STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. BUILDING ____ B. WING ____	C 10/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERNATIONAL VILLAGE	4815 SOUTH WESTERN AVE CHICAGO, IL 60609

(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) COMPLETION DATE
F 323	Continued From page 5	F 323		

The Maintenance Director will complete safety rounds every month on all beds (10) every day to ensure bed rails are securely tied down and beds are in good repair. Round findings will be recorded. The Administrator will audit these reports every week.

The nursing manage on each unit completed safety rounds on 8/29/07. The nursing manager will complete safety rounds 4 times each week to ensure bedrails are on residents that have been assessed as safe and are being used properly. Round findings will be recorded. The Director of Nursing will audit these reports every week. This will be monitored by the Administrator.

F9999 FINAL OBSERVATIONS — F9999

LICENSURE VIOLATIONS

300.1210b)6)

Section 300.1210 General Requirements for Nursing and Personal Care

b)6) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
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.

This Regulation was not met as evidenced by:

Based on closed record review, review of incident reports, and employee interviews, the facility failed to:

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1] Supervise, assess,and monitor one resident (R4) who had been diagnosed with seizure disorder, brain damage, brain surgery and ischemic encephalopathy. R4 was identified as being at high risks for falls due to being extremely agitated and wildly thrashing about.
2] Prevent R4 from getting his head/neck entrapped in the siderail. This entrapment led to R4s death from asphyxiation (suffocation) after staff found him hanging from the Siderail.
3] Reassess the continued need for siderails after implementation of a low air lost mattress for R4. The second incident with the siderails on 8/29/07 resulted in R4's death.

Findings include:

Based on closed record review, R4 was a 50 year old male with diagnoses including seizure disorder, brain damage brain surgery and ischemic encephalopathy.

Incident report of 8/20/07 states R4 was found laying halfway on floor top half of body still in the bed; siderails were up. R4's legs were on the floor. Nursing assessment of resident revealed no injuries.

Incident report of 8/29/07 states the resident was found at 1:30AM unresponsive. The resident was on a specialty low air mattress and was between the mattress and the siderail. R4 was unresponsive. Staff initiated cardiopulmonary rescitation and 911 was notified. The medical examiner's certificate of death, dated 10/4/07, lists cause of death as asphyxia as a consequence of being trapped in bed rail.

Nurses notes dated 8/20/07 at 9:15AM document

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F9999	Continued From page 7	F9999		

R4 was found on the floor halfway in bed (top part of body), and legs were on the floor, next to low bed. Siderails were up on both sides, no apparent injury.

Nurses notes dated 8/29/07 at 1:30AM state that when E25 certified nurses aide (CNA) entered the room, R4's legs were on floor. E25 called E7 (Licensed Practical Nurse, LPN) and both noted R4's head was lodged between the air mattress and the right siderail; the siderail was in the up position. E7 and E25 called for help and E22 (LPN) entered the room and proceeded to move R4's head and neck from between mattress and siderail.

R4's siderail assessment was done on admission 12/8/06, 1st reassment 1/12/07, 2nd reassment on 2/5/07 and third reassment 7/18/07. The 2nd and 3rd reassessments were blank for recommendations for siderails. No Medical Doctor's (MD) order for siderails was in current chart.

The current resident assessment, dated 6/12/07, under cognitive skills for daily decision making was marked 2 (moderately impaired). Under devices and restraints, b. Other types/ siderails used daily. On 7/30/07 the siderail assessment is incomplete, left entirely blank for siderails use.

Interview with E7 (LPN) on 9/28/07 at 3:25PM revealed E7 to state, "I walked into R4's room at about 1:00AM, his legs were laying over the mat. Observed siderails up, bed in low position, mats on floor. His neck was in the Siderail between the top of the rail. Then E22 got his neck out and started Cardio Pulmonary Resuscitation (CPR)."

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 8	F9999		

Interview with E22 (LPN) on 10/3/07 at 2:45PM, E22 stated, "When E25 called me I went into the room. R4 was in a sitting position on the mats with his head between the siderails and the air mattress face was toward the window of the room, his legs were also facing the window, he was unresponsive."

Interview with E25 (CNA) on 10/25/07 at 9:00AM, E25 stated, "I went to check R4. The nurse was with me. R4's head was lodged in the siderail. His body and legs were on the side. The nurse removed his head from the rail, we started CPR and the fire department came."

Interview with E1 (Administrator) on 9/20/07 at 11:00AM, E1 stated, "My Director of Nurses (DON) called me early in the morning as soon as staff notified her. She told me R4 was found between the mattress and the siderail. He was unresponsive, staff initiated CPR and notified 911."

Interview with E2 (DON) on 9/20/07 at 11:30AM, E2 stated, "Staff called me at home in early am stating that R4 was found in a sitting position with siderails up and his head on the siderails. R4 was not breathing. Staff started CPR and 911 was called; R4 expired.

(A)

Preparation and/or execution of this Plan of Correction in general, or any corrective action set forth herein, in particular, does not constitute an admission or agreement by International Village of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and specific actions are prepared and/or executed solely because of provisions of federal and/or state laws.

How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

Emergency services were immediately initiated for the resident and 911 notified. The incident was immediately investigated and reported to IDPH. The family and the physician were notified of the incident.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents with bed rails have been reassessed. All side rails have been removed off the beds for any resident identified with rails that were not medically necessary. Residents requiring side rail use because it is medically necessary for bed positioning have been identified. All residents identified have a physicians order for use and have been assessed by a licensed therapist to ensure side rails are medically necessary. All assessments have been documented in the clinical record. All care plans have been updated to reflect the residents current status.

1.Rounds were immediately completed and all facility beds were observed to ensure product compliance with State and Federal guidelines. Completed 8/29/07. This was completed by the maintenance director and monitored by the Administrator/and or designee.

2. All facility side rails that could be removed off the beds were immediately removed. Completed 8/29/07. This was completed by the maintenance director and monitored by the Administrator/and or designee.

3. All side rails that could not be removed were tied down. Completed 8/29/07. This was completed by the maintenance director and monitored by the Administrator and/or designee.

4. All staff were re-inserviced by Care Centers Clinical Risk Manager Stephanie Peterson RN regarding Entrapment risks including, side rails, ill fitting mattresses, broken bed parts, physical restraints, and assessment of residents requesting side rails. Completed 8/29/07. This was monitored by the Administrator and/or designee.

5. Residents requesting side rail use for mobility have been reassessed and documentation required was completed in the clinical record; including pre- restraint assessment, pre-restraint assessment, consent and care plans. Completed 10/24/07. This was completed by the Restorative Nurse and monitored by the Administrator and/or designee.

What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?

All resident requesting side rails will be assessed by a licensed therapist for safe use; the assessment will be documented in the clinical record. A physicians order will be obtained. Residents will be reassessed quarterly and with any change in condition. Completed 10/24/07 and ongoing. The Administrator and/or designee is monitoring this.

The facility is not currently using side rails as a restraint for any resident or for seizure precautions. All residents with side rails that have any alteration made to the bed or implementation of a new mattress will be reassessed for continued side rail use and safety. Any resident injury or fall will be investigated and assessed to ensure incident is not related to side rail use. This will be completed by the DON/designee.

The MDS nurse and the Restorative Nurse were inserviced 11/14/07 on correct coding of the MDS related to side rail use.

A Directed Inservice was completed by Linda Flaherty. The Inservice covered specialty mattresses and patient safety (see attached).

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

The Maintenance Director will complete safety rounds every month on all beds (10 every day) to ensure bed rails and beds are in good repair. Round findings will be recorded. The Administrator and/or designee will audit these reports every week.

The nursing manager on each unit will complete safety rounds 4 times each week to ensure bed rails are on residents that have been assessed as safe and are being used properly. Round findings will be recorded. The Administrator and/or designee will audit these reports every week.

A summary of round findings will be presented to the Q/A committee monthly until compliance is met.