

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008338	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/09/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SALEM VILLAGE NURSING & REHAB

**1314 ROWELL AVENUE
JOLIET, IL 60433**

(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 1874188/IL00103741: F686G F690D 1874035/IL00103579: F921E	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)d)2)5) 300.3240 a). 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/23/18

STATE FORM

6899

OUEM11

If continuation sheet 1 of 6

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S9999	Continued From page 1 sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide wound care in a timely manner as ordered by physician, failed to reposition and keep resident dry and clean. This failure resulted to the decline of pressure ulcer for two residents (R17 and R18) and development of a new pressure ulcer in the ischium for R18. This applies to 3 of the 5 residents (R16, R17 and R18) reviewed for pressure ulcer in the sample of 22. The findings include: 1) R16's physician order sheet (POS) dated 6/15/18 showed that R16 is an 81 year old who has multiple medical diagnoses which include impaired renal function, renal insufficiency, pressure ulcer, dementia and multiple sclerosis. Minimum Data Set (MDS) dated 6/12/18 showed that R16 is totally dependent for personal hygiene, toileting and bed mobility. R16's care plan dated 3/19/18 showed that R16 is on contact precaution for extended spectrum beta-lactamases (ESBL) in urine and	S9999			

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S9999	Continued From page 2 Carbapenem-resistant Enterobacteriaceae (CRE) in urine. R16's weekly skin assessments for June 2018 showed that R16 has stage 4 pressure ulcers to the right ischium and sacrum. On 6/28/18 at 10:30 AM R16 was lying in bed. R16's incontinence brief was slightly wet however her wound dressing to the right ischium which was dated 6/27/18 was heavily saturated with urine and already brown in discoloration. V10 (Wound Care Nurse) stated that R16 is a heavy wetter. V10 also stated that wound dressing change is to be made daily and as needed. 2) R17's POS dated 6/15/18 showed that R17 has multiple medical diagnoses which include decubitus ulcer, stage 4 coccyx wound and history of stroke with weakness to bilateral lower extremities. MDS dated 4/9/18 showed that R17 is totally dependent with toileting, hygiene and bed mobility. R17's infection log showed that she is on precaution for CRE, ESBL, Vancomycin resistant enterococcus (VRE) and Acinobacter in the urine and CRE in the wound. R17's weekly skin assessment for June 2018 showed stage 4 pressure ulcer in the sacrum. On 6/28/18 at 11:10 AM R17 was lying in bed, with multiple wound dressing in the buttocks area noted as follows: - A wound dressing in the right medial buttock by posterior thigh dated 6/27/18 was heavily saturated with urine with foul smelling odor of exudates. - The right ischium dressing was also saturated	S9999			

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S9999	Continued From page 3 with urine with foul smelling odor. - The stage 4 coccyx/sacrum pressure ulcer has a dressing which dated 6/27/18. A calcium alginate was inside the sacral wound which was heavily saturated with thick purulent exudates which overflowed to the dressing that covers the wound. On 6/28/18 at 11:15 AM V10 (Wound Care Nurse) stated she first noticed R17's pressure ulcer in the right medial buttock the day before as a stage 2 new open area, as of the present it deteriorated to unstageable pressure ulcer. V10 also stated that the Stage 4 sacral ulcer is known to have a lot of discharges and has a physician's order to change dressing twice daily and as needed, but it was not change from the night before as evidence by V10's signature in the dressing which she applied in the morning of 6/27/18. 3) R18's POS showed that R18 is an 82 year old resident who has multiple medical diagnoses which include muscle weakness. R18's infection log showed he is on precaution for ESBL in urine. MDS dated 4/30/18 showed that R18 requires extensive assistance for bed mobility, toileting and hygiene. On 6/28/18 R18's repositioning was monitored every hour from 10:25 AM through 3:00 PM R18 was noted sitting in his bed on semi upright position leaning towards his left side. At 2:47 PM R18 was in bed sleeping on semi upright position. There was a towel on top of R18's abdomen which was stained with brown discoloration and combination of dried and drying urine. There was a pervasive urine odor coming from R18.	S9999		

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S9999	Continued From page 4 At 3:00 PM V12 and V13 (Both Certified Nursing Assistants/CNA) rendered incontinence care to R18. R18's dressing in the suprapubic catheter area, incontinence brief and wound dressing to the left buttock was heavily saturated with urine and it overflowed to the incontinence cloth pad and flat sheet. The urine already formed a brown circular stain in the pad and flat sheet. R18's buttocks was wet and macerated from the long exposure to the moisture. V12 stated that R18 looks like he's been sitting in his urine for a long time. On 6/28/18 at 3:10 PM V10 assessed R18's wound and identified a new open area in the left ischium just above the left medial buttock's unstageable pressure ulcer. V10 described it with necrotic wound bed which measured as: Length (L) 0.4 centimeter x Width (W) 0.4 cm. V10 also stated R18's skin is macerated in the surrounding area of the left medial buttock wound due to long exposure to urine. Although this wound was unstageable it has a flat surface before, now it looks like it sunk in and it has an obvious depth. It has 80% slough, 10% necrotic tissue and 10% granulation. V10 added, this wound declined due to long exposure to moisture. R18's most recent skin assessment dated 6/25/18 showed 40% granulation and 60 % slough in the wound bed. On 7/3/18 at 11:01 AM V15 (Wound Physician) stated, any time there is a urine in the wound the urine's acidity breaks down the tissue which causes deterioration in the wound. The infection in the urine can also further breakdown/deteriorate the wound. The wound dressing needs to be changed every time it gets	S9999			

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S9999	Continued From page 5 soiled. Whenever there's a pressure ulcer, that area should be relieved of pressure, the resident must be turned and kept dry. (B)	S9999			