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	146035	A. BUILDING _____ B. WING _____	C 09/19/2016

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NORTH ADAMS HOME	**2259 EAST 1100TH STREET MENDON, IL 62351**

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 8/28/16/IL88218 A partial extended survey was conducted.	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide education regarding the potential risks of side rails for 37 of 39 residents (R1 through R6 and R9 through R39) reviewed for side rails in the sample of 39. Findings include: On 9/7/16, E2 (Director of Nursing) provided a list of residents that are using side rails. This list documents R1 through R6 and R9 through R39 as using side rails. The facility side rail consent form summarizes the potential negative outcomes for the use of side rails. The Facility's Side Rail Consent Form documents the Potential Negative Outcomes as,	F 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 154	Continued From page 1 "The use of side rails(s) may involve risks such as: getting caught in the rails, getting caught, between the rail and mattress, strangulation, hitting against the rail(s), causing skin tears and/or bruising and crawling over the top of a side rail risking a fall from a higher level with risk for greater injury or death." On 9/7/16 at 9:00 AM, E2 stated the facility did not obtain side rail consents until 9/2/16. E2 stated the facility did not begin to educate resident or family members regarding side rail risk until 9/2/16. E2 stated the education regarding the safety risk of side rails is included on the side rail consent form. E2 confirmed the residents without the side rail consents prior to 9/2/16 as R2 through R6 and R9 through R39. E2 stated R1 did not sign a side rail consent or receive education related to the safety risks of side rails. R1 expired on 08/28/16. E2 confirmed that R2 through R6 and R9 through R39 were admitted to the facility prior to 9/2/16. On 9/10/16 at 10:30 AM, E1 (Administrator) stated the facility did not educate the residents or family members about the risk of side rails until 9/2/16.	F 154		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		

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F 224	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility neglected to follow facility policies on care planning newly admitted residents, turning and positioning, side rail assessment, and restraints for one of one residents (R1) reviewed for restraints in the sample of 39. These multiple failures resulted in R1 being left unattended for over 4 hours and found expired from strangulation while hanging over the side of the bed with the hospital gown around R1's throat and hooked to the side rail. These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 9/19/16, the facility remains out of compliance at a severity Level Two. Additional time is needed for the facility to continue to monitor the effectiveness of training regarding care plans for newly admitted resident, timely turning and positioning, accurate completion of the side rail assessment, and appropriate placement of side rails. Findings include: R1's History and Physical dated 8/24/16 documents R1 diagnoses as Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with a Right Cerebral Artery Area Involvement, Poor Left Ventricular Ejection Fraction, Chronic Coumadin treatment, Pressure Ulcers and Ventricular Tachycardia. R1's History and Physical dated 8/24/16 documents, "R1 is very weak. R1 continues to be short of breath. R1 is 70 inches tall and weighs 225.54 pounds. R1 is alert and oriented.	F 224		

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F 224	Continued From page 3 R1's range of motion to right shoulder is restricted due to Right shoulder rotator cuff injury and left shoulder is normal." R1's physician orders documents an order dated 8/25/16 for half side rails for mobility. The facility's Side Rail Policy dated 5/16/14 documents, "...2. Maintenance will be contacted to apply appropriate side rails to the resident's bed...) On 9/6/16 at 9:51 AM, E16 Licensed Practical Nurse stated on 8/24/16 R1 was admitted to the facility. E16 stated E16 helped complete R1's admission paperwork. E16 stated E16 met with R1 and discussed care needs. E16 stated E16 completed the side rail assessment. E16 verified that during the assessment R1 was not in bed but was sitting up in a recliner. E16 stated E16 asked R1 if R1 wanted siderails and R1 stated yes. E16 stated R1 wanted the side rails to help R1 move in bed because of weakness. E16 stated E16 did not assess the actual side rail for safety or the resident's bed mobility. E16 stated the facility, "just always uses half rails." E16 stated E16 did not see the actual side rail. On 9/7/16 at 9:00 AM, E2 (Director of Nursing) stated the side rail assessment should be completed when a resident is admitted to the facility. E2 stated the side rail assessment should be completed while the resident is laying in bed. E2 also stated that if a resident has orders for side rails the side rail are used at all times even if a resident is incapable of using side rails independently. On 8/31/16 at 11:40 AM, E6 (Maintenance Supervisor) stated E6 was not contacted about R1's side rails. E6 stated that R1's side rails	F 224		

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were already attached to the bed.

On 9/1/16 at 10:25 AM, E1 (Administrator) stated the facility did not have a system in place to routinely audit the side rails. E1 stated side rails like R1's were removed (after the incident with R1) because the top bar of the side rails had an overhang.

The facility's Restraint Policy dated 7/8/2009 documents, "Educate family, resident, (power of attorney), etc. to the use, side effects, etc and obtain informed consent. R1's medical record contained no documentation of informed consent for side rail use.

On 9/7/16 at 9:00 AM, E2 stated the facility side rail consent form summarizes the potential negative outcomes for the use of side rails and that the facility did not obtain side rail consents or educate residents/families until 9/2/16.

The Facility's Care Plan Policy dated 5/7/13 documents, "...1. Upon admission an initial basic care plan will be developed based upon the residents diagnosis, needs etc."

On 8/31/16 at 2:18 PM, E9 Licensed Practical Nurse stated R1 would use the call light, R1 was incontinent of urine at times, it took two staff members to provide incontinence cares. R1 would try to use the side rail to help turn self. On 9/1/16 at 9:00 AM, E9 stated R1 would slide down in bed at times and would have to be scooted back up in bed. E9 stated R1 preferred the head of the bed to be elevated at least 75 degrees. R1 preferred R1's call light to be attached to the left side of the bed along with bed side table.
R1's New Admission Care Plan dated 8/25/16 did

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not document R1's inability to use the side rails independently for mobility, did not document R1's request for the call light to be placed on the left side of the bed, and did not document that R1 slides down in bed.

The Facility's Turning and Repositioning Policy dated 6/4/12 documents, "Changing a patient's position in bed every 2 hours helps keep blood flowing."
R1's Resident CNA (Certified Nurse's Assistant) Documentation Record dated 8/28/16 for the 2 PM to 10 PM shift documents that R1 requires assistance for bed mobility, transfer, needs assessed for safety, and needs turned and positioned every two hours. This same record contains no documentation that R1 was toileted, assisted with bed mobility, transferred, assessed for safety, or turned and positioned on 08/28/16.

On 9/7/16 at 9:00 AM, E2 stated E2 would expect R1 to be checked on at least every two hours. E2 stated R1 should have been turned and positioned at least every two hours.

On 9/6/16 at 12:00 PM, E17 Certified Nurse's Assistant stated E17 was assigned with E9 Licensed Practical Nurse on 8/28/16 to the south side of the facility in which R1 resided. E17 stated E17 helped E11 Licensed Practical Nurse position R1 in bed on 8/28/16 at 4:00 PM. E17 stated R1 would try to use the side rail but could not pull self over in bed. E17 stated R1 was total assistance with bed mobility. E17 stated R1 could not use the side rail by R1's self. E17 stated after helping R1 at 4:00 PM, E17 went down to another hallway and did not see R1 for the rest of the shift.

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F 224	Continued From page 6 On 9/1/16 at 9:50 AM, E11 Licensed Practical Nurse stated E11 worked with R1 a couple of times. E11 stated R1 preferred to have the head of the bed up 75 to 80 degrees. E11 stated R1 would wiggle some in bed. E11 stated E11 took R1 a supper tray at 5:30 PM. E11 stated R1 was sitting up in bed and E11 placed R1's supper tray on the bed side table and placed the bedside table in front of R1. R1's Accident report dated 8/28/16 at 9:45 PM documents, R1 was observed on floor and was absent of vital signs. This report documents, "(E9, Licensed Practical Nurse) entered (R1's) room to give hour of sleep medications and observed (R1) deceased. (R1) was sitting on the floor on (R1's) right hip, with (R1's) head down. Called out to (R1) and there was no response. Strings of gown noted to be caught on the side rail, which were immediately untied. Skin was pale, warm to touch with no petechiae noted to eyes or mouth area. No cyanosis noted to face. (R1) transfer status was extensive assist of 1-2 for transfers and assist with bed mobility." On 8/31/16 at 2:18 PM, E9 stated on 8/28/16 at 9:45 PM, E9 entered room to provide E9 with medications. E9 stated E9 did not see R1. E9 stated when E9 walked over to the bed, R1 was sitting on the other side of the bed. E9 stated E9 yelled out, "Are you alright." to R1. E9 stated that is when E9 noticed R1's gown strings hooked onto the side rail. E9 stated R1 was wearing a gown that was open in the back which tied closed by strings at the neck. E9 stated R1's gown strings were still tied in a bow at that time. E9 stated the strings were hooked around an exposed end on the top of the distal end of side rail. E9 stated R1 was half sitting under the bed and appeared to be hanging from the side rail.	F 224		

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E9 stated E9 felt for a pulse and R1's pulse was absent. E9 stated E9 got help from E13 (Licensed Practical Nurse). E9 stated E13 also checked vitals signs and confirmed no vital signs were present. E9 stated R1 was placed into bed and there was a mark under R1's neck. E9 stated E9 started E9's shift at 6:00 PM and entered room for the first time at 9:45 PM.

On 9/1/16 at 11:00 AM, E12 Certified Nurse's Assistant (CNA) stated when E12 entered R1's room on 8-28-16 R1 was in a halfway sitting up position facing the bed. E12 stated R1's forehead was resting on the side rail and R1's left arm was caught between the bedrail and the mattress. E12 stated both side rails were in the elevated position. E12 stated R1's call light was attached to the side rail on the right side of the bed. E12 stated they (E9, E13, and E12) removed R1's left arm from between the side rail and the mattress and put R1 back to bed. E12 stated R1 had food around R1's mouth and on R1's gown. E12 stated R1's supper tray was on the bedside table. E12 stated R1 had a mark across the neck. E12 stated there were marks on R1's wrist from the side rail. E12 stated it took some work to remove R1's arm from the side rail.

On 9/6/16 at 1:15 PM, Z1 Coroner stated on 8/28/16, Z1 received a phone call from E9 to report R1's death. Z1 stated E9 stated the death was due to Tachycardia. Z1 stated Z1 asked E9 if there has been any falls, fractures, or recent surgeries. Z1 stated E9 stated, "Well" and told Z1 that R1 was found in a sitting position on the floor with the gown tangled in the side rail. Z1 stated Z1 went to the facility and upon entering the room R1 was laying in bed wearing a hospital gown and glasses. Z1 stated the official cause of

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F 224	Continued From page 8 death for R1 was asphyxiation due to hanging. Z1 stated R1 had petechiae in the eyes, inner lips, and under the tongue. Z1 stated R1 did not have a myocardial infarction. Z1 stated petechiae is only present when hanging has occurred. On 09/14 /16 at 1:00 PM an Immediate Jeopardy was identified to have begun on 8/24/16 at 2:00 PM when the facility neglected to follow facility policy on turning and positioning and failed to follow facility policy on care plans by failing to care plan a resident's need to have the call light placed on the left side of the bed and need to be repositioned due to sliding down in bed. The facility failed to follow facility policy on side rails by failing to ensure appropriate side rails were in use. The facility also failed to follow facility policy on restraints by failing to educate resident on the safety risks of side rails and by failing to obtain consent for side rails. These failures resulted in R1 being left unattended for over 4 hours and found expired hanging over the side of the bed with hospital gown around R1's throat, hooked to the side rail. On 9/14/16 at 1:00pm E1 (Administrator) was notified of the Immediate Jeopardy. The surveyor confirmed through observation and record review and interview that the facility took the following actions to remove the Immediate Jeopardy on 9/19/16. 1) On 9/14/16 the facility developed an Admission/Initial care plan for new admissions. 2) On 9/14/16 the facility updated their Resident Admission Policy to include.."During evaluation an Admission Screen/Initial Care Plan will be completed. Upon determination of ability for	F 224		

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F 224	Continued From page 9 admission to the facility the Initial Care Plan will be entered into the EMR (Electronic Medical Record) system. 3) The Admission Screen/Initial Care Plan documents under section, "VII. Supervision Needs" a line to document the frequency in which a resident should be supervised and the reason the supervision is needed. This information will be added to the Care Plan. 4) The Facility's Inservice Sheets dated 9/14/16 and 9/19/16 documents all licensed staff were inserviced by E2 (Director of Nursing) and E3 (Assistant Director of Nursing) regarding the Admission Screen/Initial Care Plan, how to complete the form and where to find the form on the computer. 5) The Facility's Turning and Reposition Policy was updated on 9/14/16 to include, "... 1. Residents identified on (skin risk) Assessment as Moderate (score 13-14), High (score 10-12), or Severe (score <9), or any resident with current pressure ulcer will be placed in a Turn and Reposition program. 2. Turn and reposition log for sign off of completion will be initiated. 3. Staff will complete turning and repositioning every 2 hours and initial off completion on the Turn and Reposition Log..." 6) On 9/19/16 E2 provided a list of residents who now have Turning and Repositioning logs. 7) The Facility's Inservice Sheets dated 9/14/16 and 9/19/16 documents all licensed staff were inserviced by E2 Director of Nursing and E3 Assistant Director of Nursing regarding the Facility's Turning and Repositioning policy, how to complete the Facility's Turning and Repositioning sheets, and the location of the Turning and Repositioning sheets. 8) On 9/19/16 at 11:00 AM Turing and Repositioning logs were correctly completed for	F 224		

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F 224	Continued From page 10 R4, R9, R13, R17, R19, R21-R23, R26, R28, R33, and R36-R38. 9) The Facility's Side Rail policy was updated on 9/2/16 and 9/15/16. This Policy now documents procedures for the assessment of side rails, side rail use, ongoing maintenance and evaluation, and changing of the resident's bed. 10) The Facility instituted a Side Rail Consent Form on 9/2/16 which documents the potential negative outcomes of side rail use. Side rail consents were obtained for R2 through R6 and R9 through R39. 11) The Facility's Side Rail Assessment was updated on 9/2/16 and R2 through R6 and R9 through R39 were reassessed for the use of side rails. 12) The Facility's inservice sheet dated 9/2/16 and 9/7/16 documents all staff were inserviced regarding the use of side rails.	F 224		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;	F 272		

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F 272	Continued From page 11 Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to thoroughly assess bed mobility and the use of side rails for one of four residents (R1) reviewed for assessments in the sample of 39. Findings include: The facility's Side Rail policy dated 5/16/16 documents, "...1. Upon admission a Bed Mobility/side rail assessment will be completed by (licensed nurse) and/or care coordinator, and recommendations will be made in regards to side rails use." R1's History and Physical dated 8/24/16	F 272		

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F 272	Continued From page 12 documents R1 has diagnoses of Diabetes Mellitus, Diabetic Neuropathy, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with a right middle Cerebral Artery area involvement, poor left Ventricular Ejection Fraction, and Osteoarthritis of knee joint and lumbosacral spine. The History and Physical documents R1 has arthritis of the wrist joint and hand joints, R1 has right shoulder rotator cuff injury and range of motion is restricted. The History and Physical documents under Neurologic that R1 has peripheral neuropathy and vibration sense is significantly impaired in both lower extremities. R1's side rail assessment dated 8/24/16 documents, R1 does not have the ability to arise from bed independently without a Side Rail, R1 expressed a desire to have the side rails raised while in bed, and R1 does not have the ability to enter and exit the bed independently with a side rail. This assessment documents R1 does not have a visual/movement/neurological disorder. R1's History and Physical dated 8/24/16 documents R1 has movement and neurological disorders. This assessment documents R1 does not have a history of falls from bed, R1 does not use the side rails to enable self positioning in bed independently, and R1 uses the side rails to enable positioning in bed with assistance. This assessment documents that side rails are indicated and serve as an enabler to promote independence in bed mobility. On 9/6/16 at 9:51 AM, E16 Licensed Practical Nurse verified that she filled out the side rail assessment form without having R1 in bed. E16 stated R1 was admitted to the facility on 8/24/16.	F 272		

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F 272	Continued From page 13 E16 stated E16 helped complete R1's admission paperwork. E16 stated she met with R1 and discussed care needs. E16 stated she completed the side rail assessment. E16 stated R1 was sitting up in a recliner at the time of the assessment. E16 stated she asked R1 if R1 wanted siderails and R1 stated yes. E16 stated R1 wanted the side rails to help R1 move in bed because of weakness. E16 stated she did not assess the actual side rail for safety or the resident's bed mobility. E16 stated the facility, "just always uses half rails." E16 stated she did not see the actual side rail. E16 stated she did not work with R1 again. On 9/7/16 at 9:00 AM, E2 Director of Nursing stated the side rail assessment should be completed when a resident is admitted to the facility. E2 stated the side rail assessment should be completed while the resident is laying in bed. E2 stated if a resident has orders for side rails the side rail are used at all times. E2 stated if a resident is incapable of using the side rail without staff assistance the side rail is still left up. E2 stated the facility has not assessed residents to determine if side rails should be in use if the resident only uses the side rails with the assistance of staff. E2 stated the facility did not have a system in place to regularly check the side rails to ensure the side rails were in working order or met regulations. E2 stated once side rails were applied to a residents bed the side rails remained on the bed and were not checked from one resident's occupancy to another.	F 272		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 14 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise a resident (R1) known to slide down in bed. This failure resulted in R1 being left unattended for over four hours and found expired hanging over the side of the bed with a hospital gown around R1's throat, hooked to the side rail. R1 was one of four resident's reviewed for safety and supervision in the sample of 39. These failures resulted in an immediate jeopardy. While the Immediate Jeopardy was removed on 9/19/16, the facility remains out of compliance at a severity Level Two. Additional time is needed for the facility to monitor the effectiveness of training regarding identifying and care planning the supervision needs of the residents and monitoring the provision of supervision. Findings include: R1's History and Physical dated 8/24/16 documents R1 diagnoses as Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebrovascular Accident with a Right Cerebral Artery Area Involvement, Poor Left Ventricular Ejection Fraction, Chronic Coumadin treatment, Pressure Ulcers and Ventricular Tachycardia. R1's History and Physical dated 8/24/16	F 323		

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documents, "R1 is very weak. R1 continues to be short of breath. R1 is 70 inches tall and weighs 225.54 pounds. R1 is alert and oriented. R1's range of motion to right shoulder is restricted due to Right shoulder rotator cuff injury and left shoulder is normal." This history and physical documents the treatment plan as making R1 a Do Not Resuscitate, consulting physical therapy and occupational therapy for generalized weakness, apply wound gel to left heel, bilateral gluteals and coccyx and to continue oxygen therapy.

R1's physician orders documents an order dated 8/25/16 for half side rails for mobility.

R1's fall risk assessment dated 8/24/16 documents R1 as being at high risk for falls.

On 9/6/16 at 12:00 PM, E17 Certified Nurse's Assistant stated E17 was assigned with E9 on 8/28/16 to the south side of the facility in which R1 resided. E17 stated E17 helped E11 Licensed Practical Nurse position R1 in bed on 8/28/16 at 4:00 PM. E17 stated R1 would try to use the side rail but could not pull self over in bed. E17 stated R1 was total assistance with bed mobility. E17 stated R1 could not use the side rail by R1's self. E17 stated after helping R1 at 4:00 PM, E17 went down to another hallway and did not see R1 for the rest of the shift.

On 9/1/16 at 9:50 AM, E11 Licensed Practical Nurse stated E11 worked with R1 a couple of times. E11 stated R1 preferred to have the head of the bed up 75 to 80 degrees. E11 stated R1 preferred to go to bed around 2:00 PM and then R1 would watch the television. E11 stated R1 would wiggle some in bed. E11 stated on 8/28/16 R1 seemed a little shakier than normal. E11

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stated E11 assessed R1's vital signs and blood sugar level and all were within normal limits. E11 stated E11 took R1 a supper tray at 5:30 PM. E11 stated R1 was sitting up in bed and E11 placed R1's supper tray on the bed side table and placed the bedside table in front of R1.

On 8/31/16 at 2:18 PM, E9 Licensed Practical Nurse stated R1 would use the call light, R1 was incontinent of urine at times, it took two staff members to provide incontinence cares. R1 would try to use the side rail to help turn self. R1 seemed oriented. R1 would request ice water several times per shift. On 9/1/16 at 9:00 AM, E9 stated R1 would slide down in bed at times and would have to be scooted back up in bed. E9 stated R1 preferred the head of the bed to be elevated at least 75 degrees. R1 preferred R1's call light to be attached to the left side of the bed along with bed side table.

On 9/7/16 at 9:00 AM, E2 Director of Nursing stated E2 would expect R1 checked on at least every two hours. E2 stated R1 should have been turned and positioned at least every two hours.

The facility's Job Description for Certified Nurses Aide/Nursing Assistant/Resident Care Technician documents, "...Turn bedfast residents at least every two hours...Record the resident's food/fluid intake...Perform after meal care."

R1's Resident CNA (Certified Nurse's Assistant) Documentation Record dated 8/28/16 for the 2 PM to 10 PM shift does not document that R1 was toileted, assisted with bed mobility, transferred, assessed for safety, or turned and positioned. The tasks of Toileting, assisting with bed mobility, assisting with transfer, assessing for

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safety, and turning and positioning were all assigned tasks for R1.

The facility's Turn and Reposition Policy dated 6/6/14 documents, "Changing a patient's position in bed every 2 hours helps keep blood flowing..."

R1's Accident report dated 8/28/16 at 9:45 PM documents, R1 was observed on floor and was absent of vital signs. This report documents, "(E9, Licensed Practical Nurse) entered (R1's) room to give (hour of sleep medications) and observed (R1) deceased. (R1) was sitting on the floor on (R1's) right hip, with (R1's) head down. Called out to (R1) and there was no response. Strings of gown noted to be caught on the side rail, which were immediately untied. Skin was pale, warm to touch with no petechiae noted to eyes or mouth area. No cyanosis noted to face. (R1) transfer status was extensive assist of 1-2 for transfers and assist with bed mobility."

On 8/31/16 at 2:18 PM, E9 stated on 8/28/16 at 9:45 PM, E9 entered room to provide E9 with medications. E9 stated E9 did not see R1. E9 stated when E9 walked over to the bed, R1 was sitting on the other side of the bed. E9 stated E9 yelled out, "Are you alright." to R1. E9 stated that is when E9 noticed R1's gown strings hooked onto the side rail. E9 stated R1 was wearing a gown that was open in the back which tied closed by strings at the neck. E9 stated R1's gown strings were still tied in a bow at that time. E9 stated the strings were hooked around an exposed end on the top of the distal end of side rail. E9 stated R1 was half sitting under the bed and appeared to be hanging from the side rail. E9 stated E9 felt for a pulse and R1's pulse was absent. E9 stated E9 got help from E13

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(Licensed Practical Nurse). E9 stated E13 also checked vitals signs and confirmed no vital signs were present. E9 stated R1 was placed into bed and there was a mark under R1's neck. E9 stated E9 started E9's shift at 6:00 PM and entered room for the first time at 9:45 PM.

On 9/1/16 at 9:00 AM, E9 stated on 8/28/16 at 9:45 PM, E9 noticed R1's bed to be in an elevated position. When E9 found R1 on the floor, R1's pillow was underneath R1. R1's call light was not on. R1's supper tray was on the bedside table was pushed up next to the air conditioner. R1's side rail was still in the elevated position. R1's face was touching the first slat of the side rail. The gown strings were up and stretched over the back of R1's head and were pulled very taut. E9 stated the front of the gown was strangling R1's neck.

On 9/1/16 at 10:40 AM, E13 Licensed Practical Nurse stated on 8/28/16 E9 came down to the hallway in which E9 was working and asked for assistance. E13 stated E13 entered R1's room and R1 was on the floor. E13 stated R1 had no vital signs. E13 stated R1 was put into bed. E13 stated R1 had a mark on the neck.

On 9/1/16 at 11:00 AM, E12 Certified Nurse's Assistant (CNA) stated E12 was asked to go and help with a situation on the south hall. E12 stated when E12 entered R1's room was in a halfway sitting up position facing the bed. E12 stated R1's forehead was resting on the side rail and R1's left arm was caught between the bedrail and the mattress. E12 stated both side rails were in the elevated position. E12 stated R1's call light was attached to the side rail on the right side of the bed. E12 stated they (E9, E13, and E12)

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removed R1's left arm from between the side rail and the mattress and put R1 back to bed. E12 stated R1 had food around R1's mouth and on R1's gown. E12 stated R1's supper tray was on the bedside table. E12 stated R1 had a mark across the neck. E12 stated there were marks on R1's wrist from the side rail. E12 stated it took some work to remove R1's arm from the side rail.

On 9/6/16 at 1:15 PM, Z1 Coroner stated on 8/28/16, Z1 received a phone call from E9 to report R1's death. Z1 stated E9 stated the death was due to Tachycardia. Z1 stated Z1 asked if there has been any falls, fractures, or recent surgeries. Z1 stated E9 stated, "Well" and told Z1 that R1 was found in a sitting position on the floor with the gown tangled in the side rail. Z1 stated Z1 went to the facility and upon entering the room R1 was laying in bed wearing a hospital gown and glasses. Z1 stated R1 was still warm to touch with slight mottling and slight levidity, no rigidity was present. Z1 stated R1 had a ligature mark with a substantial groove to the neck. Z1 stated that it appeared R1 had slid out of bed and when sliding the gown became caught on the side rail as R1 slid out of the bed. Z1 stated the cause of death was hanging. Z1 stated R1 was asphyxiated due to hanging. Z1 stated R1 had petechiae in the eyes, inner lips, and under the tongue. Z1 stated R1 did not have a myocardial infarction. Z1 stated petechiae is only present when hanging has occurred. Z1 stated the facility staff should have left the body alone and not moved R1 the bed.

On 9/14 /16 at 1:00 PM an Immediate Jeopardy was identified to have begun on 8/24/16 at 2:00 PM when the facility failed to develop a plan of care for the supervision R1 after identifying R1 as

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F 323	Continued From page 20 having poor range of motion to the right side of the body, R1 having episodes of scooting down in bed, and R1 not being able to turn and reposition self in bed. On 9/14/16 at 1:00pm E1 (Administrator) was notified of the Immediate Jeopardy. The surveyor confirmed through observation, record review and interview that the facility took the following actions to remove the Immediate Jeopardy on 9/19/2016. 1) On 9/14/16 the facility developed an Admission/Initial care plan for new admissions. 2) On 9/14/16 the facility updated their Resident Admission Policy to include.."During evaluation an Admission Screen/Initial Care Plan will be completed. Upon determination of ability for admission to the facility the Initial Care Plan will be entered into the EMR (Electronic Medical Record) system. 3) The Admission Screen/Initial Care Plan documents under section, "VII. Supervision Needs" a line to document the frequency in which a resident should be supervised and the reason the supervision is needed. This information will be added to the Care Plan. 4) The Facility's Inservice Sheets dated 9/14/16 and 9/19/16 documents all licensed staff were inserviced by E2 (Director of Nursing) and E3 (Assistant Director of Nursing) regarding the Admission Screen/Initial Care Plan, how to complete the form and where to find the form on the computer.	F 323		
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490		

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F 490	Continued From page 21 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to effectively manage operations to maintain the safety of residents for one of four residents (R1) reviewed for safety in the sample of 39. This failure resulted in R1 being left unattended for over 4 hours and found expired hanging over the side of the bed with a hospital gown around R1's throat, hooked to the side rail. Findings include: The facility's undated Administrator Job Description documents, "..Primary purpose of your job position is to manage operations in accordance with current Applicable federal, state, and local standards, guidelines, and regulations, and as directed by the Board of Directors, to assure that the organization is operating effectively and efficiently." The facility's undated Director of Maintenance Job Description documents, "The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state and local standards, guidelines, and regulations governing our facility, and as may be directed by the Administrator, to assure that our facility is maintained in a safe and comfortable manner." This job description documents the Director of Maintenance Job	F 490		

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F 490	Continued From page 22 Duties as, "...Ensure that supplies, equipment, etc., are maintained to provide a safe and comfortable environment..." The facility side rail consent form summarizes the potential negative outcomes for the use of side rails. The Facility's Side Rail Consent Form documents the Potential Negative Outcomes as, "The use of side rails(s) may involve risks such as: getting caught in the rails, getting caught, between the rail and mattress, strangulation, hitting against the rail(s), causing skin tears and/or bruising and crawling over the top of a side rail risking a fall from a higher level with risk for greater injury or death." R1's Accident report dated 8/28/16 at 9:45 PM documents, R1 was found deceased hanging by a hospital gown from the side rail of the bed. On 9/6/16 at 1:15 PM, Z1 (Coroner) stated R1's cause of death on 8/28/16 was hanging. Z1 stated R1 was asphyxiated due to hanging. Z1 stated R1 had petechiae in the eyes, inner lips, and under the tongue. Z1 stated R1 had a ligature mark with a substantial groove to the neck. Z1 stated R1 had abrasions to the right knee. Z1 stated that it appeared R1 had slid out of bed and when sliding the gown became caught on the side rail as R1 slid out of the bed. The Facility's Side Rail Policy dated 5/16/16 documents, "...1. Upon Admission a Bed Mobility/side rail assessment will be completed by (Licensed Nurse) and/or care coordinator, and recommendations will be made fireguards to side rails use. 2. Maintenance will be contacted to apply appropriate side rails to the resident's bed."	F 490		

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F 490	Continued From page 23 On 9/6/16 at 9:51 AM, E16 (Licensed Practical Nurse) stated R1 was admitted to the facility on 8/24/16. E16 stated she completed the side rail assessment. E16 stated R1 was sitting up in a recliner at the time of the assessment. E16 stated she asked R1 if R1 wanted siderails and R1 stated "yes". E16 stated she did not assess the actual side rail for safety or the resident's bed mobility. E16 stated the facility, "just always uses half rails." E16 stated she did not see the actual side rail. On 8/31/16 at 2:55 PM, E6 (Maintenance Director) stated he was not contacted to look at the side rails on R1's bed. E6 stated after R1's incident on 8/28/16 he was told to remove all side rails like the ones that were on R1's bed. E6 stated he was not aware of regulations regarding the safety of side rails. On 9/7/16 at 8:45 AM, E2 (Director of Nursing) she is unsure what "appropriate side rails" means related to the side rail policy. E2 stated prior to 8/28/16 the facility did not ensure the side rails met regulations regarding the safety of the side rails. E2 stated when a side rail assessment is completed the resident should be lying in the bed. E2 stated if a resident has orders for side rails then the side rails are left up at all times while in bed. E2 stated if a resident is unable to use the side rail independently then the side rail is still left up. On 9/14/16 at 12:05 PM, E2 stated she looked at R1's side rails on the night of 8/28/16 after the incident. E2 stated she decided to remove all other side rails like the side rails R1 used. E2 stated she began to audit who had the side rails but stopped and waited until the next day.	F 490		

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NORTH ADAMS HOME	**2259 EAST 1100TH STREET MENDON, IL 62351**

(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 490	Continued From page 24 On 8/31/16 at 11:40 AM, E6 (Maintenance Director) stated he has been employed at the facility for six months. E6 stated he is responsible for the maintenance of the side rails if there is a problem with the side rail. E6 stated if changes in regulations occur E1 Administrator would notify him. At that time, E6 measured the side rails that were on R1's bed. The top bar of the side rail measured 30 1/8 inches long. At the end of the top bar of the side rail was a 1.25 inch and a 2.0 inch extension. The measurements between the side rail slate was 7 3/4 inches. On 9/7/16 at 9:00 AM, E2 (Director of Nursing) stated the facility did not obtain side rail consents until 9/2/16. E2 stated the facility did not begin to educate resident or family members regarding side rail risk until 9/2/16. E2 stated the education regarding the safety risk of side rails is included on the side rail consent form. E2 stated R1 did not sign a side rail consent or receive education related to the safety risks of side rails. On 9/10/16 at 10:30 AM, E1 (Administrator) stated the facility did not educate the residents or family members about the risk of side rails until 9/2/16. On 9/1/16 at 10:25 AM, E1 (Administrator) stated the facility did not have a system in place to routinely audit the side rails in the facility. R1's side rails were removed because the gown string got caught on the end piece of the side rails. E1 stated E1 was not aware of the regulations regarding the safety of side rails.	F 490		