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
	IL6008338	A. BUILDING: ______ B. WING ______	C 10/03/2022

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 Facility Reported Incident of September 2, 2022 IL151760	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)6) 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: 6) 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 regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement safe bed mobility practices to prevent a fall.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

This failure resulted in a resident (R2) sustaining a subdural hematoma and a laceration to the back of her head which required sutures.

This applies to 1 of 3 residents (R2) reviewed for assistance with bed mobility in a sample of 10.

Findings include:

The 9/6/2022 Nurse Practitioner Progress Note documents R2 with diagnoses including morbid obesity, chronic bilateral lower extremity lymphedema, and lower extremity blood clots requiring life-long anti-coagulants.

R2's 6/30/2022 Minimum Data Set documents R2 as requiring two persons extensive assistance for bed mobility.

R2's Physical Therapy Evaluation and Plan of Treatment, dated 8/20/2022, completed by V5, documents R2 as totally dependent on staff for rolling and a maximum assistance.

R2's Electronic Medical Record documents R2's weight on 9/29/2022 as 209 pounds.

The final facility State Report (dated 9/12/2022) documents R2 as mostly bedbound and requiring a mechanical lift for transfers. This report documents R2 as falling from the bed while one staff person provided care, causing R2 to land on her left side on the floor. This report documents R2 sustained a laceration to the back of her head and a hematoma to her left eye. R2 was sent for evaluation in the emergency room and returned with sutures to the back of her head. This report then documents R2 was sent out for an evaluation again on 9/6/2022, when a change in

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S9999	Continued From page 2 her mental status was identified, and she was admitted to the hospital with a diagnosis of a small subdural hematoma. The CT scan (Computerized Tomography) report, dated 9/6/2022, documents R2 with a trace subdural hematoma. On 9/30/2022 at 1:20 PM, R2 was in a large bariatric bed with an air mattress. V9 and V13 (Nursing Assistants) provided care, rolling R2 from side to side. R2 required total assist from V9 and V13 to roll from side to side. On 9/30/2022 at 1:35 PM, V9 stated on 9/2/2022, she raised R2's bed up to approximately her hip height to provide incontinence care. V9 stated while providing care with R2 laying on her left side and facing away from V9, R2 suddenly rolled forward towards the wall and fell off of the bed, landing on the floor on her left side. V9 stated she could not stop R2's fall from where she was standing because R2 is too large. On 9/30/2022 at 12:40 PM V5 (Physical Therapist) stated R2 was classified as maximum assist at the time of the fall per his assessment, which showed R2 required the assist of two persons for safe bed mobility. V5 further stated on 9/2/2022, R2 should have had 2 staff persons assisting for safety to prevent the fall while she was being rolled from side to side. 9/30/2022 2:58 PM V10 (Nursing Assistant) stated R2 recently became less alert and was not following directions as well, and he started asking for a second person to assist him for safe bed mobility. V10 stated he was afraid R2 would roll out of bed during the provision of care, and R2 was too big to stop a fall if he was by himself. On	S9999		

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S9999	Continued From page 3 9/30/2022 at 3:05 PM, V11 (Nursing Assistant) stated she recently started using 2 persons for bed mobility because R2 had declined. V11 stated R2 is too big to care for on her own, and that was the only way V11 felt she could safely roll her from side to side. On 10/3/2022 at 9:50 AM, V17 (Nurse Practitioner) stated R2's subdural hematoma diagnosed on 9/6/2022 was likely caused by the 9/2/2022 fall from bed. V17 confirmed staff should be following physical therapy recommendations for the safe provision of care. V17 stated the facility should have been using 2 staff persons during the provision of R2's care on 9/2/2022 to prevent her fall. (A)	S9999		