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S 000	Initial Comments Compliant Investigation 1863647/IL103159 300.1230 b)d)1)2)j)5)l)1-6) Complaint Investigation 1863804/IL 103328 300.690 b)c) 300.1210a)b)d)6) 300.2040b) 300.3240a)	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 Section 300.690 Incidents and Accidents 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. c) The facility shall, by fax or phone, notify the 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 300.695, 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	S9999	Attachment A Statement of Licensure Violations	

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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.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following

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S9999	Continued From page 2 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 300.2040 Diet Orders b)Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements WERE NOT met as evidenced by: Based on observation, interview and record review, the facility failed to serve diets in the right consistency for one resident (R5). This failure resulted in R5, with a known history of choking, being served a diet that was not cut into bite size pieces as ordered. R5 choked and ultimately died of anoxia (lack of oxygen to the brain) from the choking incident. The facility also failed to notify Illinois Department of Public Health for this serious incident. R5 was one of three residents reviewed for	S9999		

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therapeutic diets in the sample of 46.

Findings include:

The Physician Order Sheet (POS) dated May 2018 lists the following diagnoses for R5: Choking, Pneumonitis due to inhalation of other solids and liquids, Dysphagia, Oropharyngeal Phase and Food in Pharynx causing asphyxiation, initial encounter 3/13/18. The same POS has the order for R5's diet to be Low Concentrated Sweets (LCS), thin liquids/Regular and Special Instructions: Staff to cut up food into bite size pieces.

R5's Progress Note dated 3/13/18 at 11:30 AM documents "(R5) downstairs in sports lounge room eating a chicken dinner. At this time restorative aide came into room and noted (R5) eating chicken and (R5's) face and lips cyanotic. (R5) continued to eat chicken, no coughing noted. Restorative aide performed the (abdominal thrust maneuver) and loosened food and called first floor nurse and a code was initiated." Progress note dated 3/14/18 at 1:11 PM for R5 states " received new order for mechanical soft diet with thin liquids per (V26), Speech Language Pathologist due to choking."

R5's assessment titled Minimum Data Set (MDS) dated 3/25/18 states R5 is cognitively intact, requires setup help with one person physical assist and has a swallowing disorder with the signs and symptoms of coughing or choking during meals or when swallowing medications.

R5's Speech Therapy Daily Treatment Note dated 4/12/18 documented by V26 states: " Recertification documentation completed. (R5) educated regarding : diet upgraded to regular

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solids and need for small bites. Educated nursing staff regarding : diet order for small bites and prepared meals. Staff verbalized understanding. Diet order written."

R5's dietary tray card documents for every meal the following information : "Other: Cut up food into bite size"

R5's Progress note dated 5/20/18 at 7 PM reads : "(R5) was found in the dining room unresponsive, no pulse, not breathing. (R5) had choked on food and had a lot in (R5) throat. Started CPR (cardiopulmonary resuscitation), called 911 and was doing chest compression and hooked up defibrillator and was advised no shock. Continued compressions till ambulance arrived. Inserted 18 gauge to right arm with 2 rounds of epinephrine given. Ambulance personnel hooked up there own defibrillator and took (R5) to hospital. Notified the doctor."

R5's table mate R15, who MDS dated 4/9/18 documents R15 is cognitively intact, stated on 6/13/18 at 10:17 AM "I sit with (R5) at the table in the dining room. (R5) was used to eating very fast. (R5) was usually done with eating before we received our trays. (R5's) food was not cut up into small pieces, I would of remembered that. No staff was around (R5). No employee came over and prepared (R5's) plate. (R5) was eating fast and got too much food in (R5s) mouth and started choking. I had yelled and got someone's attention that (R5) was choking. (R5) was unresponsive, one of the CNA's (certified nursing assistant) called 911 and I remember the fireman and policemen got there fast. They worked on (R5). (R5) was unresponsive when the staff put (R5) on the floor."

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V26, Speech Language Pathologist stated on 6/13/18 at 1:55 PM " The facility restorative nurse (V62) and myself educated the CNA's for (R5) diet . If (R5) received regular textured food always cut the food into small pieces because (R5) tends to eat fast. I always individually train the staff on how to set up the meal tray for residents. (R5) always needed to have small bites. I expected the staff to cut (R5's) food into small pieces. That was the order. My expectations was for the staff to cut up (R5's) food as they were all trained to do so. (R5's) Pizza should of been cut up into bite size pieces because this was regular textured food. This information for (R5's) food to be cut up into bite size pieces should be on (R5's) care plan because it was the order."

V39, CNA stated on 6/13/18 at 3:43 PM "We were in the dining room 3 of us CNAs were passing trays to the residents. We were passing trays and (R5's) table mate (R15) called loudly to get our attention for (R5). Me and (V43) CNA went there and saw (R5) sitting in the chair not responding and not saying a word. The resident had a pizza wedge with sausage and cheese for the meal. I did not notice if it was cut up. I did not pass (R5's) tray. We was trained by therapy and restorative nurse to cut (R5's) food into small pieces. I was not the one who passed (R5s) tray. (V43) was the one who called 911. Staff (nurses) started CPR they laid (R5) on the floor."

V37, LPN stated on 6/12/18 at 4:29 PM "The CNAs were in the dining room passing trays, I had been working with a new nurse (V60, LPN) so I found her and asked her to go get help for V8, RN (Registered Nurse) who was doing CPR on (R5). I don't remember if (R5's) food was bite size we pulled lots of food out of (R5's) mouth

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and throat, the ambulance driver arrived and put a tool down (R5) and pulled out lots more of food. (R5) eats really fast (R5) and will stuff her mouth full. You really need to sit by (R5) when (R5) eats. I had a feeling it was going to happen to (R5)."

On 6/13/18 at 3:29 PM V42, Licensed Dietician verified R5 was served a pizza wedge and stated, "(R5) was on regular thin liquid diet with special instructions to cut regular textured food into bite size pieces. My expectation is the CNA staff who delivers the tray is to cut up residents food into the bite size pieces. The dietary staff only prepares special diets. They do not cut up the food into pieces."

V17, Head Dietary Cook stated on 6/14/18 at 9:02 AM " The kitchen does not cut up residents food. We only prepare the special diets like pureed, mechanical soft. The CNAs serving the trays to the residents are responsible to prepare the trays for the residents. Pizza would be placed on the tray in slices not cut up."

V26, Speech Pathologist stated on 6/14/18 at 8:50 AM "Staff in the dining room on 2nd floor were responsible to prepare (R5's) tray. CNAs should cut up (R5's) food. "

V8, RN (Registered Nurse) stated on 6/15/18 at 8:40 AM I was not the nurse who was taking care of (R5) but I was up at the medication cart and another nurse (V60) who was brand new came and told me they needed help in the dining room because there was a resident who needed help. I saw V39, CNA waving her arms and yelled 'hurry'. I found (R5) slumped over in her chair, (R5) was not breathing and no pulse and (R5's) color was very gray. I immediately placed (R5) on the floor and started CPR. I yelled at other staff to get me

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the equipment and told someone to call 911. I did 20 minutes straight of compression and was then relieved by the emergency crew. (R5) had a pulse when the emergency crew left for the hospital . I tried to sweep food from (R5's) mouth but was not able to because of doing compressions. When the emergency crew arrived they had to remove food from (R5) with a clamp of some type because they were not able to intubate (R5). This happened twice. They removed a large amount of food from (R5's) mouth. I did not see any food cut up and I did not look at (R5's) tray. There is never enough staff for all the residents that require assist with eating. More residents need assist than we have staff available. (R5) should have not died."

R5's care plan dated 3/30/2018 does not address R5's eating requirement per speech pathologist requests and doctor's order for R5 to have all regular textured food cut up into bite size pieces. V48, Care Plan Coordinator confirmed on 6/13/18 at 11:15 AM R5's care plan did not address choking incident on 3/13/18 and did not state R5's food needed to be cut up into bite size pieces.

R5's hospital report titled "Discharge Summaries-Medical Death Summary" dated 5/24/18 states "Cause of Death: Perimortem Circulatory Collapse. Admission Diagnosis: s/p (status post, condition after) Respiratory Arrest, Intubated, Concerns for Aspiration Pneumonia. Active Hospital Problem: Cardiac Arrest, Anoxic Brain Injury, Cardiogenic Shock and Acute Respiratory Failure with Hypoxia."

V38, Medical Doctor (R5's) Attending Physician Hospital stated on 6/13/18 at 12:35 PM. "(R5's) death was cardiac arrest from choking. Choking is what caused (R5) to have anoxic brain injury

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S9999	Continued From page 8 and respiratory failure with hypoxia, (R5) choking that is what lead to (R5's) death." V2, Director of Nurses confirmed on 6/12/18 at 1:20 PM " I did not report this incident to IDPH (Illinois Department of Public Health)". (A) Licensure Finding 2 of 2 Section 300.1230 b)d)1)2)j)5)I)1-6) Direct Care Staffing b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day. d) Each facility shall provide minimum direct care staff by: 1) Determining the amount of direct care staffing needed to meet the needs of its residents; and 2) Meeting the minimum direct care staffing ratios set forth in this Section. j) Skilled Nursing and Intermediate Care For the purpose of this subsection, "nursing care" and "personal care" mean direct care provided by staff listed in subsection (f). 5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act)	S9999		

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S9999	Continued From page 9 l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used: 1) The facility shall determine the number of residents needing skilled or intermediate care. 2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category. 3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility. 4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period. 5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act. 6) The amount of time determined in subsections (l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census.	S9999		

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S9999	Continued From page 10 This requirement is not met as evidenced by: Based on record review and interview, the facility failed to meet minimum staffing requirements for direct personal care for three of the 14 consecutive days reviewed. This failure has the potential to affect all 120 residents residing in the facility. Findings include: On 6/13/18, V1 Administrator provided a staffing spreadsheet and corresponding working schedules dating 5/29/18 through 6/11/18. The staffing spreadsheet documents an average daily census of 34.57 skilled residents and 86.93 intermediate care residents for a total average daily census of 121.5 residents. The staffing requirement calculation for this census requires the facility to have a minimum of 348.69 hours of direct care staff per 24 hour period. The staffing spreadsheet and working schedule document the following staffing failures: On 6/3/18 the spreadsheet documents a total of 343.40 hours of direct care, a shortage of 5.29 hours. On 6/9/18 the spreadsheet documents a total of 309 hours of direct care, a shortage of 39.69 hours. On 6/10/18 the spreadsheet documents a total of 222.42 hours of direct care, a shortage of 126.27 hours. On 6/14/18 at 10:56 AM, V1 acknowledged the facility was short on the above three days. The above calculated hours on 6/3/18, 6/9/18 and	S9999		

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S9999	Continued From page 11 6/10/18 include allowable therapy hours and licensed nursing staff hours. The Facility Data Sheet dated 6/11/18 documents a census of 120 residents residing in the facility. (AW)	S9999		