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 _____	08/21/2012

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 Annual Licensure and Certification Survey VALIDATION SURVEY FOR SUBPART U: ALZHEIMER UNIT The facility is in substantial compliance with Subpart U, 77 Illinois Administrative Code, Section 300.7000	F 000		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to document a medical symptom justifying the use of restraints, obtain consents and develop plans of care for the use of adult reclining chairs for 13 residents. This applies to three residents (R13, R14 and R18) in the sample of 30 residents and 10 residents (R44, R45, R46, R47, R48, R49, R50, R51, R52 and R53) in the supplemental sample. Findings include: During the initial tour of the 5th floor Alzheimer Unit on 8/14/2012 at 10:05 AM, and observation of activities and noon meal on 8/14/2012 and 8/15/2012, the following residents were observed in adult reclining chairs: R44, R18, R45, R46, R47, R48, R13, R49, R14, R50, R51, R52 and	F 221		

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

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F 221	Continued From page 1 R53. During initial tour on 8/14/2012, the unit manager (E21) was asked the medical reasons for the use of the adult recliners for the above residents. E21 identified the majority of the residents in the adult recliners were at risk for falls and are in a " falls prevention group. " E21 said these residents are in the chair to keep them in the day room for close observation and prevent them from falling while alone in their rooms. E21 stated assessments were not completed before implementing the use of the adult recliners. During the Daily Status Meeting on 8/16/12 at 10:50am, E1 (administrator) and E12 (unit manager) stated assessments or care plans had not been completed prior to the implementation of the adult recliners.	F 221		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop and implement the abuse/neglect prohibition policy and procedure for screening and reporting instances of possible abuse/neglect . This is for four residents (R2, R11, R20 and R23) in the sample of 30 residents; and eight residents	F 226		

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F 226	Continued From page 2 (R36 through R43) from the supplemental sample. Findings include: The facility abuse prohibition policy procedure, not dated, Section VII External Reporting of Potential Abuse noted: ' Initial Reporting of Allegations. If, during the course of an incident investigation, the administrator or designee has determined that there is reasonable cause to suspect mistreatment has occurred, the resident's representative and the Department of Public Health office shall be called. ' This policy and procedure do not include reporting all allegations of abuse and mistreatment immediately and not after the allegation was substantiated. On 8/16/12 at 3:45 pm the survey team discussed the concern with the facility administration. Observation of R2 on 8/14/12 at 11:45am observed him to be lying in bed, alert and able to answer simple questions, oriented to name only. R2 was observed to have several quarter size blood stains on his pillow case. When asked how that occurred, R2 cursed at surveyor. E8 (R2's nurse's aide) entered the room and stated that R2 is known for calling staff derogatory names including racial slurs and for being combative and resistive to care. E8 stated she had not cared for R2 yet this morning other than feeding him because R2 did not want E8 to touch him. These behaviors exhibited by R2 makes him a high risk for potential abuse/neglect by staff or other residents. E8 stated at 11:45am that she has been on duty since 6:30am and has not provided personal care or repositioned R2 because he would not allow	F 226		

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her to. E8 stated she had not told any other staff about this situation.

Medical record review shows R2 is totally dependent on staff for all activities of daily living. This was confirmed by E8 on 8/14/12 at 11:45.

E1 confirmed on 8/15/12 at 10:00am this incident of unknown origin with R2 had not been reported to the IDPH.

2. R11 was observed on all days of the survey to be wandering in and out of other resident rooms on the Alzheimer's unit. R19 stated on 8/15/12 at 12:20pm that he does not like R11 to wander in and out of his room because he's afraid of being accused of hitting her.

E20 (nurse) stated 8/16/12 at 2:00pm she (E20) has had complaints from other residents about R11 wandering in and out of resident rooms (on the Alzheimer's unit). E20 stated that is R11's behavior and that she shops (picking up other resident belongings and walking away with them).

E5 (social service director) was asked on 8/15/12 at 2:50pm how the facility assesses, care plans and monitors residents who have needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff. E8 stated the facility does not assess residents who are at risk for abuse or neglect and does not care plan for them. This was confirmed by E1 (administrator) on 8/16/12 at 3:45pm.

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F 226	Continued From page 4 On 8/17/12 at 10:45am, administrative staff (E1) provided survey team with assessments and care plans that identified 12 residents in the facility as high risk for abuse/neglect, Rs 2, 11, 20, 23 and Rs 36 through 43.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to: -ensure three female residents (R31, R32 and R34) were provided with appropriate assistance to maintain their grooming in a dignified manner. -provide five incontinent residents (R5, R32, R33, R34 and R35) with incontinent products that do not embarrass them when in public. -provide one resident's meals (R12) in a dignified and timely manner. This is for two residents (R5 and R12) in the sample of 30 and five residents (R31, R32, R33, R34 and R35) in the supplemental sample. Findings include: A group meeting of 11 alert and oriented	F 241		

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residents was conducted on 8/15/2012 at 2 PM in the first floor dinning room. Three female residents (R31, R32 and R34) stated staff prevented them from removing their facial hair by taking her razor away. R32 and R34 voiced they did not want to have facial hair but staff do not assist them in removing it. R31 complained it was un-becoming for a woman to have to present in this manner. R32 expressed concerns there was not enough staff to assist female residents in shaving facial hair.
R31, R32 and R34 were observed to have facial hair.

Also at the 8/15/2012 group meeting, R5, R31, R32, R33, R35 and R34 complained about the adult incontinent diapers and pads: R31 and R35 reported concerns staff were stealing their personal " diapers " . R5, R32, R33, R34 and R35 also complained they feel uncomfortable being wet and dirty in a cloth adult incontinent pad. R5, R32, R33, R34 and R35 expressed embarrassment that being incontinent in a cloth adult incontinent pad allowed their clothing to get wet in public.

During the noon meal on 8/14/2012, R12 was observed sitting at a back table waiting for his meal to be served. R12 was moaning loudly and crying out. When asked, R12 stated he wanted his tray and he was hungry. A certified nurse aide (CNA) standing near by reported R12 had to wait because he was sitting at a back table which was served last by staff. This CNA also said that R12 usually wanted to eat as soon as he (R12) saw the trays being served, and described R12 having a good appetite. When asked why R12 could not be served him tray sooner, E12 (the unit

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F 241	Continued From page 6 manager) gave no answer. During the Daily Status Meeting with facility administrative staff on 8/16/12 at 11:10am, E1 (administrator) was informed of the above concerns. E1 said the facility only lets her provide cloth " diapers " to residents. When asked, E1 did not identify any other incontinent product being provided to the residents that would allow them to be clean, dry and comfortable while in public. E1 and staff did not provide any evidence to support that staff shave the above females as needed. Also, E1 did not provide any evidence that staff tried to enhance R12's dinning experience by ensuring he did not have to wait and watch other residents eating and being served prior to receiving his meal.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to develop and implement interventions to address medical emergency procedures, waste management and fluid restrictions for one of two (R16) residents in the sample who are receiving hemodialysis outside of the facility.	F 309		

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F 309	Continued From page 7 Findings include: R16's admission record indicated he was admitted to the facility on 5/9/12 and he is receiving hemodialysis three times a week. R1's 5/17/12 care plan for renal failure had no interventions to address what emergency procedure the staff should follow for the prevention of hemorrhaging from the shunt site. R16's 5/17/12 care plan interventions for renal failure also did not address what interventions to follow to plan his fluid restriction. On 8/15/12 at 2:00 pm the care plan coordinator stated the dietary department has their plan and nurses are supposed to document fluid intake on Medication Administration Record (MAR). On 8/15/12 at 3:15 pm E16, Nurse on 3rd floor verified the MAR from 7/15/12 to 8/14/12 was blank. The nurse also could explain their understanding of medical emergency and waste management. E16 stated R16 is not compliant with fluid intake, he consumes fluids when he goes off unit unnoticed by staff. No dietary fluid plan was available for R16. The care plan also did not include interventions to check for the patency of shunt. R16, during the survey (8/14 - 8/17/12) left the unit independently, to visit 1st floor. On 8/14/12 at 12:10 pm R1 was notice buying carbonated beverages the vending machine, unnoticed by staff.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure that 3 residents (R19, R23, R55) were provided with services to maintain their personal hygiene and oral care.

This applies for two of 30 residents (R13 and R23) in the sample of 30 residents and one resident (R55) in the supplemental sample.

Findings include:

-During the initial tour of the Alzheimer unit on 8/14/2012 at 10:10am, R23 was observed sitting in his wheel chair with food debris in the front of his clothing and lap in addition to a wet spot on his pants. R23 was in clear view of direct care staff but was not provided with the assistance he required to maintain good personal hygiene. When asked about R23's personal hygiene, E21 (unit nursing manager) on 8/14/12 at 10:30am, described R23 as needing assistance to maintain his grooming. E21 instructed two nurses aides to change R23 and was observed to be soaked with urine, in addition to his wheelchair pad being soaked.

-During the noon meal on 8/15/2012, R55 was observed to be in the dining room with long, dirty nails. When asked, staff reported R55 needed assistance to clean under his nails.

-On 8/16/2012, R13 was observed in an adult reclining chair in the 5th floor day room, during morning activities. R13 needed oral care because of the food debris which coated her (R13 ' s)

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F 312	Continued From page 9 tongue and at the side of her mouth. After assessing the condition of R13 ' s mouth, E23 (Nurse) said that R13 needed oral care. E23 reported that R13 was on hospice and required staff to provide her (R13 ' s) oral care, and activities of daily living.	F 312		