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
	IL6004766	A. BUILDING: ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC JOLIET	222 NORTH HAMMES JOLIET, IL 60435

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S 000	Initial Comments Investigation of Facility Reported Incident of April 25, 2023/IL159464 Complaint Investigation 2373873/IL159671	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)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	S9999	Attachment A Statement of Licensure Violations	

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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.

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 were Not Met as evidenced by:

Based on observation, interview, and record review, the facility failed to have a system in place to launder and maintain the mechanical lift slings per manufacturer guidelines to prevent material breakdown and maintain the integrity of the lift slings for safe use. The facility failed to serve hot water at a safe temperature to a resident with upper extremity impairments.

This failure resulted in a sling breaking while R1 was being transferred with the mechanical lift, causing R1 to sustain a right humerus fracture.

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R1 also incurred a 3rd degree burn after spilling hot water on herself after being served hot water by facility staff.

This applies to 1 of 7 residents (R1) reviewed for accidents and incidents in a sample of 10.

The findings include:

R1's Admission Record dated 5/9/2023 documents R1 with diagnoses to include right sided Hemiparesis and Hemiplegia (weakness and paralysis) following a stroke affecting the dominant (right side), Bipolar Disorder, and morbid obesity. The Brief Interview of Mental Status dated 4/27/2023 documents R1 as cognitively intact.

1. On 5/5/2023 at 9:50 AM, R1 was in bed with a sling to her right arm. R1 stated last week, she fell from the mechanical lift while being transferred. R1 stated two nursing assistants took her from the bed to shower, brought her back to bed to get dressed, and as she was being transferred from her bed to her electric wheelchair, the strap snapped- causing her to fall onto the floor and breaking her right arm. R1 stated, "They did everything right, but the sling busted." R1's 4/25/23 Radiology Report of Right Humerus, Shoulder and Elbow shows R1 with a fracture of her right humerus.

On 5/5/2023 at 1:40, V6 (Nursing Assistant) stated on 4/25/2023, V6 and V7 (Nursing Assistants) got R1 up with the mechanical lift, showered her, and transferred her back to bed to get her dressed. V6 stated when she and V7 began to transfer R1 from the bed to her electric wheelchair, the sling loop on the upper left side broke, causing her to fall to the floor. V6 stated

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S9999	Continued From page 3 R1 always had her own sling, and it is laundered by the Laundry Department when soiled, then returned to her once it is cleaned. A facility Investigative Report dated 4/25/2023 documents during a transfer, the left loop on the mechanical lift sling broke, causing R1 to fall to the floor and incur a right humerus fracture. R1 was sent to the hospital and returned with a right arm sling. On 5/8/2023 10:18 AM, V15 (Restorative Nurse) stated prior to R1's falls, soiled slings were sent to laundry for washing. After the fall it was identified improper laundering can cause deterioration of the sling material if not washed properly. V15 stated manufacturer's guidelines showed the slings are supposed to be dried without heat or air dried and washed without using bleach. On 5/5/2023 1:20 PM, V14 (Laundry Director) stated prior to the fall, there was no specific process to launder lift slings. V14 stated lift slings were sent to the laundry to be washed and dried on the regular (hot) cycle in the dryer. V14 stated three are two cycles on the washing machines and depending on which cycle was chosen by the staff washing the laundry, bleach would be automatically added to one of the two cycles. V14 stated now the facility is washing the slings in cold water and air drying them per the manufacturer's guidelines. On 5/9/2023 at 11:45 AM, V4 (Medical Director) stated he expects the facility to follow manufacturer's guidelines for the care of slings to maintain the integrity of the equipment for the safe provision of care.	S9999		

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S9999	Continued From page 4 R1's Care Plan for fall risk dated 12/30/2016 documents R1 as a mechanical lift for transfers. On 5/8/2023 at 10:55 AM, V15 (Restorative Nurse) provided the manufacturer's guidelines for the care and use of the slings being utilized by the facility on 4/25/2023, the date of the occurrence. The undated manufacturer's Full Body Sling Instruction Manual documents washing instructions as wash in warm or cold water, air dry or tumble dry at cool. Do not tumble dry at high temperatures, and do not use bleach. Bleached, torn, cut, frayed or broken slings are unsafe and could result in injury and should be discarded immediately. The undated manufacturer's Guideline for Identifying Deteriorated Slings documents slings, especially loop straps that have been damaged from being laundered in unsuitable conditions (bleach, high heat wash or dry) may appear to be in good condition, but the actual tensile strength of the material may be compromised and poses a safety risk and should not be used for lifting a resident. 2. On 5/10/2023 at 9:30 AM, R1 stated she spilled hot water on herself on 4/24/2023 at an unknown time and did not realize she burned herself. R1 stated V6 and V7 (Nursing Assistants) identified the burns while she was being showered on 4/25/2023. R1 stated she requests staff to provide hot water from the kitchen because the hot water from the plastic thermal dispensers sometimes has a coffee taste. R1 stated on this day, she had an unknown Nursing Assistant bring her water in her personal thermal cup, which was bedside during this interaction, placed in a larger silver thermal container. She said the water was so hot she let it sit for 2-3 hours before she went to drink it. She then	S9999		

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S9999	Continued From page 5 realized she had not put the tea bag in the cup before giving it to staff to fill as she usually does. R1 pointed to the smaller thermal cup that was bedside, stating she opened it up to put the tea bag in and spilled some of the hot water on her right side. On 5/10/2023 at 10:05 AM, V18 (Nurse) pulled back R1's gown, and a few small tan pea-sized spots on her right upper thigh which were superficial and almost healed. V18 peeled back a small dressing to R1's lower right abdominal area to reveal one small irregular quarter-sized red open area. On 5/10/2023 at 11:36 AM, V6 (Nursing Assistant) stated on 4/25/2023, she noticed a red spot on R1's abdomen and leg while showering her and the areas looked "fresh." R1 reported to V6 she had spilled tea on herself the day before. V6 stated R1 always uses her own personal thermos for water but staff always put the lid on it for her. V6 further stated, "I would not trust her to be able to take a cup/thermos of hot water and put the lid on by herself safely. I would be afraid she would burn herself." On 5/10/2023 at 12:22 PM, V27 (Therapy Director) stated R1 has decreased sensation on her right side and no fine motor skills to her right hand. R1 has received therapy to learn how to compensate with her right hand and can function fairly independently with her right arm and hand after her stroke years ago. V27 stated R1 would be able to drink hot water safely after she is set up but would require assistance to safely open and manipulate the screw top of the thermal cup. The facility incident report titled "Hot Liquid Burn" for the incident discovered 4/25/2023, documents	S9999		

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S9999	Continued From page 6 R1 reporting she was pulling the lid off of the coffee cup to put a tea bag inside when she lost balance of the cup and spilled some liquid. R1 was identified with redness and 2 quarter-sized blisters. R1's Care Plan for skin alterations dated 12/30/2016 documents R1 with a history of spilling hot water on herself with an intervention dated 6/24/2021 to not give her "boiling hot liquids." On 5/10/2023 at 9:50 AM, V30 (Dietary Manager) checked the temperature of the hot water dispensing from the coffee/hot water machine in the kitchen. The hot water temperature coming from the dispenser was at 170 degrees and steam could be seen rising from the cup of hot water after it was dispensed. On 5/11/2023 at 10:12 AM, V28 (Nurse Practitioner) stated R1 incurred 3rd degree burns to her right thigh and abdomen from a hot liquid spill. V28 stated he ordered Silvadene after the incident. V28 further stated he expects the facility to serve her hot water at a temperature safe enough for her to handle it. The website ameriburn.org, for the American Burn Association, documents a third-degree burn can occur in one second with liquids at 155 degrees. (A)	S9999		