

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2012
NAME OF PROVIDER OR SUPPLIER FAIR HAVENS CHRISTIAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1790 SOUTH FAIRVIEW AVENUE DECATUR, IL 62521		
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F 323	Continued From page 14 3. Operating policy related to the use of side rails was revised to reflect "...individual factors that place resident at increased risk for potential entrapment will be evaluated and considered when determining utilization of side/assist rails or bed accessories...evaluation of entrapment zones will be evaluated to determine dimensions between the side/assist rails or bed accessory does not place the resident at increased risk of potential entrapment. The evaluation will be conducted prior to utilization of the side/assist rails or bed accessories and periodically thereafter...Manufacturer recommendations will be reviewed and incorporated into the plan of care as clinically indicated..." Completed on 9-27-12 by E1, Z2 and Z5. 4. Education was provided related to identification of unusual occurrences, incident reporting and investigation, notification of changes, bed safety and entrapment risks. Nurses who are responsible for completing Side Rail assessments and determining potential entrapment risks have been educated. Completed 9-27-12 by Assistant Director of Nursing and Regional Clinical Nurse.	F 323			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.690a)b)c) 300.1210d)6) 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a	F9999			

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F9999	Continued From page 15 resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to identify, through an ongoing comprehensive assessment, a side rail	F9999			

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F9999	<p>Continued From page 16</p> <p>entrapment hazard for R2, one of five residents reviewed for side rail use in the sample of five. This failure resulted in an immediate jeopardy situation when R2's head was found to be entrapped between the side rail and mattress.</p> <p>The facility failed to recognize this incident as a fall, failed to thoroughly investigate and document details of the incident, and failed to examine and document a root cause analysis of the entrapment.</p> <p>While the immediacy was removed on 9-27-12 the facility remained out of compliance at a Severity Level 2. The facility is in the process of monitoring the effectiveness of new policy implementation and re-education efforts directed at staff so as to identify and address potential entrapment hazards.</p> <p>Findings include:</p> <p>On 9-21-12 at 9:20 a.m. E1, Administrator stated that he was informed of R2's death on the evening of 9-13-12 by a telephone call he received from E2, Director of Nursing. E1 stated he was notified by E2 that R2's "legs had slid off of the bed" and that R2 "had not been caught in" or otherwise impacted by a side rail.</p> <p>On 9-21-12 at 9:30 a.m. E2 stated she received a call from Licensed Practical Nurse (LPN), E3 on 9-13-12 at 8:35 p.m. which indicated that R2's legs and buttocks had slipped off the bed, and that when she was discovered she was unresponsive and had no vital signs.</p> <p>A written statement completed on 9-21-12 by E2</p>	F9999			

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F9999	<p>Continued From page 17</p> <p>confirms this information. E2's document states that E3 reported to her that R2's "...legs and buttocks were on the floor and that her upper body was still on the bed...that top of head was near lower end of grab bar...(R2) was lying partially on her right side on the bed with her face away from the rail-on the mattress of bed and that her entire head, shoulders and neck were below the grab bar...her legs were on the floor and buttocks was close to the floor..." The report continues that two CNA's (Certified Nurse Aides) placed R2 "...back into bed" and that R2 "...was unresponsive and had no palpable VS (vital signs)."</p> <p>On 9-21-12 at 9:30 a.m. E1 and E2 stated that an incident report related to R2's event was not completed. E2 stated that this event was not considered to be an "incident" and that E2 "didn't see any relationship to her death and the side rail." E1 and E2 stated that this event was not reported to the State Survey and Certification Agency (Illinois Department of Public Health). E2 stated that there "was no sign of strangulation, but my impression was that she died in bed, her legs relaxed, she then fell out of bed."</p> <p>E3, LPN stated on 9-21-12 at 12:40 p.m. that she was a first responder to R2's event on 9-13-12 along with CNA, E6. E3 stated that upon entering the room R2's "body (legs and bottom) was on the floor, her head was stuck between the bed rail and mattress, the rail was pressed against her right ear, her face was into the mattress, her back was toward me (as I entered) from behind the curtain, she was in a squatted position...I couldn't believe what I was seeing." E3 stated that R2's head was positioned "right where the bed</p>	F9999			

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F9999	<p>Continued From page 18</p> <p>folds...the head of the bed was elevated approximately 30 degrees...and when she was on the floor she was sitting erect...the air mattress was squishy, it wasn't tight against her head." E3 stated she immediately assessed R2. E3 stated that R2's "nose was laying to the side, her face was smashed...when she was lying down her nose was lying toward her right cheek..." E3 stated there were no marks on her face and her eyes showed no petechiae. E3 stated R2 was not breathing, there was no pulse, and no blood pressure. E3 stated that she immediately phoned her Supervisor, E2, Director of Nursing and notified her of these details.</p> <p>E3 continued that E2 soon arrived at the facility at which time E2 examined R2. E3 stated that she was concerned about R2 strangling or suffocating. E3 stated that E2 assured her that there were no signs or symptoms of this. E3 stated that she did not document any nurse's notes and no incident report related to what she had witnessed related to R2. E3 stated that E2 indicated to her that she (E2) "would take care of it." E3 stated that she was advised by E2 to contact the Coroner, Physician, and family and notify them that R2 had "passed away". E3 stated that she was told by E2 to "be vague" and not to offer any details. E3 stated that she "just did what my Supervisor told me to do."</p> <p>On 9-21-12 at 3:00 p.m. E6, CNA stated she was a first responder to R2's incident the evening of 9-13-12 along with E2. E6 stated she "saw (R2's) feet on the floor under the curtain" when she walked by her room. E6 stated she immediately notified E2 who was present at the nurse's station. E6 stated they both entered R2's room</p>	F9999			

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F9999	<p>Continued From page 19</p> <p>where E6 described R2 as "slouched, feet on the floor, neck on the bed rail, against it...the right side of her head was against the rail, she was facing the bed, with her face against the bed...she was not breathing." E6 stated she and E2 then "placed her (R2) slowly on the floor flat on her back, her mouth was open...there were no marks on her face or head..."</p> <p>E1, Administrator stated on 9-25-12 at 9:15 a.m. that he had not been notified of the details of the event involving R2 on 9-13-12. E1 confirmed at this time that there had been no incident report completed, no nursing assessment documented, and no documentation related to an investigation or documented root cause analysis completed. E1 stated that it "was a poor decision by (E2)...that it should have been viewed as a fall." E1 stated that "there should have been an incident report completed and medical assessment documented."</p> <p>According to R2's September 2012 Physician Order Sheet, 7-4-12 Minimum Data Set, and 7-12-12 Care Plan, she had relevant diagnoses including Weakness and Decreased Range of Motion to Left Shoulder and Bilateral Hips secondary to Cerebrovascular Accident with Left Hemiplegia, Dementia with Behavioral Disturbance, Generalized Pain, Anxiety State, Depressive Disorder, and Adult Failure to Thrive. The most recent Minimum Data Set dated 7-4-12 assesses her as being cognitively intact and being totally dependent on one person for bed mobility and two persons for transfers. R2 is assessed as having range of motion impairments for both upper and lower extremities. R2 is assessed as being 66 inches in height and 153</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>pounds. She was admitted to hospice care on 6-20-12. R2 is assessed as using no physical restraints.</p> <p>Z1, Hospice Case Manager for R2 stated on 9-21-12 that R2 was admitted to hospice on 6-20-12 and utilized a low air flow mattress supplied by the hospice provider</p> <p>R2's most recent Side Rail Assessment dated 4-4-11 reflects that she was assessed for the use of Assist Rails to the left and right sides of her bed to "serve as an enabler to promote independence" and that "the resident has requested to have side rails while in bed." The assessment indicates that R2 had the assist rails in place since 7-9-10. E1 stated on 9-21-12 at 4 p.m. that this was the most recent side rail assessment for R2.</p> <p>R2's Care Plan dated 7-12-12 reflects that R2 is at risk for falls related to decreased physical mobility, weakness and decreased range of motion to left shoulder and bilateral hips secondary to Cerebrovascular Accident with left hemiplegia, dementia, and generalized pain. Her care plan addresses R2's anxiety, verbal and physical aggression, chronic pain, and hospice admission. An intervention includes to assist with turning and repositioning in bed and chair. R2's Care Plan fails to address the use of side rails and the use of a low air loss mattress and potential associated entrapment hazards.</p> <p>A Fall report dated 8-3-12 documents that R2 sustained a fall from her bed. The investigation conclusion states "interdisciplinary team review for this incident and determine resident was</p>	F9999			

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F9999	<p>Continued From page 21</p> <p>reaching for something on her bedside table, was in bed at the time leaning too far table not in reach and rolled out of bed..." The report indicates R2 sustained no injuries. The documented Plan of Action documents "make sure bedside table is within reach with personal items within reach." The fall report and investigation does not address R2's side rail use in conjunction with a low air loss mattress and potential safety/entrapment issues.</p> <p>E4, CNA stated on 9-21-12 at 12:15 p.m. that R2 "could move around in bed pretty good...she could roll left and right...she needed help getting centered in bed...she would get to the edge of the bed a lot...sometimes her shoulder would be against the side rail...we had to put her legs up on the bed a lot...we would report this to the nurse..."</p> <p>E9, CNA stated on 9-21-12 at 3:30 p.m. that R2 "used to move around in bed...that night (9-13-12) she was propped on her side with a pillow...she could have been a little more centered...she was really impatient..."</p> <p>E5, CNA stated on 9-25-12 at 11:25 a.m. that R2 had the ability to move herself to the edge of the bed but preferred to stay in bed.</p> <p>E7, LPN stated on 9-21-12 at 10 a.m. that R2 "could throw her legs out of bed if she wanted to..." E8, LPN stated at this time that R2 "could move to the edge of the bed if she wanted to..."</p> <p>E11, LPN stated on 9-26-12 at 10:30 a.m. that R2 had "...some ability to use her grab bars to hold on...she was very particular on her care and would use the call light to direct her care...on</p>	F9999			

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F9999	<p>Continued From page 22</p> <p>occasion would get her feet and lower legs over the edge of the bed indicating she wanted to get up and we'd get her up...she did have increasing confusion and bursts of energy indicating she wanted up or repositioned..."</p> <p>Examination of R2's bed on 9-25-12 at 2 p.m. with E1, Z2 Corporate Director of Quality and Compliance, and Z5 Corporate Administrator reflected that the bed was equipped with bilateral assist bars measuring approximately 12 inches wide by approximately 16 inches in height. R2's bed was equipped with a mechanically operated inflatable air mattress 8-10 inches thick when inflated. The assist bar placement was immediately adjacent to the segment of the mattress and bed frame that articulates the head of bed. A 4 to 5 inch gap exists between the assist rail and the compressed edge of the mattress when weight or pressure is applied to the air mattress surface. The gap widens when the head of the bed is elevated creating an entrapment hazard.</p> <p>The manufacturer's User-Service Manual for the Assist Handle that was used on R2's bed specifies "Important Precautions" and documents multiple warning statements including "Warning: Risk of Serious Injury or Death...Use a properly sized mattress in order to minimize the gap between the side of the mattress and the assist device. This gap must be small enough to prevent a resident from getting his/her head or neck caught in this location. Make sure that raising or lowering the bed, or articulating the sleep surface does not create hazardous gaps. Failure to do so could result in serious injury or death."</p>	F9999			

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F9999	Continued From page 23 This manual also states "Warning: An optimal bed system assessment should be conducted on each resident by a qualified clinician or medical provider to ensure maximum safety of the resident. The assessment should be conducted within the context of, and in compliance with, the state and federal guidelines related to the use of restraints and bed system entrapment guidance, including the Clinical Guidance for the Assessment and Implementation of Side Rails published by the Hospital Bed Safety Workgroup of the U.S. Food and Drug Administration..." The manual continues and states "Note: The assist device is intended for use as an aid in entering or exiting the bed sleep area, as well as a stable handhold during self positioning within the bed sleep area." Facility policy titled "Proper Use of Side Rails" dated 12-20-11 states "...Upon admission, quarterly and with a significant change in condition, an assessment will be completed to determine the resident's symptoms or reason for utilizing side rails...the use of side rails as an assistive device will be addressed in the resident care plan...when side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk of entrapment..." Z2 stated on 9-26-12 at 1 p.m. "...our current side rail assessment clearly does not address potential entrapment hazards. Anything attached laterally to the side of the bed can be potentially hazardous and should be evaluated...the current process here involves maintenance services	F9999			

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F9999	Continued From page 24 evaluating the beds and rails...there needs to be a better clinical correlation on an individualized basis..." Z2 confirmed at this time that there was no other, more current assessment for R2's side rail use other than the April 2011 assessment. A	F9999		