| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145628 | A. BUILDING _____ B. WING _____ | C 03/22/2006 |

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| **EVERGREEN NURSING & REHAB CENTER** | **1115 NORTH WENTHE EFFINGHAM, IL 62401** |

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| F 000 | INITIAL COMMENTS<br>Complaint Investigation #0650544/IL21189.<br><br>(Reinvestigation of Complaint #0552823/IL17750 )<br><br>An extended survey was not conducted.<br><br>The Evergreen Nursing and Rehab Center is in compliance with 42CFR Part 483, Requirements for Long Term Care facilities for this survey. | F 000 | | |
| F9999 | FINAL OBSERVATIONS<br>LICENSURE VIOLATIONS<br><br>300.1210b)6)<br>300.2420j)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b)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.<br><br>Section 300.2420 Equipment and Supplies<br><br>j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal | F9999 | | |

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

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| F9999 | Continued From page 1<br><br>commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars, and reciprocal pulleys.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, adminsitrator, employee or agent of the facility shall not neglect a resident.<br><br>These regulations were not met as evidenced by the following:<br><br>Based on record reviews, interviews and observations the facility failed to provide adequate supervision and assistance for one resident (R1) to prevent death by positional asphyxia, and failed to ensure that the. resident's environment remained free of accident hazards including ensuring that metal bedside rails were in good condition and properly maintained.<br><br>Finding include:<br><br>According to the admission face sheet for R1 dated 3-09-05, R1 was 84 years old and admitted with Peripheral Vascular Disease and had a left femoral popliteal bypass surgery on 5-20-05. According to staff interview with E2 (Director of Nursing) on 02-15-06 at 9:20am, R1 was alert and oriented and was out with the family on 06-21-05 for a physician's appointment returning at 3 :30pm. R1's Minimum Data Set Assessment dated 6-07-05 indicated R1 was ambulatory with assistance and independent in decision making. E2 stated R1 would ambulate on his own in his room, and go to the bathroom without assistance at times. R1 was assessed by the facility on 5-25- | F9999 | | |

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| F9999 | Continued From page 2<br><br>05 to use the bed siderails to aid in bed mobility. E2 stated R1 used only the top 1/2 siderails.<br><br>Per nurses notes dated 6-21-05 3:30am by E3 ( Licensed Practical Nurse) and confirmed by interview with E3 on 02-15-06 at 2:20pm, R1 was found by E4 and E5 (Certified Nursing Assistants ) with his upper body slumped over the left side of the bed siderail with his left arm caught in the siderail with blood noted on both of R1's hands. R1 did not respond, his body was cool and R1 had no pulse, respirations or blood pressure. R1 was noted to be a full code status and cardiopulmonary resuscitation (CPR) was initiated by E3, E4 and E5. The ambulance, physician, and family were notified by phone by E 8 (Registered Nurse) on 06-22-05 at 3:40am which was confirmed by interview with E8 on 02-16-06 at 1:45pm per phone. R1 was transported to the emergency room by ambulance with CPR in progress according to the nurses notes on 06-22-05 at 4:05am. R1 was pronounced dead at the emergency room on 06-22-05 at 4:14am according to the Emergency Record.<br><br>According to the "Coroner-Verdict Statement" report dated 06-22-05, R1's cause of death was due to positional asphyxia which was the result of getting caught in a bedrail. An inquest was held by Z2 (County Coroner) on 08-24-05 and R1's death was ruled accidental. Per interview with Z2 on 02-15-06 per phone at 3:00pm, Z2 stated the left upper siderail on R1's bed had the center portion missing when she investigated R1's death . Z2 took pictures of R1, his room and bed and the pictures also confirmed the missing center portion of the left upper siderail. Z2 stated the markings on R1's chest and arms along with | F9999 | | |

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| F9999 | Continued From page 3<br><br>results of an autopsy done by Z4 (Forensic Pathologist) on 06-22-05 at 1530 reveal the cause of R1's death was positional asphyxia evidenced by pressure marks on the chest, neck and left arm, hemorrhage in the neck muscles and petechiae on R1's face. Z2 stated on 02-15-06 at 3:00pm, "The pictures of R1 and his bed reveal his head and chest went through the center of the left upper siderail." Z2 also stated the forensic pathology report concurrs with the pictures of R1, and the diameter of the bedrails match the markings on R1's chest, "This is factual evidence." Z2 stated "The hemorrhage on R1's face - petechia - is consistent with the downward position of his head - the blood pooled and petechia occurred - all this points to positional asphyxia." Z2 stated "R1's 2 inch red mark from right side from the axillae area to the left side of R1's neck (30 inches long by 2 inches wide) indicate this position was where R1 spent most of his time as hemorrhage occurred. The left side of R1's chest also had a red mark 20 inches long and 2 inches wide from the left side of the neck to the left anterior upper arm." Z2 stated these markings indicate R1 was caught in between the top and bottom rail on the left upper side rail. Z2 confirmed the middle portion of the left upper side rail was missing on 6-22-05 when she inspected the bed. This resulted in positional asphyxia causing death for R1.<br><br>According to the "Post Mortem Examination Report" dated 06-22-05 by Z4 (Forensic Pathologist), R1 had "pressure marks on the chest" with the "neck muscles - showing focal hemorrhage; anterior strap muscle and posterior laryngeal constrictor." "The dissection of the anterior chest shows no evidence of rib or sternal | F9999 | | |

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| F9999 | Continued From page 4 | F9999 | | |

fracture. There is hemorrhage in the soft tissue of the upper midline neck" according to the autopsy report. The autopsy summary concludes R1 died as a result of positional asphyxia. According to interview with Z4 on 03-15-06, Z4 stated based on the autopsy, "R1 lay in a face down prone position and had an imprint across his chest in the same diameter as the siderail." Z4 stated the autopsy indicated R1 had diffuse bleeding in the anterior chest and R1 was pinned in the siderail. Z4 stated "R1 being pinned in the siderail was a tight fit but this made sense with his marking on the chest and dense bleeding."

Observations on 03-15-06 at 11:10am with E7 ( Maintenance Supervisor) of the same type bed siderail as was on R1's bed measured 26 inches length and 9 inches width. A 1/2 inch metal piece was welded on the vertical ends at the center of the siderail. Two horizontal openings of 4 1/2 inches top and bottom was present with the center metal support in place. According to interview with E7 at this time, he was aware the middle metal piece was broken and missing on R 1's upper left siderail on 6-23 or 6-24-05 as E7 and E2 (Director of Nursing) inspected the siderail. When asked if this was reported to anyone, E7 stated "Everyone knew about it." E7 was not made aware of the broken side rail prior to the 6-22-05 incident involving R1. When questioned about the sturdiness of the center metal piece of this siderail, E7 stated "I put my knee and weight (#250 pound) against the rail and popped out the center piece of the siderail." When asked if R1 could do this, E7 stated "I don't know but I doubt it." R1's broken siderail and center piece were disposed of by the facility after the inquest according to interview with E7.

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| F9999 | Continued From page 5<br><br>According to interview with E11 (housekeeper) on 03-15-06 at 10:00am, E11 stated she cleaned R1's room and bed on 06-22-05 at approximately 10am and found the metal piece of the siderail under R1's bed, E11 thought it was a part of a hand crank and placed the 1/2 inch by 25 inch metal piece on R1's bed frame, without reporting this finding. E7 stated he found this metal piece on 06-23 or 06-24-05 at the top of R1's bed under the mattress and on top of the bed frame per statement on 03-15-06 at 11:10am. Z2's ( coroner) pictures taken of R1's bed on 06-22-05 between 6am-6:30am, show this metal siderail piece under the center of R1's bed.<br><br>Per interview with Z1 (physician) per phone on 02 -16-06 at 12:45pm, Z1 stated R1 was a frail type and in a weakened state. According to Z1, R1 was not a large frame man. Per facility's vital sign and weight record on 5-25-05, R1's weight was #158.5. Z1 stated he was not made aware of R1 being caught in the bed siderail and does not feel R1 was strong enough to get free if caught in the siderail or break the siderail.<br><br>(A) | F9999 | | |