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 03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM VILLAGE NURSING & REHAB	1314 ROWELL AVENUE JOLIET, IL 60433

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S 000	Initial Comments Facility Reported Incident of February 6, 2023 IL156636 Complaint Investigation 2371755/IL157031	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 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. 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 requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff performed safe transfers while using a resident sling with a mechanical lift. These failures resulted in a sling breaking while R1 was being transferred with the mechanical lift. R1 sustained a laceration to her left forehead requiring 3 staples. The facility also failed to provide adequate supervision to a resident displaying aggressive behaviors (R6). This applies to 2 of 8 residents (R1 and R6) reviewed for accidents and supervision in a sample of 8. The findings include: 1. The Brief Interview of Mental Status, dated 1/1/2023, documents R1 as cognitively intact.	S9999		

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S9999	Continued From page 2 R1's Care Plan for Activity of Daily Living assistance, dated 4/29/2022, documents R1 is to be transferred with a mechanical lift with the assistance of 2 staff. R1's final State Reportable Event, dated 2/13/2023, documents during a transfer the mechanical lift sling straps ripped causing R1 to fall to the floor and incur a laceration to her head. R1 was sent to the emergency room and returned with 3 staples to her scalp wound. On 2/27/2023 at 11:20 AM, R1 was laying on bed with a scabbed healed wound to her left upper scalp area at the hairline. R1 stated they were putting her back to bed from her wheelchair when she suddenly fell onto the floor and "blacked out." R1 stated only one staff member was present when this incident occurred. R1 stated she was taken to the hospital for evaluation because her head was bleeding. On 2/28/2023 at 10:50 AM, V5 (Nursing Assistant) stated she was transferring R1 from her wheelchair to her bed without any other staff present bedside to assist with R1's transfer. V5 stated after R1 was lifted about 3 feet in the air, she moved the wheelchair out from under her, and the strap on the sling broke unexpectedly causing R1 to fall. On 2/27/2023 at 1:27 PM, V1 (Administrator) and surveyor inspected the torn lift sling that failed during R1's transfer on 2/6/2023. The lift sling has 2 black straps on each of the 4 corners of the lift pad, with a series of 3 colored loops attached to each of the black straps. The laundry tag had been removed and white material remained around the area where the tag had been. The 2	S9999		

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S9999	Continued From page 3 sets of black straps on the right side were intact, and the bottom left strap has one broken strap at the location where the first set of loops begin. Both of the top right black straps are broken at the location where the first set of loops attach. The blue loop attached to the black upper left straps had visible wear on the edge; the blue loop attached to the black upper right straps has slight fray on one edge; the green loop attached to the black lower left straps shows visible wear on one edge; and the blue loop attached to the black upper right lower straps has visible fray on one edge. Upon manipulation of the intact black straps near the location where the colored loops are attached, the material was brittle and can be heard separating and ripping. On 2/27/2023 at 9:15 AM, V1 stated prior to this incident, laundry was washing the slings when they were soiled in water that was probably too hot. V1 stated manufacturers guidelines state to replace the lift slings when they are worn, and staff are to inspect the lift slings prior to use. On 2/27/2023 at 10:05 AM, V9 (Central Supply Director) provided the company guidelines for the care and use of the slings being utilized by the facility on 2/6/2023. The User Guide for the Full Back Sling documents to check sling stitching before each use. Using bleached, torn, cut, frayed or broken slings is unsafe and could result in serious injury or death to the patient. Destroy and discard worn slings. On 2/27/2023 10:25 AM, V6 (Laundry Lead) stated the lift slings were washed by their department, and there was no set system to launder the lift slings. V6 additionally stated the lift slings were at times washed in hot water with bleach.	S9999		

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S9999	Continued From page 4 On 2/27/2023 at 10:40 AM, V7 (Laundry Aide) stated she was hired approximately 2 months ago. She stated she was washing the lift slings with other clothing and towels on a cycle with hot water, and she sometimes used bleach. V7 did not recall any training specifically to care for lift slings. On 2/27/2023 at 1:27 PM, V1 confirmed no laundering process was in place to clean the lift slings at the time of R1's fall on 2/6/2023. V1 was unable to provide information on how long the lift slings had been in place or when they were replaced at the facility. Additionally, V1 stated the Therapy Department completes assessments for each resident to determine each individuals transfer status and the facility follows their recommendations. V1 confirmed R1's transfer status a 2 person transfer with a mechanical lift. On 2/28/2023 at 1:52 PM, V1 stated the facility is to be following manufacturers guidelines for care of the slings. On 2/28/2023 at 10:00 AM, V8 (Medical Director) stated, "I expect them to do everything by the book." V8 then confirmed he expects the facility to follow manufacturers recommendations to care for lift slings to maintain the integrity of the material and to provide safe transfer assistance during a transfer to prevent injury. The company 2017 "10 Steps to Maintain Sling Safety" manual includes, 1. Inspect slings before each use. Ensure all components of the sling (attachments, fabric, stitching, and loops) do not show signs of wear, damage, discoloration, deterioration, or loose threads. If any of the above is observed, the sling should be replaced. 7.	S9999		

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Launder the sling per the manufacturer's instructions. Slings have laundering instructions on their tags and in their manuals, and these instructions should be followed during every wash to prevent material breakdown and maximize a safe, useful life. 8. DO NOT use bleach. Bleach will damage the sling's material and make it unsafe for use.

2. R6's Resident Face Sheet, dated 8/2/2022, with diagnoses to include Anxiety, Delirium, Hallucinations, Dementia and Psychotic Disturbance.

R6's Brief Interview of Mental Status, dated 12/30/2022, documents R1 with severe cognitive impairments.

On 3/3/2023 at 8:22 AM, V27 (Nurse) stated on 2/23/2023, he worked from 3 PM- until 7 AM. V27 stated, "(R6) will wander, clean things, and is generally re-directable and is usually only aggressive when you stop her from doing what she wants to do or another resident takes something from her." He further stated she requires frequent supervision and when he works his regular shift (11PM-7 AM) she usually only sleeps 2-3 hours, and will stay at the nurses station most of the night. V27 stated she was at her baseline most of the evening of 2/22-23/2023, until she threw water on the medication cart, and then picked up the pill crusher and threw it at him. V27 had two nursing assistants help him, and brought R6 to her bedroom.

On 3/2/2023 11:04 AM, V26 (Nursing Assistant) stated R6 had been wandering most of the night beginning when she started her shift at 11 PM. Because of this, V26 was providing activities to distract her and supervising her. V26 stated after

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S9999	Continued From page 6 R6 threw a pill crusher at V27, R6 was brought back to her room where V26 stayed to supervise R6 until she felt she was calm. V26 stated within 15 minutes of leaving R6's room, R8 put on her call light and when V26 entered the room, R6 was in R8's room with a hanger in her hand saying she was going to hit R8. V26 stated she intervened and R6 did not strike R8, but as she was intervening, R6 began hitting V26, and it was at that time she noticed R6 had a disposable razor in her hand. V26 was able to get both items from R6, stating she was not sure where R6 found the razor. V26 confirmed R6 had been exhibiting increased behaviors that evening, and required increased supervision, which was not being provided at the time R6 entered R8's room. On 3/3/2023 at 8:22 AM, V27 stated R6's behavior towards R8 was unexpected, and R6 had not had any altercations with R8 or any other residents. R6's 2/23/2023 Resident Progress Notes document R6 was sent to the emergency room for evaluation and returned without any new orders. These notes also document R6 with continued behaviors after return on 2/23/2023, and V28 (Psychiatrist) was notified and he ordered R6 to be sent for an evaluation at an inpatient psychiatric hospital where she was admitted. (B)	S9999		