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 |
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| | IL6004758 | A. BUILDING: _____ B. WING _____ | C 11/12/2019 |

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| RIVER VIEW REHAB CENTER | 50 NORTH JANE ELGIN, IL 60123 |

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| S 000 | Initial Comments<br><br>Complaint Investigation Survey #1978220/IL117335 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation:<br><br>300.610a)<br>300.1210b)<br>300.1210d)2)<br>300.1210d)3)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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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 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.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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. (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 ensure the safety of a resident by not implementing interventions for a resident (R1) with a history of dysphagia and impulsive eating. This failure resulted in R1 choking during a meal, requiring CPR, and

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subsequent hospitalization. R1 expired in the hospital on August 31, 2019, from aspiration pneumonia related to the choking incident. The facility failed to supervise a resident at risk for aspiration during meals.

This applies to 3 of 3 residents (R1-R3) reviewed for safety and supervision in the sample of 3.

The findings include:

1. R1's Speech Therapy Evaluation and Plan of Treatment dated April 25, 2019 showed R1 was at risk for aspirating food and liquids related to her diagnoses including dysphagia (swallowing disorder), anoxic brain injury, aphonia (nonverbal), and her cognitive communication deficit. The evaluation showed R1 received a mechanical soft diet with nectar thickened liquids. Swallowing interventions for R1 included education of staff members to ensure R1's oral intake rate was controlled to facilitate R1's swallowing of food.
A "Swallowing Precautions for (R1)" staff education checklist provided by V6 Speech Therapist (ST) showed, "5. Patient can feed herself to encourage self-feeding; however, make sure she goes slowly and that she has swallowed what's in her mouth before next bite/sip ..."

R1's Progress Note dated August 25, 2019 at 8:45 PM showed a nurse was called to R1's room by a CNA (Certified Nursing Assistant) because R1 "was not looking good" after the CNA noticed R1 was having "trouble swallowing". The nurse found R1 "looking pale with a faint carotid pulse." The nurse began CPR on R1 while another nurse suctioned ground meat from R1's mouth. At 8:52, EMS (emergency services/911) arrived at the facility and found R1 to be pulseless and

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continued CPR with emergent transport to a local hospital.

R1's EMS report dated August 25, 2019 showed when EMS arrived at the facility, R1 was pulseless. CPR was continued as EMS "checked patient's airway and small particles of food were found."

R1's Emergency Department Physician Report dated August 25, 2019 showed, "Impression; Cardiac Arrest related to choking and pneumonia." The report showed R1 presented to the hospital, intubated and unconscious after going into cardiac arrest following "choking on food 30 minutes ago." R1 was admitted to the intensive care unit (ICU) in critical condition.
R1's Report dated August 28, 2019 showed R1 was discharged from the ICU, with withdrawal of treatment per R1's family, and placed on hospice care in the hospital due to R1 remaining unresponsive with a poor prognosis. An EEG (electroencephalogram/brain activity test) study completed on R1 on August 26, 2019 showed R1 was "markedly abnormal" with findings of an "anoxic brain injury with poor prognosis."

R1's Certificate of Death Worksheet showed R1 expired in the hospital on August 31, 2019 with her cause of death as "Complication from Aspiration of Food Bolus".

On November 6, 2019 at 9:40 AM, V4, Certified Nurse Assistant,stated she was the CNA caring for R1 on August 25, 2019. V4 stated she was aware R1 was at risk for aspiration. V4 stated, "Around 8:00PM, I gave (R1) her food and noticed she was eating fast so I asked her to slow down. She didn't, so I tried to feed her but she wouldn't let me. I let her eat (leaving the food tray

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in front of R1). I started to notice she wasn't looking good, she was having trouble swallowing and her breathing sounded funny. I gave her drinks of her (thickened) water to try to help get her food down. (R1) continue to look bad so I went and got a CNA, (V12). (V12) came into (R1's) room and got some food out of (R1's) mouth and told me to go get the nurse. I went and got the nurse and she came in and started CPR on (R1)... I didn't think she was choking." V4 stated she did not check R1's mouth for food, suction R1's mouth, attempt abdominal thrusts/Heimlich maneuver, or check to see if R1 had a pulse at any time during the incident. V4 stated from the time R1 started to develop "trouble swallowing" to the time the nurse entered R1's room was "about 3-5 minutes." R4 stated she was CPR certified which included receiving education on the interventions and treatment for choking.

On November 6, 2019 at 3:05 PM, V12, CNA,stated, "I was sitting at the nurse's station charting that night (8/25/19) when (V4,CNA) came and got me. She asked me to come into (R1's) room because (R1) wasn't looking good. I went into (R1's) room, she was sitting up in her wheelchair, with food coming out of her mouth. She was pale and was having trouble breathing, her breathing was noisy. I told (V4, CNA) to go get the nurse. The nurse came in right away but by that time, (R1) had become unconscious and the nurse started CPR right away."

On November 6, 2019 at 11:20 AM, V5, Registered Nurse (RN) stated V12, CNA notified her on the evening of August 25, 2019 that "(R1) wasn't looking good. I went into (R1's) room and within two seconds, she had become unconscious and didn't have a pulse so I started

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CPR on her right away.

On November 6, 2019 at 10:15 AM, V6, Speech Therapist stated, "(R1's) aspiration risk is directly related to her eating too fast. She was impulsive, with a tendency to eat too fast. She needed 1:1 supervision with eating and constant cueing and reminders to slow down. We would allow her to try and feed herself. If she started eating too fast and wasn't following the cues, staff knew to take over and feed her. If she started showing signs of choking, trouble swallowing, or was eating too fast, they were to pull the food away from her, check for pocketing of food, and notify the nurse immediately. You don't continue to feed her or give her something to drink. All the staff know this and have been in-serviced on how to feed (R1) because she was such an aspiration risk." On November 6, 2019 at 12:00 PM, V3, Nurse Practitioner stated R1 was at risk for aspiration and needed supervision with eating due to her impulsivity. V3 stated, "If a resident developed difficulty swallowing or choked while eating, staff should immediately stop feeding the resident, pull the food away from the resident, and notify the nurse immediately. (V4, CNA) should have gotten the nurse immediately when (R1) started to have trouble swallowing." V3 stated the expectation is that nursing staff can identify when a resident is choking and emergently intervene as needed. V3 stated any delay in intervening when a resident is choking, can lead to death, cardiac arrest, and/or lack of oxygen to the brain.

On November 6, 2019 at 12:10 PM, V2, Director of Nursing (DON) stated R1 was at risk for aspiration "especially when she fed herself because she had a tendency to eat too fast". V2 stated if a resident began choking or had trouble swallowing while eating, nursing staff are to stop

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feeding the resident, remove the food, do the Heimlich if needed, and get the nurse right away. V2 stated all of the nursing staff are CPR certified and have been trained on the Heimlich maneuver.

The facility's Emergency Care Policy dated May 2014 showed, "Principles of Emergency Management: To preserve life ...1. Maintain a patent airway, employing resuscitation measures, if necessary..." The policy showed, "Choking 1. Follow American Heart Association procedure using abdominal thrusts ..."

2. R2's admission record dated 12/20/2017 showed R2 had multiple diagnoses including; chronic obstructive pulmonary disease, gastro-esophageal reflux disease without esophagitis, schizoaffective disorder, and dysphagia.
R2's October 23, 2019, facility assessment showed that R2 is cognitively impaired and required supervision of one person when eating.
R2's physician order dated 5/10/2019 showed R2 received a general/regular mechanical soft diet, chopped meat texture, nectar consistency liquids, and no beef and no pork.
The Care Plan for R2 dated 10/29/2019 showed R2 had dysphagia with a related goal that R2 will not have signs of coughing/choking during oral intake through next review. Interventions included encourage her to eat her meals in the dining room, but when she refuses, due to her paranoia, serve her tray in her room, observe for swallow safety while she eats, and have in upright position for all oral intake; observe for coughing/signs of choking during meals.
The Speech Therapy Discharge Summary dated 5/22/2019 written by V6, Speech Language Pathologist showed R2 was to receive distant

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supervision for oral intake. It recommended R2 eat in dining room for general supervision; it was not recommended that R2 eat alone in her room due to choking/aspiration risk.
On 11/6/2019 at 8:15 AM, R2 was seated in her room, in her wheelchair, eating breakfast. R2's breakfast included eggs, toast, pears, oatmeal, thickened apple juice, and thickened milk. She was alone in her room with no staff and no staff in the hallway near her room.
On 11/6/2019 at 12:30 PM, R2 was seated in her room with her lunch tray in front of her, eating. V10 was exiting R2's room. V10, Rehab Aide, said R2 normally eats by herself in her room.
On 11/6/2019 at 12:40 PM V6, Speech Language Pathologist, said that she had previously seen and treated R2 but hasn't for a while. She said that R2 frequently refused to go to the dining room to eat and had combative tendencies. V6 said that R2 should be supervised and should not be alone when eating.

3. R3's admission face sheet dated 4/13/2018 showed R3 had multiple diagnoses including; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, major depressive disorder, schizoaffective disorder, and dysphagia oropharyngeal phase.
R3's facility assessment dated October 23, 2019 showed R3 required supervision when eating.
R3's physician order dated 10/3/2018, showed R3 received a mechanical soft diet, chopped meat texture, thin consistency liquids, and double portions with meals.
A physician order dated 11/3/2019 for R3 showed, "please call NP ... if resident is still coughing while eating after the completion of the antibiotic for pneumonia on 11/8/2019."
A physician order dated 11/3/2019 for R3 showed,

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" Levaquin Tablet 750mg (levofloxacin/antibiotic) give 1 tablet by mouth one time a day for slight left basilar pneumonia for 5 days."
The Care Plan for R3 dated 10/29/2019 showed interventions for R3's dysphagia included strict aspiration precaution; have in upright position for all oral intake; observe for signs of coughing or choking while eating and drinking; report problems to MD.
On 11/6/2019 at 8:00 AM, R3 was seated in his wheelchair in the dining room eating breakfast and coughed several times. V8 CNA (Certified Nursing Assistant) asked R3 if he was ok; R3 said yes. R3 continued to cough while pushing himself away from the table, across the dining room, and exited the dining room, still coughing.
On 11/6/2019 at 11:30 AM, V8 said that he remembers R3 coughing at breakfast this morning and he did report the incident to V11 RN (Registered Nurse).
On 11/6/2019 at 11:35 AM, V11(RN) states that she was notified of R3 coughing during breakfast but did not report it to the physician. V11 said that she did not notify the MD because R3 still has three days left of his antibiotic, and the physician order says to call the Nurse Practitioner if R3 is still coughing after he finishes his antibiotic. V11 said that she is not aware of R3's Care Plan.
On 11/6/2019 at 11:40 AM V9, MDS/Care Plan Nurse, said that R3's Care Plan was last updated 10/29/2019. V9 said that the Care Plan intervention is in place for any instances when R3 starts coughing while eating. The physician order dated 11/3/2019 is in regards to the antibiotics and possible persistent infection after the antibiotics have been completed.
On 11/6/2019 at 12:20 PM V3 Nurse Practitioner states that if R3 was coughing during breakfast, it should be reported to her, or if Speech Therapy is

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there, (like she was that day) it should be reported directly to Speech Therapy.
On 11/6/2019 at 12:40 PM V6 said that she has not seen R3 in years, but he does have a history of dysphagia. V6 said that no staff had notified her that R3 was coughing when eating. She said that any problems including coughing, choking, not eating, or any change at all in the dining room should be reported to her.
The facility's Aspiration Precautions policy dated 12/2014 states " ...3. If aspiration is suspected, the nurse will monitor the resident's temperature and lung sounds and report abnormal findings to the physician. 4. Speech Therapist is to be notified for possible screen and/or evaluation."

"AA"