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 |
|---|---|---|---|
| | IL6003008 | A. BUILDING _____ B. WING _____ | C 07/31/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **BERWYN REHABILITATION CENTER** | **3601 SOUTH HARLEM AVENUE BERWYN, IL 60402** |

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| Z9999 | FINDINGS<br><br>LICENSURE VIOLATIONS<br><br>300.1210a)<br>300.1210b)6)<br>300.1220b)2)<br>300.1220b)3)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>a) The facility must 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 assessment and plan of care. 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.<br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.<br>3) Developing an up-to-date resident care plan | Z9999 | | |

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| Z9999 | Continued From page 1<br><br>for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These Regulations were not met as evidenced by:<br><br>Based on interviews and record reviews, the facility failed to provide one resident (R2), in a sample of four closed records, with adequate supervision and appropriate nursing interventions to ensure:<br>1. The resident's environment was free of possible accident/hazards from the use of bed side rails.<br>2. The facility's nursing staff communicate observations of one resident's unsafe behaviors (banging on the side rails and trying to get out of bed while the side rails were up), and providing appropriate interventions to address these behaviors.<br>2. An assessment was done to evaluate the continued need for side rails after implementation of a low air loss mattress for R2.<br>3. The safety of R2 was maintained by not | Z9999 | | |

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| Z9999 | Continued From page 2 | Z9999 | | |

allowing outside vendors to change the resident's side rails without notifying staff.
4. The nursing staff followed the facility's restraint policy and procedure.

These failures resulted in R2 becoming unresponsive after being entrapped between the mattress and side rails. R2 was transferred to the Emergency Room (ER) and was pronounced dead.

Findings include:

The facility's Final Investigation Report dated 7/11/08 stated that the resident (R2) "was a 53 year old male with diagnosis of seizures, 75% body burns, chronic renal failure, gall stones, chronic insomnia, history of respiratory failure, anoxic brain damage, morbid obesity and past history of cardiac arrest... On 7/06/08 the resident was found unresponsive, ...(emergency services) was immediately started and 911 was called. R2 was transferred to ...Emergency Room where it was learned he had expired."

The narrative of the fire department's paramedic report of 07/06/08 documents the following: "Called to local nursing home for male unresponsive (R2). Upon our arrival staff ...states ...walked into (R2's) room to find patient (R2) in between hand rails and the bed without a pulse. Currently, Patient (R2) has no pulse. No respirations. Asystole on the monitor. Patient's (R2's) arms still warm. Pale throughout trunk and extremities...."

Review of R2's death certificate, provided by R2's family member on 7/30/08, documented the immediate cause of R2's death as "Asphyxia." "Entrapment" was documented as the condition

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| Z9999 | Continued From page 3<br>leading to the cause of R2's asphyxia.<br><br>Review of R2's physician order sheet (POS) was observed to contain documentation that R2's primary physician ordered 1/4 side rails length as an enabler.<br><br>Review of the facility's final Report of the incident dated 7/11/08 was observed to document that R2 was place in a bed with full length side rails. The following was documented: The (R2's) bed was serviced on Saturday July 5th, 2008 due to a side rail being broken. Initially the ... (repairman from an outside vendor) was not able to repair R2's side rails, stating he (the repairman) would return. The facility learned (after the incident) that the original one-quarter rails were replaced with full side rails.<br><br>Review of R2's nursing notes documented that R2 had behaviors of sudden loud outburst, banging on the bed side rails with his fist, being agitated, restless, confused and demanding.<br><br>Review of R2's clinical record contained only a Pre-Restraining Assessment dated 6/06/08. R2's Pre-Restraining Assessment contained documentation of facility's staff evaluating R2 for the use of 1/4 side rails for bed mobility. This assessment documented that R2 leans sideways while sitting. However, there was no documentation in R2's Pre-Restraining Assessment or clinical record that staff had reassessed R2 for the use of side rails as a restraint or for the use of full length side rails, which were in use during the incident. Also review of R2's Pre-Restraining Assessments did not contain any reassessment or interventions to address the safety issues of R2 banging on side rails and attempting to get out of bed while the | Z9999 | | |

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| Z9999 | Continued From page 4<br><br>side rails were up. Per staff interviews, R2 was seen trying to get out of bed while side rails were up.<br><br>Review of R2's plan of care identified that R2 was at risk for accident or injury related to potential for falls. R2's care plan did not address R2's use of side rails to prevent falling. R2's plan of care also lacked interventions to address R2's unsafe behaviors (such as: physical restlessness, attempting to exit his bed unassisted around the side rails and banging on the side rails) while side rails were being used.<br><br>Review of the facility's Physical Restraint Policy documents the following instructions for staff: Standards: ...4. Restraint assessments are performed at a minimum with the initial application, change in type of restraint and change in the resident's condition which affects how the resident responds to current treatment."<br><br>The facility displayed no evidence of staff following this policy. The staff reported using side rails as a safety device to prevent R2 from falling and getting out of bed. The facility had no evidence in R2's clinical record of reassessing R2's side rails as a device to prevent R2 from falling. The facility did not have evidence in R2's clinical record of doing a reassessment of the side rails after staff observed R2 displaying unsafe behaviors, while side rails were being used. The facility staff put R2 in a different bed with a inflatable mattress and full length side rails. The facility had no evidence in R2's clinical record of assessing if it was appropriate to put an agitated R2 in this new bed, with full length side rails and an inflatable mattress.<br><br>E11 (CNA-Certified Nurses Aide) who found R2 | Z9999 | | |

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| Z9999 | Continued From page 5<br><br>unresponsive on 7/06/08, was interviewed by phone on 7/10/08 at 3:06 PM. E11 stated, "Yes, R2 was trapped between the mattress and the side rails. I saw his left arm and head were out at the end at the top of the the bed. The railing was up. His arm was over the rails... He (R2) was lying on his left side. I called out his name and tried to lift him up and he was too heavy. He was like dead weight. I called the respiratory therapist, who was across the hall. He came in and tried to lift him. Once the respiratory therapist let the air out of the mattress, he (R2) fell back into the bed." E11 said R2 was agitated on 7/06/08, banging on the side rails and complaining of being cold.<br><br>The respiratory therapist that E11 called on 7/06/08 was E12. E12 was interviewed on 7/11/08 at 5:30 PM. E12 described observing R2's neck being wedged between the rails on 7/06/08. E12 stated, "I freed him (R2), so I know he (R2) was wedged between the mattress and side rails. E12 stated, "I was working. I was doing my rounds. An aide (E11) came calling for help. He (R2) was stuck in the side rails. He (R2) was between the mattress and bars. The mattress gets firm and soft. I think he (R2) fell between the mattress and rails. As I came into the room, I saw the aide trying to get him out from between the mattress and the rails... I've seen residents trapped like this before, ...So, I knew what to do. I immediately deflated the mattress. I checked the carotid pulse. He (R2) wasn't breathing. He (R2) was not looking good. He (R2) was cyanotic (blue in skin color). I told the aide to go call code blue... He (R2) had the full rails from top to bottom. ...The rails were going from head to toe. His (R2's) neck was wedged at the rails big times. I can't say his air way was cut off, but he (R2) was wedged pretty good across his neck." | Z9999 | | |

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| Z9999 | Continued From page 6<br><br>E10 (The nurse who was responsible for R2's care on 7/06/08) was interviewed on 7/10/08 at 1:40 PM in the administrator's office. E10 stated, "The last time I saw him (R2) alive was around 4:30 AM, when I gave him (R2) his medications.... (Later on 7/06/08 at 6:40 AM) I heard a distressed sounding voice. E11 came and got me. She (E11) said R2 did not look good.... When we were walking back to the room, E11 said she (E11) thought he (R2) had got caught in the rail. She (E11) said she went into the room and found him (R2) in between the rails...."<br><br>A Cook County Medical Examiner (Z3) was interviewed by phone on 7/25/08 at 2:29 PM. Z3 stated that an autopsy was done after the police department received reports from the facility's staff that R2 was discovered trapped between the rails and mattress (on 7/06/08). Reading from the report of R2's death, Z3 stated that the cause of R2's death was from asphyxia due to entrapment.<br><br>During the survey, several staff members reported that R2 had side rails to prevent him from getting out of bed. Staff also reported observing R2 being restless and making attempts to get out of bed in an unsafe manner, while the side rails were up.<br><br>The following interviews were given: On 7/10/08 at 1:40 PM, E10 said, "The time I saw him (R2) try to get out of bed, he (R2) lowered his body thru the side rails. Yeah, they were up. I was in a room across the hall. I saw him (R2) on the floor he (R2) was wet. He (R2) was deaf on coming to you if you did not come to him. He (R2) picked his moments. It did not happen often. He (R2) | Z9999 | | |

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| Z9999 | Continued From page 7 | Z9999 | | |

knew he would be heavy to pick up. He (R2) was a big man. ...One day I came into the room and he was trying to get out of bed. I and some other girls had to use the sheets to get him back in bed. ...(R2) He was very needy. If I could I would put him (R2) on one to one." E10 indicated R2 was also restless when he was wet, cold, or in pain.

E4 (nurse) was interviewed on 7/10/08 at 3:45 PM. E4 stated, "R2's side rails were for bed mobility and safety. He could fall out (of bed)."

A CNA was interviewed on 7/10 at 3:55 PM in the dayroom of the second floor. This CNA stated, "He (R2) was confused sometimes ...We put it (side rails) up all the time. ...One time I came in the room and he got his one leg out of the bed and almost fell. ...He was trying to get out of bed and he could not walk."

Z4 (R2's primary physician) was interviewed by phone on 7/10/08 at 2:25 PM. Z4 reported that R2 had side rails because of agitation and a high risk of falling out of bed.

Per interview on 7/06/08 at 3:06 PM, E11 stated, "He (R2) likes to keep his light (call light) on. He would be up all night ringing the bell. He did not talk. You had to ask questions and he would shake his head. ...He was always agitated. I don't know if he wanted attention. He was always wet."

During the survey, a police investigation into the death of R2 was conducted. On 7/31/08 at 9:40 AM a representative from the police department (Z7) was interviewed by phone. Z7 said facility staff reported to the police officer during interviews that R2 was observed entrapped

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| Z9999 | Continued From page 8<br>between the mattress and bed rails on 7/06/08.<br><br>During the Daily Status interview with the administrative staff: E1(Administrator), E2 (Assistant Administrator), E3 (Director of Nursing) and E13 (Risk Manager) on 7/09/08, 7/10/08 and 7/11/08, surveyor asked why R2 was not in a bed with 1/4 side rails. E13 stated that R2's beds rails were found to be broken just before the incident. E13 stated that a company was called to repair the bed. E12 said that the vendor's repairman could not repair the side rails, but replaced the bed. E13 stated that the replacement bed had full length side rail instead of the ordered 1/4 length rails. E13 said that the repairman never told facility staff about the change in the length of the side rails. Surveyor asked why the staff did not notify R2 was in a different bed with full length side rails. None of the administrative staff present gave any evidence of the full length side rails being assessed and addressed in the care of R2. Surveyor also expressed concerns to administrative staff that R2 had a history of attempting to get out of bed, around the side rails. The administrative staff stated this information was not shared with all of the treatment team members. However, the administrative staff did not provide any evidence of R2's behavior being addressed with supervision or nursing interventions.<br><br>(A) | Z9999 | | |