R2 was pronounced dead by the paramedics. R1 was placed on monitoring by local law enforcement until 2:00AM November 18, 2023, and arrested and removed from the facility. V2 added an autopsy was scheduled, and local police told him they were waiting for the district attorney to decide on charges. V2 and surveyor toured the 6th floor laundry room	S9999		

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S9999	Continued From page 4 on November 19, 2023. The unit is shaped like the letter L, with the laundry room in the corner. The room contained a household washer and dryer and two vending machines. V2 stated residents on the 6th floor can do their own personal laundry in this room. V6 (Nurse Aide) was interviewed on November 20, 2023, and stated the disagreement between R1 and R2 started in the laundry room. According to V6, R1 was swearing at R2, and complaining R2 put BM (bowel movement) on the washing machine. V6 stated R2 was trying to be nice, but R1, "jumped out of his chair and started hitting and punching (R2). He got strength from nowhere." V6 stated V5 and V7 were trying to break up the fight. V6 added R1 was very upset about the BM stains on the washer, however, there were no BM stains or evidence of BM on the washer. According to V6, R1 could be grouchy and argumentative sometimes, and calm and nice other days. V7 (RN-Nurse Supervisor) was interviewed by phone November 20, 2023, and stated he was completing rounds on the unit when he heard R2 yelling, "He {meaning R1} is abusing me". V7 stated he went to laundry room, and R2 was on the floor, his back against the wall, and R1 had R2's walker. V7 asked R2 if he was okay, and then went to R1, and R1 started to try to hit V7. V7 then stated he heard R1 yell, "I am assaulting you {meaning R2}." V7 stated he tried to separate the residents, called V2 (DON), called the police and 911. V7 stated, "(R2) then became short of breath, and we started oxygen and called 911 again." V7 added they then had to start CPR and the local paramedics took over, and R2 expired. V7 added R1 appeared to be proud of what he did, and was bragging to the local police	S9999		

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S9999	Continued From page 5	S9999		

that he, "pulled him and punched him hard!" V7 went on to say he was "totally surprised" R1 was that aggressive.

V5 (LPN-Nurse) was interviewed November 19, 2023, and stated she was completing medication pass around 9:00PM on Friday night, when she saw R1 standing and punching R2, and then started to try to punch V7. V5 called 911, and then R1 was still trying to hit V7. V5 went on to add she called 911 again after she saw R2 was short of breath. V5 stated V7 then started CPR on R2, and the paramedics and police came, and R2 was pronounced dead. V5 added the police had R1 under supervision. V5 stated R1 was unhappy with life, and the nursing staff often had to call social services when he could not be redirected.

V11 (Police Detective) confirmed during interview of November 21, 2023, that R1 had been arrested and was being charged with murder of R2. V11 also added this was an open investigation and could not comment anymore.

V12 (Masters of Social Work/MSW-Social Worker) was interviewed on November 19, 2023, about R1 and described R1 as, "stubborn, loud, swearing, and a hard candy." V12 went on to add R1 was upset about a situation with his ex-wife and her new boyfriend, which R1 found upsetting. According to V12, once R1 doesn't like you, he has a reason for rude behavior. V12 also stated R1 had a hard time re-directing himself when he was upset, and V12 would talk with him, and R1 would change his mind almost daily about a facility transfer. V12 stated R1 wanted to live at the VA (Veterans Administration) home, and then would change his mind and not want to transfer. V12 could only recall two other incidents involving

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S9999	Continued From page 6 R1's behavior and that was "swatting another resident" and "kicking a wheelchair and calling the other resident a name." V10 (Advanced Practice Nurse-APN Psychology) was interviewed by phone on November 20, 2023, and stated direct care staff complained R1 would swear, scream, and yell. R1 would complain about the food and R1 had anger issues. V10 also added R1 "had a temper". V8 (LPN-Nurse) stated on November 19, 2023, R1 was, "aggressive, had a couple of incidents on the elevator and a temper with impulse control." V8 indicated most of time, R1 could be re-directed, but R1 really wanted to get out of the facility. V15 (Restorative Nurse Aide) described R1 on November 19, 2023, as, "aggressive, verbally." V15 also stated R1 was in some type of fight or disagreement with other residents at least one time a month. V14 (Activity Aide) described R1 on November 19, 2023, as "not happy and angry". A review of facility incident reports indicate R1 was involved in two other incidents with other residents, R3 and R4. On July 10, 2023, per the facility incident report, "(R4) reached over (R1) to push the button, and (R1) lifted (R4's)arm out of the way". V20 (Facility's former Administrator) documented in the incident report R1 was agitated, gritting his teeth, and swearing. V20 documented she called Social Services to re-direct the resident and interviewed other residents from the 6th floor. According to V20, other residents were interviewed, and they said R1 was rude and mean. After this incident, R1	S9999		

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S9999	Continued From page 7	S9999		

was discharged to the hospital, but returned later that night. V12 charted, "resident will require one to one sitter due to aggression and they do not have a bed available will attempt placement tomorrow." V20 (Former Administrator) charted on July 10, 2023, R1 became aggressive when she spoke with him about the incident with R4. V20 charted, "He became aggressive, balling up his fists."

R4 was interviewed on November 26, 2023, and recalled the details of the incident. R4 stated R1 hit her on the elevator, and this caused a bruise. R4 went on to add R1 had a very bad temper, and it scared R4 when R1 came back the next day. R4 went on to add that, "He was scary, and I was afraid of him since I have a history of being battered." R4 went on to add R4 hopes R1 never comes back, since she heard R1 hurt R2. R4's BIMS (Brief Interview for Mental Status) is 15, indicating R4 is cognitively intact.

R1 and R3 were involved in an incident on October 6, 2023, when R1 started kicking R3's wheelchair and yelling at R3. R1 then started to yell at staff, and the two residents were separated. R3 was interviewed on November 26, 2023 about the incident, and recalled R1 was yelling at her and pushing and kicking her wheelchair. R3 also mentioned that one day, R1 picked up a chair in the dining room and came towards her. R3 stated she was afraid of R1. V9 (LPN-Nurse) described R3 as alert and orientated. R3's BIMS Assessment of November 1, 2023, codes R3 as being cognitively intact.

V12 (MSW/Social Worker) documented on October 6, 2023, she spoke with R1 regarding recent physical and verbal aggression directed at other residents. V12 also added R1 was advised

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S9999	Continued From page 8 to use alternative methods to verbalize his concerns, such as ignoring the other resident or speaking with Social Services. V12 charted again on October 10, 2023, follow up to "recent verbal and physical aggression directed towards another resident." V13 (ANP-Advanced Practice Nurse) documented on November 3, 2023, "gathered from staff: pt (Patient) was verbally aggressive towards a female resident in the dining room. No behavior updates noted on chart review." "Pt exhibits increased anger, frustration, and irritability." V23 (Care Plan/MDS nurse) provided the survey team R1's entire care plan from admission. The care plan from August 25, 2022 documents only adjustment to the facility and desire to return to the community as behavioral issues. R1's plan of care was not updated after the resident to resident incident of July 10, 2023. R1's care plan, dated August 22, 2023, list as a problem under behavior: "Resident exhibits physical and verbal aggression directed to others including residents and staff. He exhibits poor impulse control, has presence of delusions, partakes in risk-taking behaviors, and has presence of anger/hostility. Resident has been involved in physical and verbal altercations with other residents." "Resident has verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others." Approaches for R1's behaviors were documented as: "Encourage resident to express himself. Provide emotional support as needed." "Encourage resident to participate in different	S9999		

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S9999	Continued From page 9 activities/interaction." "Provide education on boundaries and appropriate behaviors." "Remove/redirect resident from unsafe situations." "Do not confront, argue, or deny residents belief system." "Maintain a calm, slow, understandable approach." "Provide reassurance as needed." Care plan interventions are not specific to R1's needs, and were not revised after the incident with R3 on October 6, 2023. The same general interventions have been in place since August 22, 2023. The facility's Abuse Prevention and Reporting Policy, revised January 11, 2023, documents: "Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents." The facility's last abuse training was conducted March 29, 30, and 31, 2023. This training covered: 1. Exploitation and Misappropriation 2. Abuse prevention and reporting 3. Compliance 4. Ethics 5. Fraud, waste, and abuse Resident to resident abuse and interventions were not covered in the training." (AA)	S9999		

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