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
	IL6016729	A. BUILDING: ______ B. WING ______	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY GARDENS NSG & REHAB	212 AIRPORT ROAD NORTH AURORA, IL 60542

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S 000	Initial Comments Complaint Investigation # 1971674/ IL110197	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)2)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility 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.	S9999	Attachment A Statement of Licensure Violations	

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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:
2) All treatments and procedures shall be administered as ordered by the physician.
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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to implement interventions to supervise a resident with identified risk for aspiration of food.

This failure resulted in the choking death of R1.

This applies to 1 of 5 residents (R1) reviewed for altered diets and supervision while eating, in the sample of 7.

The findings include:

According to the Progress Notes in the facility electronic medical record, R1 was admitted to the facility on March 4, 2019 with diagnoses including, but not limited to fracture of nasal bones, history of falling, gastro-esophageal reflux

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disease with esophagitis, unspecified dementia with psychosis, diverticulum of esophagus acquired, and dysphagia. Additionally, R1's most recent Brief Interview for Mental Status was done in November of 2018 and showed a score of 3, significant cognitive and memory impairment.

The facility incident investigation "Reportable Form" dated March 9, 2019 shows R1 and R2 were seated at the lunch table at the beginning of lunch service, when R2 alerted staff that R1 was in distress. A staff member responded, starting Heimlich maneuver. R1 became unresponsive as the Nurse took over continuing Heimlich thrusts. The Nurse then attempted to obtain vital signs, finding no pulse or respirations. R1 did have a Do Not Resuscitate (DNR) order, so further Cardiopulmonary Resuscitation (CPR) was not done.

On March 13, 2019 at 9:52 am, V17 (Coroner's office) stated he worked on the autopsy of R1. V17 stated he found the throat "packed" with solid white meat. V17 went on to state R1 had a Zenker's diverticulum (a deformation of the esophagus which forms a pouch-like structure) that was also packed with "solid food." Finally, V17 stated the autopsy report is not complete due to pending toxicology reports, but the preliminary Cause of Death is "aspiration of food bolus."

On March 13, 2019 at 3:43pm, V13 (Speech therapist) stated she saw R1 in November after staff at the supportive living facility reported R1 with coughing and choking during eating. V13 stated she did a bedside swallow exam and did observe coughing and choking in that exam so set up a video fluoroscopic swallow study. It was discovered at that exam that R1 had the Zenker's diverticulum. V13 further stated that R1 had

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difficulty swallowing that was partially relieved by alternating bites of food, chewing slowly, and then a sip of liquid. V13 stated she could do this with cueing.

On March 13, 2019 at 11:32 am, V10 (Medical Doctor - MD) stated he was familiar with R1 and was involved in the facility investigation of R1's death. V10 went on to explain R1 had lost weight due to not wanting to eat related to discomfort with the diverticulum in her throat and so taking only liquid diet. V10 stated also, R1's son did not want to allow corrective surgery for his 90 year old parent. V10 stated as well, R1 was at high risk for choking. V10 stated the pureed diet was ordered for R1's comfort as she was then on hospice.

On March 12, 2019 at 2:30pm, V5 (Certified Nurse Assistant - CNA) stated she was familiar with R1 and that R1 had a pureed diet. She stated she was not informed of any special need to monitor R1 beyond any others. V5 stated on March 9, 2019 she was serving lunch in the dining room and heard a resident (R2) call out, "She's choking." V5 said she stopped what she was doing and heard R1 state, in a quiet voice, "I need something to drink." V5 went on to state R1 reached for a cup on the table with non-thickened liquid and brought it up, then began turning blue very quickly and her lips became pale. V5 stated V6 (CNA) began doing Heimlich maneuver on V1. Additionally, V5 stated she saw a food plate next to R1 on the table containing regular (not pureed) food, a pork chop which had been cut up.

On March 12, 2019 at 2:05 pm, V4 (CNA) stated as she started serving food in the dining room, she heard, "She is choking" and when she turned saw V6 doing Heimlich. V4 stated she saw a

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S9999	Continued From page 4 plate with non-pureed pork chop on it. V4 went on to say she had seen R1 reach for other resident's food on at least 2 occasions before. V4 stated R1 had said she doesn't like her pureed food. V4 stated she has taken solid food from R1 on previous occasions. V4 stated she was not instructed to monitor beyond normal. On March 12, 2019 at 2:40 pm, V6 stated she heard someone say, "is she choking"- it may have been V5. V6 further described that R1 had a cup with thin liquid in her hand and was turning color. "I said, if she's choking, she shouldn't be drinking." V6 went on, she started doing Heimlich and we called for the Nurse (V11) who arrived very quickly and took over Heimlich. V6 stated as well she saw a regular diet plate next to R1 on the table. V6 stated also, she later went to the cook and said, "Please tell me R1 wasn't given the wrong plate!" V6 stated R2 (at the same table) might have put the food in front of R1 as she had shared her food at other times. V6 stated R1 could feed herself and staff did not assist her nor had staff been informed of any additional choking risk for R1. R2 was interviewed on March 12, 2019 at 3:00 pm but remembered poorly what occurred at lunch on March 9, 2019. On March 13, 2019 at 12:02 pm, V11 stated she was just outside the dining room when a CNA called for her and started Heimlich as soon as she arrived and continued as they moved R1 from the dining room to the resident room. V11 stated a scant amount of food came out that was pork chop color. V11 stated as well, she saw only one plate on the table next to R1 with a regular diet on it. V11 stated she had been informed of R1 having a problem with choking and heard R1	S9999		

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had behavior of grabbing food from other resident's plates.

On March 12, 2019 at 10:48 am, V12 (Dietary server and supervisor) stated she was serving on March 9 during lunch. V12 stated she remembered the meal ticket for R1 was still on the steam table shelf at the time of R1's choking incident and so she knew R1 had not yet received her pureed lunch.

The physician's order sheet shows R1 had a pureed diet with Honey thick liquids.

The Interim Care Plan (initial care plan started at admission to the facility) shows R1 is able feed herself. As well, the care plan shows R1 has a risk of aspiration and on March 6, 2019, R1's tablemate shared solid food with R1. The intervention shown in the Interim Care plan was supervision and monitoring in the dining room and inform the tablemate's not to share.

The Progress notes presented by the facility show that on January 10, 2019, prior to admission to the facility, R1 was transferred to the hospital via emergency transport after a choking incident with change of color and loss of ability to speak.

(A)