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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145681	A. BUILDING ______ B. WING ______	C 06/26/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN CENTRAL	13259 SOUTH CENTRAL AVENUE PALOS HEIGHTS, IL 60463

(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 7 in-services are held at the facility education institute bi-annually. The January 31, 2008 session included management of sun-downing behaviors. On-going staff meeting with both CNA's and licensed staff continue monthly. 7. The DON/DCNA will audits 10 charts monthly for six months to determine compliance with timely completion of fall risk assessments, side rail assessments and appropriateness of interventions. After six months the audits will be quarterly for an additional six months. Results of the audits will be reported quarterly to the administrator and summarized at the quarterly QI/QA meeting.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care 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. b) General nursing care shall include at a minimum the following and shall be practiced on	F9999		

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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 REGULATIONS are not met as evidenced by:

Based on closed record review, review of incident reports, and employee interviews, the facility failed to supervise, assess, and monitor one resident (R6) in the sample of 10 who had been diagnosed with Syncope, Severe Dementia with Behavior Disorder, Mental Status Changes, Hypertension, and Convulsions with Agitated Behavior.

R6 was identified as being at high risks for falls due to being extremely agitated and night agitation (sun downing). The facility failed to prevent R6 from getting her head entrapped in the side rail. This entrapment led to R6's death, with the cause of death being Compressional Asphyxia trapping between bed rail after staff found her sitting on the floor.

The facility failed to re-assess the continued need for side rails after implementation of a low bed, bed alarm, and mattress pad on the floor for R6.

Findings include:

Based on closed record review, R6 was a 99 year old female whose diagnoses including Syncope, Severe Dementia with Behavior

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Disorder, Mental Status Changes, Hypertension, Convulsions with Agitated Behavior, Renal Insufficiency, Skin Cancer, and Cataract. R6 was totally dependent on the staff for Activity of Daily Living. R6 was confused.

Review of the nurses notes dated 01/11/08 at 7:00 pm stated, "Patient slid down to the floor from her wheelchair and caught by a visitor in the dinning room. No injury noted after the fall. Patient was taken to her room to bed. Shortness of Breath noted and oxygen 2L (liter) started.

Nurses notes dated 01/27/08 at 6:00 am documented R6 at the beginning of my shift, I did my round at 2315 and R6 was in bed sleeping; bed in low position, bed alarm on and mat on the floor. Call button within reach. patient was sleeping comfortably. Safety precaution maintained. The Certified Nurse Aide (E3 - CNA) did her 1st round at 2305 and patient was sleeping. At 0030 am, the CNA was doing her 2nd round and found resident sitting on the floor with her left side of the neck in between the bed and rail. Side rail was taken down and patient was put in bed and Cardiac Pulmonary Resuscitate (CPR) started immediately, and 911 was called. When patient was found on the floor, her alarm (bed) was still attached to her and bed alarm did not go off.

Further review of the Nurses Notes dated 01/27/08 state a nurse from Z2 contacted the facility stating that the patient had expired.

Review of the incident report of 01/11/08 found their was no documentation of this fall.

Incident report of 01/27/08 at 08:16 am stated,

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"At the beginning of my shift, I did my rounds at 2315 and patient was in bed sleeping, bed in low position with mat on the floor and bed alarm on. Call button within reach. At 2305 the CNA did her 1st round and patient was in bed sleeping comfortably. The CNA (E3) did her 2nd round at 0030 and found sitting on the floor by the side of her bed with her left side of the neck in between the bed and side rail. The rail was taken down and patient put on the bed and CPR started immediately. 911 was called immediately. Preventive measures at the time of fall: Alarm - Not sounding, Call light -Off and Bed -regular bed -low position. Bed Rail - Left Head Rail - Up and Right Head Rail - Up."

Review of the Medical Examiner report dated 01/27/08 at 9:00 am stated, "External Evidence Of Injury: On the left side of the neck, in the supraclavicular region, there is a blue bruise, 3.0 X 1.5 inches in it greatest dimension. This is accompanied by corresponding subcutaneous hemorrhage. Evidence of Internal Injury:

(1) There is a fracture of the tip of the hyoid bone on the left side. This is accompanied by hemorrhage in the surrounding soft tissues.

(2) Subcutaneous hemorrhage on the left side of the neck corresponding to the bruise noted externally.

(3) Hemorrhage in the mucosa of the posterior pharyngeal wall, on the right side.

Opinion: In consideration of the circumstance surrounding her death, the available history scene investigation, and autopsy findings, the death of this 99 year old white female R6, is attributed to Compressional Asphyxia due to trapping between bed rail and mattress.

During daily status meeting on 06/19/08 at 4:00

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pm in the family dining room, E1 stated, "R6's bed alarm did not go off. R6 had two upper head rails. They were pulled up. She also has a low bed and mattress pad on the floor. I don't know how she climbed out of bed. Her head was propped up on the side rail with chin in the rail. Her body was sitting on the floor. She was not breathing. CPR was started and 911 was called. This happened on 01/27/08 at 0030 (12:30 am)."

According to interview with E3 on 06/23/08 at 11:40 am per telephone, E3 stated, "I saw R6 at 11:00 pm, she was in bed. She had bed alarm, bed low to floor, two upper side rail up and floor pad. The side rail were pulled up. They are the upper rails where the head goes. I made round about 12:15 am to 12:30 am. She was on the floor. Her chin was between the side rail. Her head was on the side rails. She was in a sitting position on the floor. She was not breathing. The bed alarm did not go off. The side rails were up when I found her. Bed was low and pad on the floor. She was not ambulatory. When she tried to get out bed. The staff would bring her out to the dining area."

Surveyor asked E3 how often did R6 try to get out of bed. E3 stated,'' She would often try to get out of bed during the night."

E4 (Nurse) was called multiple times (06/23/08 and 06/26/08). The telephone numbers were disconnected.

Review of the Minimum Data Set (MDS) Quarterly 01/14/08 and 01/28/08 stated, "Section B4 - Cognitive Skills For Daily Decision-Making 2 (Moderately impaired - decision poor; cues/supervision required)."

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F9999	Continued From page 12 Further review of the MDS on the above dates states G1 - (a). Bed Mobility - 3/2 (Score 3- Extensive Assistance- while resident performing part of activity, over last 7 - day period, help of following types provided 3 or more times: Weight-bearing support and Full staff performance during (but not all) of last 7 days and Score 2 - One person physical assist). G1 - Section b - Transfer 3/2. G1 - Section c- Walk in room and Section d - Walk in corridor - Score 8/8 (Activity did not occur during entire 7 days and ADL activity itself did not occur during entire 7 days.) G1. Section e - Locomotion on Unit and Section f - Locomotion off Unit - Score 4/2 (Total Dependence - Full staff performance of activity during entire 7 days and One person physical assist). Further review of the medical record confirmed there was no assessment for the side rail. Also there was no assessment for a less restrictive device. (A)	F9999		