STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E322	A. BUILDING _____ B. WING _____	C 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	3614 NORTH ROCHELLE PEORIA, IL 61604

(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 Complaint Investigation 1720730/IL91600	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1	F 157		

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to notify the physician of a choking incident and subsequent change of condition for three hours for one of three (R1) residents reviewed for notification of change in condition in the sample of three.

Findings include:

The Facility "Change of Condition Policy and Procedure" documents in part, "The facility shall promptly notify the resident, his/her physician, and representative of changes in the resident's condition...The Nurse will notify the resident's attending physician or on-call physician when there has been: an accident or incident involving the resident...need to alter the resident's medical treatment significantly; a need to transfer the resident to a hospital/treatment center..."

On 2/8/2017 at 3:15PM E9 Certified Nurse Aide (CNA), stated, "I was passing meal trays. I

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F 157	Continued From page 2 passed by (R1) who started to cough. I came over and did the Heimlich. It was about 6:15 or 6:20PM. R1 had a regular (consistency) tray... (E10) Registered Nurse came over while I was doing the Heimlich and looked at him and in his mouth." On 2/8/2017 at 3:25PM E10 stated, "I was in the dining room passing med's. I didn't notice anything until (E9) CNA was leaning over (R1) looking concerned. I went over and checked on him. I didn't ask E9 what happened. I didn't think R1 had choked so I didn't do an assessment, call the doctor or tell the oncoming nurse. I was only (working) for 10-15 minutes after the incident." R1's Nursing Progress Notes dated 2/5/2017 at 9:47PM E7 Registered Nurse (RN) documented, "Resident choked on a brat at supper. (Certified Nurse Aide) CNA performed Heimlich maneuver. Resident continued to produce copious amounts of phlegm, (complained of) difficulty breathing. Send to Proctor (Emergency Department) per (Doctor's) Order." On 9/9/2017 at 11:15AM E11, R1's Physician and facility Medical Director, stated he could not give direction or orders for R1 after the choking incident because he was not notified. E11 states, "I rely on the Staff to let me know when these things happen or I cannot be of any help to the resident."	F 157		
F 363 SS=G	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must-	F 363		

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F 363	Continued From page 3 (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed follow their policy by not using tray cards to ensure correct diets are followed for one of three residents (R1) reviewed for therapeutic diets in the sample of 12. This failure resulted in R1 being served the wrong diet, choking and requiring hospitalization for aspiration pneumonia. Findings include: The facility policy for "Resident Tray Identification Card" documents, "Purpose: to identify the resident's diet and food preferences in order to ensure correct meal service...the resident tray	F 363		

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F 363	Continued From page 4	F 363		

identification card will contain at least the following information: Resident name, room number, diet as ordered by the physician, resident dislikes, special items to be served: either by the resident request or per care plan approaches, adaptive equipment and dining location."

The Facility policy "Feeding the Impaired Resident" documents, "Purpose: The primary purpose for feeding an impaired resident is to provide the resident who needs assistance with eating a well-balanced diet. Key Procedural Points:...Make sure the right tray is served to the right resident...Be observant during the feeding process. Watch for signs of choking or anything unusual..."

An Incident Report for R1 on 2/5/2017 at 6:30PM documents, "Resident choked on a bratwurst at dinner. Certified Nurse Aide (CNA) performed Heimlich and meat expelled."

On 2/8/2017 at 3:15PM E9 Certified Nurse Aide (CNA), stated, "I was passing meal trays. I passed by (R1) who started to cough. (R1) couldn't speak and was drooling. I did the Heimlich several times. I swiped his mouth and took out a quarter-size piece of meat. It was about 6:15 or 6:20PM. R1 had a regular (consistency) tray... (E10) Registered Nurse came over while I was doing the Heimlich and looked at him and in his mouth...Sometimes we use the tray cards and sometimes we don't. We did not use the tray cards on Sunday (2/5/2017)."

The Hospital Emergency Department notes dated 2/5/2017 at 10:12PM document, "(R1)...presenting to the emergency department

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F 363	Continued From page 5	F 363		

due to choking. Patient was sent here from (Facility). Per (Emergency Responders) EMS patient was eating around 5:00PM tonight when choked on a piece of meat."

R1's 2/6/2017 Nursing progress notes at 1:04AM document, "(R1) being admitted to (hospital) due to Aspiration Pneumonia."

R1's current Physician's Orders documents R1's diet as "Mechanical Soft Diet."

R1's Tray/Diet card documents R1 is to receive a "Mechanical Soft diet."

R1's Care Plan developed 4/18/2016 documents, "The resident has a diagnosis of Dysphagia, is on a Mechanical Soft Diet." The goal is documented, "The resident will remain free of injury related to aspiration that requires hospitalization." The Care Plan interventions are listed as: "Diet to be followed as prescribed, Monitor for shortness of breath, choking, labored respirations, lung congestion. Monitor/document/report (as needed) any (signs and symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing...appearing concerned during meals."

On 2/7/2017 at 5:45PM, E2 Assistant Director of Nursing (ADON) stated, "Sunday night (2/5/2017) the Staff did not use the Tray cards on the trays."

On 2/7/2017 from 12:10 - 12:45PM and again from 6:00 - 6:45PM an observation of the meal service: A CNA standing outside the meal serving window pulled a resident's tray card for a resident seated and waiting in the dining room.

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F 363	Continued From page 6 The cook inside the kitchen would then be told by the CNA what diet to serve: Mechanical soft, General, double portions, no gravy, etc. The cook then prepared the tray as requested without visualizing the tray card. In the mean time, if a resident left the dining room or wanted a substitution, the tray and card would be brought back to the CNA with the tray cards and the tray was assigned to another resident with a General, Mechanical soft diet by the CNA near the serving window. Meals served for R1 - 15 were observed during both meals. On 2/8/2017 at 11:20AM E5 Dietary staff, who prepared food on the meal trays 2/5/2017, stated, "The CNAs (Certified Nurse Aides) outside the window pull the (tray) cards for the resident's sitting in the dining room and ready to eat. They try to pull the Special diets first, then Mechanicals then the General, then the puree when the CNAs are available to watch/assist them to eat. The CNAs don't say who the tray is for but the CNAs say what diet should be served and if they need double portions or a sub." On 2/8/2017 at 11:20AM, E4 Dietary Manager for the nursing Complex states, "All residents have a tray (diet) card. The Tray cards are in the kitchen and the dietary staff are to use the cards to set-up each tray for each resident then send the tray out to be delivered. There is no way for the cook to serve according to the tray cards for likes, dislikes, allergies, special needs if they do not see the tray card."	F 363		