STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016216	A. BUILDING: _____ B. WING _____	C 08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING BURR RIDGE	6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60521

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S 000	Initial Comments Complaint Investigation #2376825/IL163306	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.780b)c 330.4240a) Section 330.780 - Incidents and Accidents 330.780b) 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. These REQUIREMENTS are not met as evidenced by: Based on interview and record review the facility failed to notify the department of a serious incident that occurred for 1 of 3 residents (R4) reviewed for accidents and incident reporting in the sample of 10. The findings include: R4's Nursing Notes on 6/23/23 at 6:34 AM shows, "RA (Resident Attendant) from AL (Assisted Living) called this nurse to [R4's room]. Res. (Resident) was noted with body partially on floor and her neck and head area caught between bed railing and mattress. Res. unresponsive, with no respirations, no B/P (blood pressure), no pulse, pupils fixed and dilated .....[V5-Director of Wellness] also aware of above."	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 On 8/29/23 at 12:28 PM, V13 (RN) said that when she went into R4's room on 6/23/23 she saw R4 on her left side. R4's body was halfway out of the bed with her feet touching the floor and her head was in between the sideral and mattress. V13 said that the side rails on R4's bed were rectangular, in the upright position and located on the top half of both sides of R4's bed. V13 said that R4's mouth was touching the vertical bars on the siderail. V13 said that she immediately called V5 and described what she saw and V5 directed her to call hospice. On 8/28/23 at 12:54 PM, V1 (Administrator) said that V5 never reported the incident to her but should have so an investigation could have been immediately started and an incident report sent to IDPH (Illinois Department of Public Health). V1 said that she first heard of the incident on 7/14/23 (21 days after R4's death) when she was discussing another resident's death with hospice. On 8/29/23 at 1:28 PM, V1 (Administrator) said that to date they still do not have an incident report to send to IDPH due to the fact that she was not aware of the incident until it was "too late' to investigate. V1 said that any incident or accident that is unusual should be reported to IDPH and investigated immediately. V1 said that R4's incident would have been a reportable incident if she was made aware of it. V1 stated that the facility does not have a policy regarding reporting of unusual incidents or accidents to IDPH. Section 330.780 - Incidents and Accidents 330.780c) c) The facility shall, by fax or phone, notify the	S9999		

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S9999	Continued From page 2 Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. 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. Ill. Admin. Code tit. 77, § 330.780 These REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to notify the state agency of a reportable incident that had caused death within 24 hours to 1 of 3 residents (R2) reviewed for reportable incident in the sample of 10. The findings include: On 8/28/23 at 12 noon, V1 (Administrator) said she was not aware of R2's death. It was R2's son who called V1 on 7/14/23 (24 hours after R2's death). V1 said R2's son asked what was being done regarding R2's death due to his neck being stuck in the siderails. V1 said she called the Director of Wellness (Memory Care Director) and asked what happened to R2 and why it was not reported to her. V1 said she terminated V5 due to this incident. V1 said R2 died on 7/13/24 due	S9999		

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S9999	Continued From page 3	S9999		

to his head being stuck in the siderails. V1 said she faxed R2's incident to notify the state agency on 7/14/23 at around 9am (more than 24 hours later). V1 said the state agency should be notified of any accident and incidents resulted in death within 24 hours.

R2's progress notes dated 7/13/23 at 3:00 AM, by V11 (Registered Nurse RN) show R2 was observed unresponsive. Pulseless and no respirations noted.

The Hospice Nurse Discharge Summary dated 7/13/23 shows, [R2] was found deceased between 2:45-3:00 AM by staff. R2 was observed lying on his left side on the floor of the left side of the bed. His head/neck was between the bed and the halo bar (siderails) ... Pt had some blood on his left side of face which appear to be from scratches to his left check. This RN called the coroner's office at 0410. (Coroner) came to investigate the situation.

Review of the Facility Reported Incident regarding R2 show it was faxed to the state agency on 7/14/23. R2's medical record show R2 died at around 3AM on 7/13/23.

Section 330.4240 Abuse and Neglect

330.4240a)

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B)

These REQUIREMENTS are not met as evidenced by:

Based on interview and record the facility

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neglected to ensure resident's safety while in bed with siderails. This failure resulted in R2 and R4's neck being stuck between the mattress and the siderails that caused R2's death. This failure rises to the level of neglect.

The findings include.

1.R2's electronic medical record show R2 is 93 y/o with diagnoses of end stage Dementia, myasthenia gravis and cognitive communication deficits. R2 was on hospice services on 4/7/23 due to end stage dementia. R2 was total care.

R2's death certificate dated 7/13/23 show R2's cause of death was.

1. positional asphyxiation (suffocation)
2. entrapment of neck between bedrail and mattress.

The same death certificate of R2 show that an autopsy was conducted, and the findings of the autopsy was used to determine cause of death.

R2's progress notes dated 7/13/23 at 3:00 AM, by V11 (Registered Nurse RN) show R2 was observed unresponsive. Pulseless and no respirations noted.

The Hospice Nurse Discharge Summary dated 7/13/23 show, [R2] was found deceased between 2:45-3:00 AM by staff. R2 was observed lying on his left side on the floor of the left side of the bed. His head/neck was between the bed and the halo bar (siderails) ... Pt had some blood on his left side of face which appear to be from scratches to his left check. This RN called the coroner's office at 0410. (Coroner) came to investigate the situation. She decided to open an investigation

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S9999	Continued From page 5 and have the body transported to the coroner's office." The Facility's Incident Report entitled Fall Scene Investigation dated 7/14/23 by V2 (Director of Nursing) show: describe the fall: Aide reported that resident was seen half his body was on the floor while his head was between the rail and mattress. The Facility's Investigation Summary dated 7/14/23 show ... on 7/13/23 identified resident (R2) unconscious in room around 3AM during rounds. R2's head was stuck in between railing against the side of the wall and his body positioned on the left side. His hand was gripping on the rail...Assessment of Resident/Describe of death position asphyxiation due to neck entrapment between mattress and siderails. On 8/28/23 at 11AM, V11 (RN) said she was the Nurse working on 7/12-7/13/23 night shift. V11(RN) said she came in to work at 10 PM. V11 said at around 11:30 PM, she made rounds and saw R2 in bed asleep with his partial siderails (halo bar) intact on each side of his bed. At around 3AM, V11 said V7 (Certified Nursing Assistant-CNA) called her into R2's room. V11 said upon entering R2's room, R2's neck was underneath the left siderails, his legs and feet were on the floor. R2 was unconscious and pulseless. R2 also had a bowel movement. R2's bed was in the middle of the room when normally it was by the wall. R2's air mattress was also sideways. V11 said she was upset and does not know how R2's neck was stuck underneath the halo ring (siderails). V11 said R2 might have been trying to get up out of bed. On 8/28/23 at 9:35 AM, V6 (Hospice Nurse) said	S9999		

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S9999	Continued From page 6 she was notified of R2's death around 5AM by the Hospice Night Nurse who came to the facility on 7/13/23. V6 said that R2 died due to his neck being stuck between the mattress and the side rails. V6 said she saw R2 the day before and he was fine. V6 said the bed and his siderails have been in use since his hospice admission last 4/23. On 8/28/23 at 1:47 PM, V2 (Director of Nursing) said R2 did not have an assessment for the use of siderails. All residents on siderails should be assessed for the risks and benefits of the siderails. V2 said R2 died due to his neck being trapped in the rail. On 8/29/23 at 9:30 AM, V15 (Maintenance) said prior to the incident of R2's death due to being stuck in the siderails, he was not checking the bed, mattresses, and siderails in the Sheltered Care Unit. V15 said it was only after the incident of R2's death that V1 (Administrator) instructed him to do a whole house audit of beds, mattresses and siderails. On 8/24/23 at 12:42 PM, V1 (Administrator) said R2's death was traumatic. V1 said R2 was found with his neck under the siderails. V1 showed this surveyor a bed with the Halo Ring (side rail) which was similar to R2's bed and siderails. The halo ring was a circular rail that was vertically mounted at the upper side of the bed approximately 12 inches in diameter. V1 said R2's side rails might have been installed incorrectly, however V1 said she did not see R2's actual bed and maintenance did not check R2's bed. V1 said the facility had no system in place to check beds with siderails. The facility had no system in place to monitor equipment being brought to the facility that can cause entrapment,	S9999		

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S9999	Continued From page 7	S9999		

and no system in place for any preventive maintenance of beds, mattresses, and siderails. V1 also said R2 had no side rail assessments, no consent for the use of siderails, and therapy was not involved to assess the use of R2's siderails. V1 said it was only after R2's death that she instructed Maintenance (V15) to check all beds, mattresses, and siderails. V1 said as of this time the Company had not put a new policy in place to do preventive maintenance of durable medical equipments-bed, mattresses, and siderails.

The Halo User's Manual dated 11/2020 shows, "Entrapment, serious injury or death can occur if the Halo Safety Ring or Halo Safety Wing is not properly installed and if users are not properly assessed and monitored. A user's movement in bed can increase the risk of entrapment, injury or death from mattress compression or the creation of gap space ... ...Measure, test and evaluate each bed system and user individually per state and federal guidelines. Variations in mattress thickness, size, density, etc. and a user's movement in bed can increase the risk of injury or death from mattress compression or the creation of gap space."

The facility's Restraint Free Care Policy revised on 5/2020 shows, "Prior to use of any side rail, a bed mobility assessment must by conducted by a therapist or licensed nurse. The resident must be able to demonstrate that they are capable of using them for bed mobility; complete the half side rail bed bar assessment ...All side rails used must be fitted appropriately to the bed. ...If a side of bed rail is used, the community will complete the following: Asses the resident for risk of entrapment from bed rails, prior to installation by completing the half side rail/bed bar assessment, review the risk and benefits of bed rails with the

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resident or resident representative and obtain informed consent prior to installation, ensure that the bed's dimensions are appropriate for the resident's size and weight, follow manufacturer's recommendations and specifications for installing and maintaining bed rails."

2. R4's Face Sheet shows diagnoses of: vertigo, dementia, muscle weakness, difficulty walking, lack of coordination and a history of falling. R4's Care Plan for transferring revised on 2/9/23 shows that she requires assistance for getting in and out of bed and requires the use of railings or devices.

R4's Durable Medical Equipment Invoice shows that she received a low air loss mattress, full electric low bed frame, and a pair of half-length side rails on 5/15/23.

R4's Nursing Notes on 6/23/23 at 6:34 AM shows, "RA (Resident Attendant) from AL (Assisted Living) called this nurse to [R4's room]. Res. (Resident) was noted with body partially on floor and her neck and head area caught between bed railing and mattress. Res. unresponsive, with no respirations, no B/P (blood pressure), no pulse, pupils fixed and dilated.

R4's Hospice Notes dated 6/23/23 shows, "FN (Facility Nurse) [V13-Registered Nurse/RN] called to report pt (patient) was found by CNA (Certified Nursing Assistant) at 0400 in between side rails on left side of bed-pt is unresponsive and unconscious in this event ....FN [V13] described "her mouth is opened and stuck in between the railings." At 0500, this RN arrived to facility and received [R4] rolled onto left side of bed. Bilateral lower extremities were lying on the floor and bilateral arms dangling with head/neck in

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S9999	Continued From page 9 between left side rail and mattress." On 8/29/23 at 12:28 PM, V13 (RN) said that when she went into R4's room on 6/23/23 she saw R4 on her left side. R4's body was halfway out of the bed with her feet touching the floor and her head was in between the sideral and mattress. V13 said that the side rails on R4's bed were rectangular, in the upright position, and located on the top half of both sides of R4's bed. V13 said that R4's mouth was touching the vertical bars on the siderail. On 8/28/23 at 9:30 AM, V15 (Maintenance) said that on 7/14/23 he did a side rail audit for entrapment risk of about 15 residents who had side rails. V15 said that he used a bed rail entrapment zone measurement tool that they facility had bought over one year ago. V15 said that he removed any of the side rails that had failed the entrapment test. V15 said that he removed about half of the side rails because they failed the entrapment test. V15 said that on 7/14/23 was the first time he had done side rail entrapment testing for the assisted living area. On 8/29/23 at 9:20 AM, V15 said that a resident's head should never be able to get stuck in between the mattress and side rail. V15 said that is why they should be tested with the entrapment tool before the resident uses the bed. V15 said that he had never seen R4's bed and did not know that R4 had a siderail. V15 stated, "Where I used to work, they had a procedure for this (siderails). This facility does not." On 8/29/23 at 1:30 PM, V1 (Administrator) said that they have a restraint policy that the facility has used for years that talks about side rails. V1 said that R4 does not have any side rail	S9999		

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S9999	Continued From page 10 assessments or consents for use. V1 stated, "I gave you everything we had regarding R4 and side rails." R4's clinical record does not contain any side rail assessments, consents for side rail use or documentation that the side rail was checked prior to use for risk of entrapment. The facility's Restraint Free Care Policy revised on 5/2020 shows, "Prior to use of any side rail, a bed mobility assessment must by conducted by a therapist or licensed nurse. The resident must be able to demonstrate that they are capable of using them for bed mobility; complete the half side rail bed bar assessment ...All side rails used must be fitted appropriately to the bed. ...If a side of bed rail is used, the community will complete the following: Asses the resident for risk of entrapment from bed rails, prior to installation by completing the half side rail/bed bar assessment, review the risk and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation, ensure that the bed's dimensions are appropriate for the resident's size and weight, follow manufacturer's recommendations and specifications for installing and maintaining bed rails." (AA)	S9999		