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	145343	A. BUILDING _____ B. WING _____	C 12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	**4900 NORTH BERNARD CHICAGO, IL 60625**

(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 000	INITIAL COMMENTS Incident Report Investigation of 11/28/2016/IL90244 - F279, F323, F514 Complaint Original Investigation: 1687134/IL90509- No deficiencies cited	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		

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

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F 279	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow care plan and aspiration precaution policies and procedures. The facility failed to have a comprehensive care plan addressing aspiration precautions for one of three residents (R2) reviewed for meal supervision in a sample of nine. Findings include:	F 279		

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The facility's "Diet Type Report" dated December 13, 2016 reads in part:
R2 - NAS/NCS (no added salt, no concentrated sweet), mech (mechanical)/soft, thin liquids, Additional directions: Aspiration precaution

R2's MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 10/13/2016 shows that R2 needs supervision and one person physical assist for eating.

R2's Comprehensive and Interdisciplinary Plan of Care does not address aspiration precaution interventions and goals as ordered by the physician.
R2's Physician Medication Review Report dated 12/13/2016 reads in part: Diet Order Summary - Aspiration precaution

On 12/20/2016 at 11:06am, Z3 (Speech Therapist) stated in part that [R2] has dysphagia and on aspiration precautions. Any resident on aspiration precautions should eat in the dining room with supervision. Staff should be looking for any signs of having difficulty swallowing, to make sure residents are taking small bites and small sips, and not eating too fast. If any resident is seen coughing during meals, then she is called to evaluate the patient because coughing is an overt sign that something might be going on.

On 12/20/2016 at 11:36am, E7 (Assistant Director of Nursing) stated in part that if a resident is on aspiration precautions, that should be in the care plan. At 3:50pm, E2 (Director of Nursing) confirmed aspiration precautions were not in R2's comprehensive care plan.

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F 279	Continued From page 3 The facility's undated policy and procedure titled, "Care Plan Policy and Procedure" reads in part: 9. c. Each of the Interdisciplinary Care plans will be reviewed d. The care plan will be updated with any additional identified problems or approaches as indicated The facility's policy and procedure titled, "Aspiration Precautions" dated 02/23/11 reads in part: 2. After an assessment of the aspiration is completed a plan of care is developed to minimize the risk of aspiration.	F 279		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		

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F 323	Continued From page 4 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure policies and procedures for aspiration precautions and meal services were followed. The facility failed to adequately supervise residents on aspiration precautions that affected three of three residents (R1, R2 and R3) reviewed for supervision in a sample of nine. The facility also failed to identify a resident choking in the dining room, which resulted in R1 dying due to asphyxia and choking from a food bolus. Findings include: R1's nurse progress note by E5 (Licensed Practical Nurse/LPN) reads in part: Late Entry 11/28/2016 [3:53PM] Type: Incident note - 12pm - Res (resident) in dining room, having lunch, in stable condition, no Resp (respiratory) distress noted. 12:30pm - Reported by CNA (Certified Nursing Assistant) to check Res, went to dining room immediately with team 1 nurse and observed Res unresponsive, head was slumped to side, skin cool and pale, one arm was on the table, one arm was down, carotid artery pulse palpable but very weak, unable to take BP (blood pressure), no breath sounds noted, code blue called. Rechecked VS (vital signs), unable to obtain pulse at this time, CPR (cardiopulmonary resuscitation) initiated, 911 called, MD (medical doctor) notified, called brother but no answer, left voice message. 12:40pm - Chicago Fire Dept (department)	F 323		

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arrived. 1:10pm- skin turned pink, started breathing, peripheral pulses palpable. 1:20pm - Sent to [local] ER (emergency room) [4:20pm]- Receive phone call from [local hospital], Res passed away at ER and nurses are trying to talk to brother.

The fire department's report reads in part:
11/28/2016:
Time dispatched - 12:36pm
1st on scene -12:38pm
Patient contact - 12:40pm
Ambulance arrival: 12:50pm
Pt (patient) found lying in 3rd floor dining room, CPR in progress, in care of RN (registered nurse) staff. According to staff, Pt was eating a large piece of sausage which he aspirated. Upon transition of care, CPR was maintained, monitor pads applied, and attempted to ventilate Pt. Pt airway was opened and [forceps] were used to remove several pieces of large sausage from the Pt upper airway and lower airway (beyond the vocal cords).
Incident type- person unconscious not breathing
Cause - Foreign body
Complaint - Unresponsive
Ambulance called to location to find unresponsive 63 year old male on the floor with CPR being performed by [Local Fire Department] truck. Per Truck, patient was eating his lunch in the nursing home and began to choke on food. When truck arrived patient was pulseless and apneic. Truck was able to remove a large amount of the airway obstruction. Patient was in asystole upon arrival. CPR continued and ALS (advanced life support) cardiac arrest protocols initiated.

R1's Hospital records reads in part:
Emergency Physician Evaluation - 11/28/16 -

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F 323	Continued From page 6 Patient is a 63-year-old male brought in by EMS (emergency medical services) from the nursing home in full cardiopulmonary arrest. According to EMS they got a call for a person unresponsive and not breathing. When he arrived they found the patient cyanotic with the staff doing chest compressions. EMS attempted to intubate him and found several large pieces of sausage blocking his airway which they removed with [forceps]. R1's Certificate of Death Worksheet reads in part: Date of death: November 28, 2016 Cause of death: a. Asphyxia b. Choking on food bolus Describe how injury occurred: Choked on food bolus On 12/13/2016 at 3:24pm, E3 (Certified Nursing Assistant/CNA) stated in part, during lunch time, she was in the dining room observing residents. [E4/CNA] was feeding [R4] and when [E4] was done, [E4] said she was going to leave to check if anyone else needed assistance with feeding. E3 stated she said ok, then she stayed in the dining room. [E1/Administrator] came in with a guest [Z1/Administrator in Training] and there were still trays on the table. E3 stated she asked [E1] to watch the residents while she was going to get the food cart to get the rest of the trays that were left in the dining room. E3 stated that [R1] did not have a tray and did not have any food. E3 stated she got the food cart, picked up the trays and told [E1] that she was going to push the trays and cart back to the elevator. E3 stated when she was pushing the cart, that's when all of this happened. [E1] came out the dining room and said [R1] needed help. E3 said she and [E5/Licensed	F 323		

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Practical Nurse/LPN] ran in the dining room. E3 said that [E1] called the nurse and [Z1] was trying to help. [R1] was in distress and needed help. [E5] was sweeping [R1's] mouth. E3 stated she assisted by clearing the tables and helping [R1] to the floor and then wheeled other residents away in the hallway and doesn't know what else happened. E3 stated that she doesn't remember [R1] with any food in the mouth and was not choking.

On 12/14/2016 at 10:16am, E1 stated in part that [E3] and [E6/CNA] took trays out of the table and were putting them in the carts when he found [R1] unresponsive. E1 stated he left [Z1/Administrator in Training] with [R1] and ran to the nurse's station and called [E5] for help. E1 stated that was no food and there was no tray by [R1]. E1 stated that [E3] told him that [E3] was going to put trays in the carts and that's when he stayed in the dining room to introduce [Z1] to the residents. E1 stated that there were no CNA's or nurses at the dining room at the time [R1] was found unresponsive and that he is not clinical. [R1] looked like [R1] was sleeping. E1 stated that [E5] was the first one present in the dining room and code blue was initiated. E1 stated that [R1] left with a pulse and died at the hospital due to cardiac arrest and that this information was from the hospital and [R1's] attending physician (Z2).

On 12/14/2016 at 10:06am, Z1 stated that on that day [11/28], she was touring with [E1] at the dining room and [E1] went over to [R1] who appeared to be unresponsive. [E1] said, sir, sir and ran and got some help. Z1 stated she was left in the room, and tried rubbing [R1's] shoulder, but [R1] was not responsive. Staff came within less than 10 seconds. Z1 stated she did not do

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the Heimlich maneuver or CPR. Z1 stated she has no clue if [R1] was choking because she is not clinical and just knew that [R1] was not responsive. There were no other staff except for [E1] when [R1] was found unresponsive.

On 12/13/2016 at 12:39pm, E5 (LPN) and E8 (LPN) were interviewed. E5 stated in part that her and [E8] were at the nurse's station. E5 stated that [E3] called her, so she and [E8] went to the dining room and found [R1] blue, with face/chin down to the chest, head down and not responding. [R1] was pale and skin was cold. E5 stated that she tried to wake up [R1], tried to clean [R1's] mouth because she saw food in [R1's] mouth, on the table, and on the floor. E8 stated that, [R1] is a big guy, so she held [R1's] head while [E5] was sweeping [R1's] mouth until all the food was out. [R1] was still unresponsive, called code blue. E5 stated this happened about 12:30pm when [E3] was around there and other CNA's were feeding, cleaning tables and helping other residents. While [R1] was still in the chair, [E7/Assistant Director of Nursing] tried doing the Heimlich [maneuver] but was not successful. [R1] was assisted to the floor. Everyone came in to help, tried CPR and called 911.

On 12/14/2016 at 11:58am, E6 (CNA) stated in part that she was assigned to [R1] that day and [R1] was not at risk for choking. E6 stated that only one cart of trays came up. [R1] ate lunch from the first cart. [R1] was done eating, but there were still other residents eating because the other two carts filled with trays came in later. E6 stated she picked up [R1's] tray, and [R1] said he was finished. E6 stated that there was another CNA in the dining room, so she left to go feed another resident. E6 stated while she was

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feeding, she heard the code blue and ran to the dining room.

On 12/13/2016 at 12:39pm, E11 (CNA) stated in part that she was not in the dining room during lunch time the day the incident occurred. E11 stated that her resident was adamant that she give the resident a shower so that is what she was doing at the time.

On 12/14/201 at 3:08pm, E4 (CNA) stated in part that [R1] was not at risk for choking or had aspiration precautions that she knew of. E4 stated that they have to monitor all residents. E4 stated that she went downstairs to bring the carts filled with trays and that's when she heard the code blue. E4 also stated that during lunch, residents were eating polish sausage, vegetables and bread.

E2 (Director of Nursing) provided an interview written statement by E12 (CNA) reads in part: 11/28/2016 "When the tray came up, I passed the tray and gave him his tray. He was in a playful mode and I sat his tray in front of him. There were 3 staff members in the dining room during lunch passing trays. I went and fed a resident after passing out trays and left other staff members in there. After I was done feeding my residents I went back and helped to pick up trays and I noticed the resident sitting up in his chair watching TV (television) with no distress; I did not notice any chewing movements and he was calm looking towards the TV as usual. After we finished picking tray I went down and heard a code blue."

On 12/14/2016 at 1:39pm, E2 stated in part that

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F 323	Continued From page 10 she faxed an initial report to IDPH (Illinois Department of Public Health) on 11/28/2016 before 3pm even though the fax sheet says 1900 (7PM) that "CPR initiated, 911 called. MD (Medical Doctor) notified and ordered to send resident to ER for further evaluation. Notifications made." E2 stated that she responded to the code blue, when she got there, [R1] was being transferred to the floor from the chair. E2 stated she guided and did CPR, they suctioned food particles that looked like meat and mixed vegetables out of [R1's] mouth. The paramedics asked if [R1] was eating, but [R1] said [R1] was done eating. [R1] was on a regular diet, no aspiration precautions. Staff are to observe residents in the dining room, monitor those who gets fed, and make sure if any type of concern occurs that someone is there to address or call appropriate person. E1 stated that no one saw [R1] choke and no one said [R1] was doing the universal sign that [R1] was in distress. [R1's] last speech evaluation was in 2014. Any resident on aspiration precautions, have to make sure, at least can be seen at all times when they are eating. Staff are to visualize what person is doing and must be in sight. Staff should know who they are supposed to look at for those at risk of choking, those who are not eating, those who need cueing, repositioning to upright position, and be mindful and careful, provide comfort and support. E1 also stated that she sent the final report to IDPH on 12/2/2016 at 6:07pm that reads resident who is alert and oriented ...was noted unresponsive. E1 said she spoke with the physician who stated with co-morbidities, [R1] had a cardiac arrest. E1 stated that she did not mention to [Z2] that [R1] had food in [R1's] mouth.	F 323		

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On 12/14/2016 at 12:37pm, E7 (Assistant Director of Nursing) stated in part that she heard a code blue called, [R1] was in the dining room, unresponsive, CPR initiated. E7 stated she did not do the Heimlich maneuver. E7 stated in part that she didn't think [R1] was on aspiration precautions. E7 stated that for those on aspiration precautions, staff are to monitor them, supervise during meals, make sure no signs of aspiration. The expectations are for staff to continuously monitor, supervise and usually someone is in the dining room doing this. If patient refuses to go to the dining room, then staff need to monitor by staying close by and provide supervision where staff can see the patient. If someone is choking, nurses are to perform the Heimlich maneuver and try to help that patient. Patient's usually give a universal sign of choking.

On 12/14/2016 at 2:05pm, Z2 (Attending Physician) stated in part that they called her and the nurse said [R1] was unresponsive and called 911. Z2 stated that she received a fax from the hospital saying that [R1] had a cardiac pulmonary arrest. Z2 stated that her office cannot find the fax. Z2 stated that [R1] was diabetic, hypertensive and had MS (multiple sclerosis). [R1] may have had history of dysphagia, but she did not know of any recent problems. [R1] may be on aspiration precautions, and that should be done for all residents in a nursing home. Z2 stated that she was shocked when the staff said [R1] was unresponsive. Z2 stated that staff did not tell her anything about any food found in [R1's] mouth. If staff did tell her, then [R1] could have aspirated. If there was food, they would see [R1]choking on food and staff could have performed the Heimlich maneuver. Z2 stated that those on aspiration precautions, staff are to watch

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F 323	Continued From page 12 them eat, encourage to eat slowly, and not very fast. On 12/13/2016 at: -11:24am, R5 stated in part that he was in his room and [R1] was eating in the dining room. [R1] either had a heart attack or was eating too much. [R1] is deceased. -11:30am, R6 stated in part that [R1] was his roommate and [R1] died. [R1] was in the dining room during lunch and staff told him that [R1] was eating and choked. -12:25pm, R7 stated in part that she was eating in the dining room and [R8] was eating by [R1]. R7 stated [R1] was at the table behind her and someone said [R1] was turning blue. Multiple other residents were interviewed and stated they did not witness anything in the dining room. R1's November 2016 Physician Medication Review Report reads in part: Diagnoses - Multiple Sclerosis, obesity, and dysphagia, oropharyngeal phase Diet order summary: NAS (no added salt)/NCS (no concentrated sweets), regular texture, thin consistency R1's MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 9/9/2016 shows that R1 needs supervision and one person physical assist for eating. R1's Interdisciplinary Plan of Care reads in part: 9/19/16-Concern - The Resident's Nutritional Status is/may be potentially compromised, and is / may be at risk for weight loss r/t (related to) Dx (diagnoses) and order for therapeutic diet.	F 323		

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Interventions: Aspiration precautions
9/7/16 - Needs/Problem - Impaired swallowing related to Dysphagia
Goals - Will have no choking episodes with eating
Will have no s/s (signs and symptoms) of aspiration - 12/7/16

On 12/13/2016 at:
-11:47am, R2 was eating lunch in R2's room near the back wall, with no staff present. R2 was not visible from the nurse's station and hallway. During continuous observation until 11:57am, there were no staff members watching R2. At this time, E8 (LPN) followed the surveyor in R2's room. E8 asked R2 if R2 needed anything. R2 had consumed 75% of the meal. E8 left the room.
-11:59am, R3 was sliding down in bed, the head of the bed not at a 90 degree angle (approximately 45 degrees), with the over the bed table in front of R3. R3 was eating lunch in the room with no staff present, feeding self without utensils.
-12:05pm- R2 was still in the room, drinking soup, with no staff watching R2.
-12:06pm - E11 walked out of R3's room and said in part that [R3] was not done eating yet, she just checked and [R3] still eating. R3 was not repositioned and was not sitting upright in a 90 degree angle.
-12:08pm- R2 was still in room, slight cough while drinking milk with no staff watching R2.
-12:12pm- R3 was in the same position, using fingers and hand to finish eating beans, and then drank the juice from the fruit cup. During continuous observation until 12:21pm, E11 walked in to pick up R3's tray. E11 stated in part that [R3] gets out of bed for meals on Mondays, Wednesdays and Fridays. Today is Tuesday, so

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F 323	Continued From page 14 [R3] stays in bed. -5:22pm - dinner arrived. R2 and R3 were in the dining room. R3 was facing towards the window (north) and R2 was at the same table facing east. Staff were passing out trays. -5:29pm, E9 (Restorative CNA) was the only staff member present in the dining room, with R3's back facing towards E9's view. -5:48pm, E12 (CNA) walked in the dining room stated in part that there's usually one CNA who does not have feeders, so today it would be her in charge of watching the dining room. The surveyor asked E12 why she was not at the dining room monitoring residents during dinner. E12 responded, "I was passing out trays." From 5:30pm - 5:50pm, there were four times when there were no staff members present while 15 residents were eating in the dining room, and no staff members were looking in at neither 4 doors of the dining room. E9 was feeding R4, but repeatedly left the dining room. While E9 was feeding R4, E9 was sitting at the south end of the room, where there was a wall obstructing her view of R2 and R3. At 5:50pm, there was no one in the dining room. R3 was drinking milk and R2 finished dinner. R2 asked the surveyor, "can you help me get out of here?" The facility's "Diet Type Report" dated December 13, 2016 reads in part: R2 - NAS/NCS, mech (mechanical)/soft, thin liquids, Additional directions: Aspiration precaution R3 - NAS, mechanical soft, thin liquids, additional directions - 1:1 supervision R2's MDS with ARD of 10/13/2016 shows that R2 needs supervision and one person physical assist for eating.	F 323		

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F 323	Continued From page 15 R2's Comprehensive and Interdisciplinary Plan of Care does not address aspiration precaution interventions and goals as ordered by the physician. R2's Physician Medication Review Report dated 12/13/2016 reads in part: Diet Order Summary - Aspiration precaution R3's Physician Medication Review Report dated 12/13/2016 reads in part: Diagnoses: Gastro-esophageal reflux disease, dementia, dysphagia R3's MDS with ARD of 9/16/2016 shows that R3 supervision and one person physical assist for eating and has an active diagnosis of Dysphagia, oral phase. R3's Interdisciplinary Plan of Care of Nutrition reads in part: 9/16/16: Interventions - Position resident for meals upright Reminders to clear food in cheeks Supervision/cues/encouragement Needs/Problem - At risk for aspiration R/t (related to) Hx (history) of aspiration PNA (pneumonia) Approaches - 3. Assess for coughing or clearing of the throat after a swallow 6. Position resident in upright position for meals 9. Allow ample time for swallowing On 12/20/2016 at 11:06am, Z3 (Speech Therapist) stated in part that [R1, R2 and R3] have dysphagia and on aspiration precautions. Any resident on aspiration precautions should eat in the dining room with supervision. Staff should be looking for any signs of having difficulty swallowing, to make sure residents are taking	F 323		

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small bites and small sips, and not eating too fast. If any resident is seen coughing during meals, then she is called to evaluate the patient because coughing is an overt sign that something might be going on.

On 12/20/2016 at 10:35am, E1 (Administrator) stated in part that there should always be at least one to two staff members assigned to supervise the dining room whose role is to only supervise and not do other tasks such as pass out trays or feed residents.

The facility's policy and procedure titled, "Aspiration Precautions" dated 02/23/11 reads in part: Aspiration is a common problem among the residents who have difficulty swallowing or dysphagia. Aspiration mean food or fluids that should go into the stomach go into the lungs instead. When such material goes into the lungs it can cause Aspiration Pneumonia. Aspiration Pneumonia can worsen quickly if not properly identified and treated. It is important for signs of aspiration be identified.
Procedure:
2. After an assessment of the aspiration is completed a plan of care is developed to minimize the risk of aspiration. 3. Residents that have been assessed to be a risk of aspiration will be monitored on a regular basis.

The facility's policy and procedure titled, "Meal Service" dated 08/11/11 reads in part: It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs including meal service and assistance with eating. 8. Residents will be monitored for appropriate positioning, diet consumed, food preferences and feeding

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F 323	Continued From page 17 assistance...	F 323		
F 514 SS=D	0. 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 514		

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F 514	Continued From page 18 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a medical record accurately document what occurred when a resident was found unresponsive with food in the mouth and airway. These failures affected one of four residents (R1) reviewed for accuracy of medical records in a sample of nine. Findings include: On 12/13/2016 at 12:39pm, E5 (Licensed Practical Nurse/LPN) and E8 (LPN) were interviewed. E5 stated in part that she was the nurse for R1. E5 stated that she and [E8] were at the nurse's station. E5 stated that [E3] called her, so she and [E8] went to the dining room and found [R1] blue, with face/chin down to the chest, head down and not responding. [R1] was pale and skin was cold. E5 stated that she tried to wake up [R1], tried to clean [R1's] mouth because she saw food in [R1's] mouth, on the table, and on the floor. E8 stated that, [R1] is a big guy, so she held [R1's] head while [E5] was sweeping [R1's] mouth until all the food was out. [R1] was still unresponsive, called code blue. E5 stated this happened about 12:30pm when [E3] was around there and other CNA's were feeding, cleaning tables and helping other residents. While [R1] was still in the chair, [E7/Assistant Director of Nursing] tried doing the Heimlich [maneuver] but was not successful. [R1] was	F 514		

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assisted to the floor. Everyone came in to help, tried CPR and called 911.

R1's nurse progress note written by E5 reads in part:
Late Entry
11/28/2016 [3:53PM] Type: Incident note - 12pm - Res (resident) in dining room, having lunch, in stable condition, no Resp (respiratory) distress noted. 12:30pm - Reported by CNA (Certified Nursing Assistant) to check Res, went to dining room immediately with team 1 nurse and observed Res unresponsive, head was slumped to side, skin cool and pale, one arm was on the table, one arm was down, carotid artery pulse palpable but very weak, unable to take BP (blood pressure), no breath sounds noted, code blue called. Rechecked VS (vital signs), unable to obtain pulse at this time, CPR (cardiopulmonary resuscitation) initiated, 911 called, MD (medical doctor) notified, called brother but no answer, left voice message.
12:40pm - Chicago Fire Dept (department) arrived. 1:10pm- skin turned pink, started breathing, peripheral pulses palpable. 1:20pm - Sent to [local] ER (emergency room)
[4:20pm]- Receive phone call from [local hospital], Res passed away at ER and nurses are trying to talk to brother.

On 12/20/2016 at 2:02pm, E2 (Director of Nursing) stated in part that the progress note by [E5] was the only documentation regarding the incident in [R1's] medical record.

The fire department's report reads in part:
11/28/2016:
Time dispatched - 12:36pm
1st on scene -12:38pm

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F 514	Continued From page 20 Patient contact - 12:40pm Ambulance arrival: 12:50pm Pt (patient) found lying in 3rd floor dining room, CPR in progress, in care of RN (registered nurse) staff. According to staff, Pt was eating a large piece of sausage which he aspirated. Upon transition of care, CPR was maintained, monitor pads applied, and attempted to ventilate Pt. Pt airway was opened with forceps were used to remove several pieces of large sausage from the Pt upper airway and lower airway (beyond the vocal cords). Incident type- person unconscious not breathing Cause - Foreign body Complaint - Unresponsive Ambulance called to location to find unresponsive 63 year old male on the floor with CPR being performed by [Local Fire Department] truck. Per Truck, patient was eating his lunch in the nursing home and began to choke on food. When truck arrived patient was pulseless and apneic. Truck was able to remove a large amount of the airway obstruction. Patient was in asystole upon arrival. CPR continued and ALS (advanced life support) cardiac arrest protocols initiated. R1's Hospital records reads in part: Emergency Physician Evaluation - 11/28/16 - Patient is a 63-year-old male brought in by EMS (emergency medical services) from the nursing home in full cardiopulmonary arrest. According to EMS they got a call for a person unresponsive and not breathing. When he arrived they found the patient cyanotic with the staff doing chest compressions. EMS attempted to intubate him and found several large pieces of sausage blocking his airway which they removed with [forceps].	F 514		

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F 514	Continued From page 21 R1's Certificate of Death Worksheet reads in part: Date of death: November 28, 2016 Cause of death: a. Asphyxia b. Choking on food bolus Describe how injury occurred: Choked on food bolus The facility's policy and procedure titled, "Medical Records Access" dated 07/2012 reads in part: The facility maintains clinical records on each resident in accordance with acceptable professional standards and practices that are complete, accurate, readily accessible, and systematically organized.	F 514		