| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6003875 | A. BUILDING: _____ B. WING _____ | C 05/15/2018 |

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| PARK POINTE HEALTHCARE & REHAB | 1223 EDGEWATER MORRIS, IL 60450 |

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| S 000 | Initial Comments<br><br>Complaint Investigation #1872956/IL102433<br><br>Statement of Licensure Violations | S 000 | | |
| S9999 | Final Observations<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following | S9999 | Attachment A<br>Statement of Licensure Violations | |

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procedures:
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

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide safe bed placement to prevent injury.
This applies to 1 of 3 residents (R1) reviewed for falls in a sample of 5.
This failure resulted in R1 falling from the bed and expiring due to positional asphyxia.

Findings include:

The Admit/Readmit Assessment dated March 28, 2018 documents R1 admitted to the facility on March 27, 2018 after surgical repair of a left hip fracture.

R1's Baseline Care Plan dated March 27, 2018 documents R1 with activities of daily living (ADL)/mobility deficit due to weakness related to fractured left hip. This Care Plan documents interventions to include R1 is to be assisted for

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| S9999 | Continued From page 2 | S9999 | | |

turning in bed and to use a mechanical lift for transfers.

R1's computerized ADL documentation dated April 1, 2018 documents R1 requiring extensive assist of two staff members for bed mobility.

A facility incident report dated April 2, 2018 documents at 2:10am R1 was found between the bed and the wall face down. R1 had no heartbeat, pulse or respirations.

On May 11, 2018 at 6:29am, V5 (Nurse) stated at around midnight on April 2, 2018 V5 checked on R1 and R1 was asleep with the head of the bed at approximately a 45 degree angle in low position approximately 12 inches from the wall. V5 stated checked on R1 next between 2-2:10am and when V5 walked into the room R1 was between the bed and the wall in a tight space, face down with buttocks up in the air and head face down towards floor, R1's right side and arm was against the wall and the left side against the bed and left arm behind R1. V5 stated R1's bed had a scoop mattress, was in low position and was found with the head of the bed at a 90 degree angle. V5 stated V5 and V8 (Nursing Assistant) had to pick up the bed and move it away from R1 when R1 was found. V5 stated R1 did not move or change positions after the bed was moved. R1 was not breathing, did not have a pulse and had a do not resuscitate order. V5 stated V3 (Coroner) was called and came to the facility. V5 further stated R1 was alert and oriented, able to adjust head of bed independently, used the call light for help, could not get out of bed independently and required assistance of 2 for positioning. V5 stated if R1's bed was further away from the wall she probably wouldn't have been wedged between the wall and bed after falling.

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| S9999 | Continued From page 3<br><br>On May 11, 2018 at 10:00am V8 stated at approximately 12am R1 was last repositioned. In order to reposition R1 the bed has to be moved away from the wall. V8 stated, "Oh yeah, last time I moved her I was on that side (wall side) and there was about a foot of space." V8 stated beds at the facility are positioned with enough space between bed and wall so if a resident fell it would allow the resident space to fall on the floor and not get wedged in between bed and wall. V8 stated R1 required the assistance of 1 to 2 persons to reposition in bed due to not having enough lower body strength. V8 stated if R1 fell she didn't have enough strength to get up. V8 stated R1's bed was locked at the time R1 was found on the floor.<br><br>On May 10, 2018 at 2:14pm, V3 stated he arrived at the facility to investigate after R1 was found expired on the floor. V3 stated the cause of death is ruled accidental due to positional asphyxia which was determined by petechia of R1's eyes and a picture taken at the facility and provided to V3.<br><br>R1's Certificate of Death dated May 1, 2018 documents R1 expired on April 2, 2018 with a cause of death listed as positional asphyxia due to a fall from bed. The picture provided by V3 shows R1 face down on the floor with knees and feet touching the floor and head down and not visible. The call light cord and bed remote are seen with the resident on the floor with blankets under R1. The bed is seen in low position with the head of the bed close to a 90 degree angle and the foot of the bed pulled out further away from the wall than the head.<br><br>On May 11, 2018 at 6:55am, V5 identified the | S9999 | | |

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| S9999 | Continued From page 4<br><br>model of bed being used by R1 at the time of the death and put the bed into the position V5 found it at the time R1 was observed on the floor. V5 stated the beds are difficult to move in low position and V5 had to lift the foot of the bed to place it into position. V5 moved the bed out approximately a foot in low position. V5 stated R1 was wedged between the bed and wall face down with R1's bottom a little lower than the middle section of the bed. V5 confirmed the picture provided by V3 was the picture taken at the facility and stated it was the position R1 was in after the bed was moved away.<br><br>The facility policy Resident Fall Prevention and Management Policy dated December 8, 2016 documents to initiate fall safety interventions based on the residents risk factors and individualized needs.<br><br>(B) | S9999 | | |