STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145618	A. BUILDING _____ B. WING _____	C 01/19/2013

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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F 000	INITIAL COMMENTS Complaint Investigation: 1370110/IL #61065- F314, F315 1370165/IL #61122- no deficiencies cited	F 000		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent the development of facility acquired pressure ulcers and failed to implement individualized interventions to attempt to stabilize or remove underlying risk factors to promote healing for 2 (R 2, R 7) of 3 residents reviewed for pressure ulcers. These failures resulted in R2 and R7's pressure ulcer progression. R2 acquired one Stage II pressure ulcer in the sacrum that progressed to Unstageable. R 7 acquired one Unstageable and one Stage II pressure ulcer on the right and left metatarsal. The Stage II progressed to an Unstageable pressure ulcer. Findings include: (1) On 01-19-13 at 1:00 PM, R 2 was observed	F 314		

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

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in bed. R 2 stated " I'm waiting for the CNA to clean me up. I think I did # 2 (BM). I got up this morning at 7:00 AM. I don't go back to bed until after dinner. I sit in my chair for a long time. If they need to change me they put me back to bed. I can't move one side (right) of my body, I need someone to help me. I'm very uncomfortable right now waiting for someone to come clean me. "
At 1:30 PM, E6 (Certified Nursing Assistant-CNA) turned R2 on her right side and noted R 2 with feces on her adult incontinence diaper. There was two dressings noted on R2's buttocks (on the sacrum and on the ischial area both smeared with feces). E 6 stated R2's " totally dependent on staff with everything. She's paralyzed on one side, she can't move her right side. She's a mechanical lift transfer with two assist."
R2's most current Braden scale for predicting pressure sore risk provide by the facility (unable to read the date) showed a score of 15 (Low Risk).
Review of the facility weekly wound report dated 01-05-13 - 01-11-13 showed R2 acquired a Stage II pressure ulcer on the right inner buttocks (sacrum) on 12-18-12. As of 01-05-13 - 01-11-13 (from the weekly wound report), this area was measured at 0.3 cm X 0.2 cm. On 01-19-13 at 2:45 PM. The Treatment Nurse (E 7) measured and identified this area as follows: Area: Sacral; Measurement 2.0cm X 1.0 cm: Described with 100 % yellow slough; Stage: Unstageable pressure ulcer.
(2) On 09-19-13 at 10:20 AM, R 7 was observed sitting in her wheelchair parked by the wall in front of the dining room. R7 was observed with only socks on her feet. R 7 was observed to be confused and disoriented. At 2:10 PM, R7's family

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F 314	Continued From page 2 member (Z1) was at the bed side. Z1 claimed, "Every day I come and visit. Yes she has a sore on her feet. It happens here and she's not even a diabetic and they can't heal it. The service here is poor. This dressing had not been changed for three days when I checked yesterday. " Review of the facility weekly wound report dated 01-05-13 - 01-11-13 showed R7 acquired a Stage II pressure ulcer on the left distal end of R7's 1st metatarsal on 08-01-12. The measurement of this Stage II area as of 01-05-13 - 01-11-13 (base on the weekly wound report) was recorded at 0.8 cm X 0.9 cm. The area on the right metatarsal acquired in the facility on 12-18-12 was identified as Unstageable. On 01-19-13 at 2:27 PM, E 7 identified and measured the areas as follows: (1) Left distal end of the 1st medial metatarsal: Measured at 0.9 cm X 1.0 cm with 50 % yellow slough with sero sanguinous drainage, Unstageable pressure ulcer. (2) Right distal end of the 1st medial metatarsal remained Unstageable. E7 claimed " her (R7) metatarsal gyrates/rubs while in bed which causes friction. We applied bunny boot but it's small. It did cover the entire area. " Review of R7's plan of care reads: Continue to have bilateral foot boots while up in chair and in bed. This intervention was not implemented during the observation on 01-19-13. E 7 confirmed on 01-19-13 at 3:00 PM the facility has no comprehensive assessment developed for R 2 and R 7.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide individualized incontinence interventions to enhance quality of life and functional status and consistently implement the interventions listed in the plan of care for 2 (R5,R6) of 4 residents reviewed for incontinence.
These failures resulted in R 5 sitting in a urine saturated disposable diaper that penetrated his pants from his waist down to his legs and R 6 sitting on feces soiled disposable diaper that leaked through her pants.
Findings include:
(1) On 01-19-13 at 10:20 AM, R 5 was observed sitting in an adult reclining chair in the dining room with very strong urine odor. E 3(Certified Nursing Assistant- CNA) identified R 5 as mentally retarded and unable to communicate his needs. On 1/19/13 at 12:20 PM, a lunch tray was served and at 12:30 PM, R 5 was fed by the staff. R 5 remained in the dining room observed to be sleeping at 1:00 PM. There was no staff were observed to have repositioned or toileted R 5. At 1:35 PM (more than three hours) R 5 was requested to be toileted.
E 3 and E 4 (CNA's) pulled R5's adult reclining

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chair backwards to his room. The staff stated, "They go back to bed when they need changing. There's really no specific time. You could smell it. I'm assuming this late (time) of the day, he's wet. He has a very strong urine odor. " Both CNAs confirmed 5 had a very strong urine odor.
E3 and E 4 used a mechanical lifting device to transfer R 5 from his adult reclining chair to his bed. As R5 was lifted from the chair, R 5's pants were observed to be saturated with urine from waist down to his legs. R 5 ' s disposable diaper was fully saturated with urine.
The CNA in charge stated R 5 was gotten up at around 9:00 AM and not toileted since. These CNAs stated, "We are short of staff. "
On 01-19-13 at 5:20 PM, the facility staff provided R 5 ' s plan of care that reads: check every two hours for incontinence episodes and look for signs of need to void (facial grimace and restlessness.) These plans were not implemented or followed during observation on 01-19-13.

(2) On 01-19-13 at 10:20 AM, R6 was observed in the dining room sitting in her wheelchair, leaning on the left side of the wheelchair. There was no positioning device noted. Review of R6's incontinence plan of care showed diagnosis including mental retardation, cerebral palsy and bipolar disorder. At 12:00 PM R6's lunch tray was placed in front of her. At 12:10, R6 was crying and saying, " Feed me! " repeatedly. After lunch R6 remained in the dining room. There was no staff observed to have repositioned or toileted R6. R6 had a strong BM odor. At 2:00 PM R6 was requested to be toileted.
E3 and E4 transferred R6 from her wheelchair to her bed using a mechanical lift at 2:25 PM (after four hours). The CNAs stated they can tell she

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F 315	Continued From page 5 (R6) needs changing. As R6 was being lifted, R6 pinched her nose with one hand and fanned her nose with the other hand. When E4 and E3 pulled down R6's pants, a large amount of soft stool was noted on R6's inner legs, smeared on her pants and on her adult disposable diaper. R 6 groin was noted to be red in color. E3 and E 4 stated " she (R6) has psychotic diagnosis; sometimes she can verbalize her needs (for toileting) but rarely. " Review of R6's bladder and bowel incontinence care plan reads as follows: check every two hours for incontinence episodes. Keep clean and dry. Remind resident to void. Encourage to voice need to move bowels. On 01-19-13 for more than four hours (10:20 AM thru 2:25 PM, there was no staff observed that implemented these interventions on R 6.	F 315		