Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008593	A. BUILDING: ____ B. WING ____	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE AT THE LAKE,THE	2534 ELIM AVENUE ZION, IL 60099

(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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)2) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/30/18

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S9999	Continued From page 1	S9999		

that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidenced by:

Based on observation, interview and record review the facility failed to provide supervision during a meal to a resident (R136) with a history of choking. The facility failed to safely transfer a resident (R82).

This resulted in R136 choking during a meal, requiring CPR (cardiopulmonary resuscitation), and subsequent hospitalization with tracheostomy (trach) and gastrostomy tube (G-tube) placement.

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S9999	Continued From page 2	S9999		

This applies to 1 of 19 residents (R136) reviewed for supervision during meals in the sample of 33 and one resident (R143) outside the sample.

The findings include:

1. R136's Care Plan dated September 30, 2016 and revised August 2, 2017 showed, "SWALLOWING PROBLEMS The resident demonstrates some risk to potentially choke or aspirate food or liquids. This problem is related to diagnosis of dysphagia... Observe resident during mealtimes for any signs and symptoms of aspiration, coughing, throat clearing, drooling, holding food in mouth (pocketing), prolonged swallowing time, repeated swallows per bite or difficulty swallowing..."
R136's Progress Note dated February 15, 2017 at 6:08 PM, showed R136 choked on a hot dog while in the dining room, requiring the Heimlich maneuver. R136 was sent to the hospital for an evaluation.
R136's Progress Note dated March 23, 2017 at 12:41 PM, showed R136 had a second choking episode in the dining room requiring the Heimlich maneuver.
A facility Incident Report dated February 23, 2018 at 6:00 PM showed R136 had a third choking episode. The report showed V18 Certified Nursing Assistant (CNA) notified V12 Licensed Practical Nurse (LPN) that R136 was having difficulty breathing while in the third floor dining room. V12 LPN "observed food" in 136's mouth and attempted to remove the food. R136 became unresponsive as the Heimlich maneuver was being done. A "Code Blue was called" and CPR was started on R136. R136 was taken by ambulance to a local hospital.
R136's hospital History and Physical Report

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S9999	Continued From page 3	S9999		

dated February 26, 2018 showed, "It appears (R136) aspirated at the nursing home and had a respiratory arrest..." The report showed that R136 had a bronchoscopy while hospitalized which showed "food particles were extracted from the bronchi..." R136 had a tracheostomy surgically placed on March 6, 2018 due to "worsening respiratory status".
R136's Order Summary Report dated July 10, 2018 showed physician orders for tracheostomy care and enteral feeding with R136 being NPO (nothing by mouth).

On July 9, 2018 at 10:18 AM, R136 was lying in bed, watching television. R136 had a tracheostomy in place connected to humidified oxygen via a trach mask. An enteral feeding pump was noted next to R136's bed.

The facility's nursing schedules dated February 23, 2018, showed V12 LPN, V16 LPN, V13 CNA, V14 CNA, V15 CNA, and V18 CNA were the staff working the evening shift on the third floor when R136 choked in the dining room.
On July 12, 2018 at 9:30 AM, V1 Administrator stated V12 and V16 LPN, V13-V15 CNA, and V18 CNA were the only staff working on the third floor on February 23, 2018 when R136 had a choking episode. Based on interviews of all staff working on the third floor on the evening of February 23, 2018, no staff member stated they were the actual person to find R136 choking.
On July 10, 2018 at 1:45 PM, V12 LPN stated that on February 23, 2018, during dinner time, she and V16 LPN were seated at the third floor nurses station when a "CNA wheeled (R136) to me in a wheelchair, saying she was having trouble breathing. I can't remember who the CNA was. (R136) was pale, not talking. I could tell she was choking on something. We wheeled

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S9999	Continued From page 4 (R136) down to her room and put her on the bed. I looked in her mouth and saw food. I did a finger sweep and pulled out pieces of meat. I checked for a pulse, she did not have one and was not breathing so I started CPR right away...I am not sure if (R136) was at risk for choking or had choked before..." V12 LPN stated neither her nor V16 LPN were in the dining room when R136 was choking. On July 11, 2018 at 10:00 AM, V18 CNA stated that she was not the staff member that found R136 choking in the dining room on the evening of February 23, 2018. V18 stated she was not even in the dining room. V18 stated, "I was passing meal trays in the hall. I saw a female CNA wheeling (R136) to the nurse's station, stating she (R136) couldn't breathe. I don't know who the female CNA was... I helped take (R136) to her room and get her into bed.... I was not aware that (R136) was at risk for choking." On July 11, 2018 at 11:06 AM, V13 CNA stated on the evening of February 23, 2018, "I was passing trays in the hallway so I was not in the dining room when (R136) choked." On July 11, 2018 at 11:31 AM, V14 CNA stated he was not in the dining room on the evening of February 23, 2018 when R136 choked. V14 CNA also stated he was not sure if R136 was at risk for choking prior to the incident. On July 12, 2018 at 9:25 AM, V15 CNA stated on the evening of February 23, 2018, "I was not in the dining room when (R136) choked. I was out in the hallway." On July 12, 2018 at 9:15 AM, V17 (Physician) stated, "Any resident with a history of choking or dysphagia should be under direct supervision of staff when eating. I feel that any residents with a history of choking or aspiration precautions should be seated at a table together with at least 1-2 aides seated with them while they are eating."	S9999		

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2. R143's Care Plan dated June 1, 2018 showed R143 had a diagnosis of dysphagia and swallowing difficulties. One of R143's Care Plan Goals showed R143 "will not have any episode of choking or aspiration through next review... Provide/serve the resident's nutritional diet as ordered. Prescribe diet is renal, puree, nectar..." R143's Order Summary Report dated July 11, 2018 showed an order for a pureed diet. R143's Minimum Data Set dated July 6, 2018 showed R143 required extensive assistance of one person for eating.

On July 11, 2018 at 11:55 AM, R143 was seated in the second floor dining room, feeding herself a mechanical soft diet of beef, rice, and pineapple. The dietary card on R143's tray showed R143 was served a mechanical soft diet. Three CNA's were passing lunch trays to residents. No staff were sitting next to or assisting R143 with eating. At 12:15 PM, R143 remained at the dining room table, feeding herself pineapple with no assistance. One CNA remained in the dining room, as she was picking up lunch trays with her back turned to R143.

On July 11, 2018 at 12:15 PM, V29 CNA/Guest Relations stated, "(R143) feeds herself. Residents are served diets based on what diet is listed on their dietary card."

On July 16, 2018 at 11:36 AM, V1 Administrator stated the facility does not have a policy on monitoring residents at risk for choking or with aspiration precautions during meals.

(A)