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S 000	Initial Comments Facility Reported Incident of 10/10/2020/IL128081 A partial extended survey was conducted	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1030a)1)2) 300.1030c) 300.1030d) 300.1210a) 300.1210b)4) 300.1210c) 300.1210d)2)6) 300.2040b) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1030 Medical Emergencies	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 2 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident	S9999		

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S9999	Continued From page 3 who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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 300.2040 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. (Section 2-107 of the Act) These regulations were not met as evidenced by:	S9999		

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Based on interview and record review, the facility failed to provide the required supervision and verbal cueing during mealtimes and failed to provide the correct textured diet for R1, a resident with a documented history of choking while eating. This failure resulted in R1 choking while eating unattended and eventual death. In addition, the faciity failed to ensure that staff trained and certified in CPR (Cardio Pulmonary Resuscitation) were available each shift.

FINDINGS INCLUDE:

R1's facility Profile Face Sheet, documents that R1 was admitted to the facility on 3/8/2019 with the following diagnoses: Morbid Obesity, Schizophrenia, Anxiety Disorder, Schizoaffective Disorder, Dementia with Behavioral Disturbances and Adjustment Disorder.

R1's Nursing Admission Assessment, dated 3/8/19 documents, "Diet/Feeding: Regular, thin liquids; cut up meat."

R1's Dietary Admission Assessment, dated 3/9/19 documents, "Swallowing problems identified: shoves food into mouth."

R1's Baseline Care Plan, dated 3/11/19 documents, "Eating: supervision/VC (verbal cues), cut meat, chewing concern, stuffs mouth."

R1's Dietary Notes, dated 3/12/19 document, "(R1) has been moved to a feeder table."

R1's Nurse's Notes, dated 4/7/19 at 5:35 P.M. document, "(R1) noted to be choking. Not able to speak, (skin) color abnormal. Not able to do

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Heimlich in upright position, lowered to the floor and Heimlich successful to dislodge meat. Color returns to normal. (R1) able to speak. 9-1-1 here at this time to assess (R1). V7/ sister acknowledges that (R1) has had that problem or is prone to choking because (R1) eats fast and shovels food into (R1's) mouth. Physician notified and new orders received for a Mechanical Soft diet."

R1's Dietary Notes, dated 4/7/19 document, "(R1) is at high risk for choking. (R1's) diet has been switched to Mechanical Soft due to (R1) shoving food into (R1's) mouth and is now eating with cues from staff."

R1's Care Plan, dated 5/30/19 documents, "Problem: I have a tendency to choke on my food due to not chewing my food. I have a diagnosis of anxiety and a diagnosis of schizophrenia, depression and Schizoaffective disorder, so I tend to swallow my food without chewing to finish it as soon as possible. Approach: Prepare food to recommended consistency of Speech Therapist and ordered by MD (Medical Doctor). Give verbal cues to stimulate chewing or swallowing. Stroke throat lightly at Adam's apple to stimulate swallow."

R1's Care Plan, dated 9/20/19 documents, "Problem: When I eat, I always eat too fast and I do not chew my food completely. I do not swallow my food prior to putting another bite in my mouth. I also take too large of bites in my mouth. I also take too large of bites for me most of the time. I do eat very fast. I am always hungry, it may have to do with my psyche medications I take for my depression and schizophrenia, Schizoaffective disorder, depression and anxiety. I do have anxiety when I have food and especially at meal

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times. I have nurses or CNAs (Certified Nursing Assistants) sit with me to help me slow down and remind me to take smaller bites and chew my food and swallow before taking another bite and to drink in between bites. When I am done eating even though I didn't always comply with the staff's cueing I asked 'How did I do' I am looking for reassurance and praise. I do need assistance with my eating. I have had several choking episodes before coming to the facility. I am on an eating restorative program. Approach: Assist me with setting up my meal the way I like it. Remind me when I become anxious and want to eat fast and not chew my food completely what the outcome could be. Assist me to cut my food into smaller bites. Cue me to put my utensils down and take sips of fluids between bites. Give praise when the meal is over. Inform nurse of any difficulties during his meals. During meals, provide verbal cues to resident to slow eating, take small bites and chew prior to swallowing, encourage liquids as needed. If resident doesn't finish greater than 50 percent of meal, staff to assist resident with the rest of the meal."

R1's Dietary Notes, dated 10/31/2019 document, "Dietician recommended all breads be quartered and moistened both sides with butter, gravy or jelly at every meal."

The facility policy, Cycle Menu, dated (revised) 4/17 directs staff, "Diets are modified according to the current edition of the (state) Simplified Diet Manual with some minor adjustments as noted within the diet descriptions below: Mechanical Soft: Designed for individuals who have difficulty chewing but are able to tolerate a wide variety of foods. This diet is designed to permit easy chewing. This diet includes foods soft in texture such as cooked fruits and vegetables, moist

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ground meat and soft bread and cereal products. Modifications in the diet need to be individualized according to the resident's needs."

R1's Physician Progress Notes, dated 7/25/19 include the following physician order: Discharge Speech Therapy, program complete. Please remind (R1) in slowing down rate/small bites, sips and alternate bites/sips with supervision with all intake."

R1's Nurse's Notes, dated 1/15/20 at 6:00 P.M., document, "(R1) had choking episode with no loss of consciousness. Able to remove soft food from (R1's) mouth. 9-1-1 called for back up if needed. Continues to sit at feeder table during meals for supervision and encouragement to eat slowly and to chew food well before swallowing."

R1's Physician Orders, dated 1/23/2020 document, "Speech Therapy to eval (evaluate) and treat."

R1's Speech Therapy Progress and Discharge Summary, dated 2/18/2020 documents,"Diagnosis: Dysphagia. Discharge Plans and Instructions: Discharge to facility with mechanical soft diet and thin liquids via straw. Continue taking small bites/sips at a slow rate. Supervision is recommended with intake to remind (R1) in slow rate and smaller size bites."

R1's Nurse's Notes, dated 9/26/2020 at 1857 (6:57 P.M.) document, "When writer entered (R1's) room to give medications to (R1), was choking on food. Writer able to get (R1) to lean forward. That helped (R1) able to cough food out on (R1's) own."

R1's Nurse's Notes, dated 9/27/2020 at 10:15

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S9999	Continued From page 8 A.M. document, "Noted to be choking/coughing during meal." R1's Care Plan, dated 10/31/2019 documents, "Problem: When I eat, I always eat too fast and I do not chew my food completely. Approaches: All breads are to be served moistened with gravy or jell, both sides (of bread) with butter and quartered, before serving, at all meals. Problem: Resident with difficulty chewing or swallowing (dysphagia) as evidenced by alteration in consistency of food (mechanical soft). Approaches: Prepare foods to recommended consistency of Speech Therapist and ordered by Physician. See Physician Order Sheet for most current order. Assess tolerance to consistency. Minimizes pocketing, choking, coughing, discomfort during swallowing." This same Care Plan includes the following update on 3/14/2020, directing staff, "Allowing family to bring in food on Fridays for resident's mental health to decrease depressive episodes. Food to be delivered to kitchen to be prepared per resident's diet." R1's October 2020 Physician Order Sheet includes the following diagnoses: Depression, Adjustment Disorder with Mixed Anxiety, Schizo-Affective Disorder, Schizophrenia, Anxiety, Morbid Obesity and Dementia with Behaviors. This same document includes the following physician orders: Mechanical diet, soft ground meat, bread quartered and moistened with butter, gravy or jelly. R1's Nurse's Notes, dated 10/10/2020 document, At approximately 6:00 P.M. writer (V6/Licensed Practical Nurse) responded immediately to (R1's) room, CNA (V3) in room and assisted writer to get (R1) to the floor. (R1) was conscious and attempting to draw in a breath. (R1's) face was	S9999		

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grayish in color. Writer had staff call 9-1-1. (R1's) mouth (was) observed and food present on (R1's) dentures. Writer removed food and dentures. Abdominal thrusts initiated. Assisted breathing with bag valve mask to maintain airway. Airflow noted with some resistance. Attempted to remove airway obstruction when (R1) inhaled deeply, again obstructing airway. Continued abdominal thrusts and noted loss of consciousness. Assessed (R1) and no pulse and no respirations noted. CPR (Cardio Pulmonary Resuscitation) initiated. Officer arrived and assumed chest compressions while writer maintained airway. AED (Automated External Defibrillator) utilized by Officer and no shockable rhythm arose. CPR continued. EMS (Emergency Medical Services) arrived and assumed care of (R1). Able to remove obstruction with forceps. Resuscitation efforts continued. At 6:25 P.M., Physician, Resident's Responsible Party (V7), Administrator (V1) and DON (V2/Director of Nurses) notified of (R1's) condition. EMS contacted Medical Control and (R1) pronounced (deceased) at 6:44 P.M."

R1's Ambulance Service Report, dated 10/10/2020 documents,"Dispatched/responded to (facility) where a male who was choking and is now unresponsive with CPR in progress. Upon arrival (R1) is found unresponsive laying supine in room with CPR in progress. Staff states (R1) was eating a grilled cheese sandwich when he began to choke. (R1's) airway was opened with a MAC 4 and large amounts of food are removed from the airway with maguil forceps."

R1's State Certificate of Death, dated 10/13/2020 documents, "Cause of death: Anoxia, Choking on Food Substance."

On 10/24/2020 at 1:28 P.M., V4/Food Service

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Supervisor stated, "(R1) was on a mechanical soft, no added salt diet. Our mechanical soft diet includes soft bread. Bread needed to be moistened and quartered. We started doing this in September or October of 2019 because (R1) ate too fast and he was a choking risk with bread. On 10/10/2020, I had a call in (from staff) and I was filling in. The sandwich that (R1) ate that night, was a grilled tuna melt from (a local restaurant). (R1's) sister would bring one in every Friday and (R1) would eat half of it on Friday and the other half on Saturday. It was supposed to be moistened on both sides with milk or water, before it was served. I saw (V5/Evening Cook) take it out of the refrigerator and put it in the microwave to heat it up. I did not witness (V5) moisten the bread before she put it on the plate to be served."

On 10/24/2020 at 1:40 P.M., V5/Evening Cook stated, "(R1) was on a mechanical soft diet. The bread had to moistened with milk. If it were a sandwich, both pieces of bread were spread with butter or mayo (mayonnaise). All sandwiches were cut into bite-sized pieces. (R1's) sister brings in a grilled tuna melt sandwich every Friday. I cut it into bite sized pieces. I put it in the microwave for one minute, to make it softer. I put about twelve pieces on the plate. I also sent mayo with the tray. I did not moisten the pieces (with milk) or add additional condiments (to the bread) before I served it."

On 10/24/2020 at 2:52 P.M., V3/Certified Nursing Assistant (CNA) stated, " I have been working here about a month. I didn't know (R1's) bread was supposed to be moistened I guess (R1) had special instructions (for eating), but I wasn't aware of them. No one told me (R1) shoved food into his mouth. I didn't know. I delivered his tray

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and left the room. I finished passing the other trays. I was gone maybe five minutes. (R1) had a grilled tuna melt, cut up. The bread wasn't wet. When I came back (into R1's room), I was helping his roommate, my back was turned to (R1). When I turned around, I saw (R1) inhale and then (R1) started choking, (R1) was slumped over. I tried to pull the food out of his mouth. I got a couple of pieces of sandwich out. There was a chunk at the back of (R1's) mouth, towards his throat. I yelled for the nurse and she came in and started CPR. I didn't know I wasn't supposed to leave (R1) alone when (R1) was eating."

On 10/24/2020 at 2:05 P.M., V6/Licensed Practical Nurse (LPN) stated, "(The evening of 10/10/2020) I was sitting with another resident and I heard V3/CNA yell for help. I immediately went to (R1"s) room. (R1) was sitting in a chair, slumped to the side, gasping. (R1) was gray. (R1) looked at me, but (R1) couldn't talk. I grabbed (R1's) belt and pulled (R1) to the floor. I opened (R1's) mouth and saw food. It was bread. I took (R1's) dentures out. I did a couple of abdominal thrusts (on R1). I yelled for someone to call 9-1-1. A policeman was the first on the scene. He took over CPR. He left and ran back to his car and got the AED. (R1) had no shockable rhythm. The EMTs showed up and took over. They pulled a large amount of food out of (R1's) throat. They worked on (R1) for about thirty five minutes and then called the ER (Emergency Room) doctor and the ER doctor said to stop resuscitation efforts at that time."

On 10/26/2020 at 8:15 A.M., V7/R1's sister stated, "(R1) had a previous choking episode prior to admission (to the facility). I found (R1) unresponsive on the floor of his apartment. (R1) spent a week in ICU (Intensive Care Unit). I am a

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Licensed Speech Therapist. I told (the facility) of (R1's) history and stressed that (R1) was only able to eat or drink under supervision. I know of a couple of incidents while (R1) was at the facility, he choked. One of the more recent episodes, I specifically asked the nurse if a staff member was in the room with (R1) and she said no. I repeated how (R1) had to have someone with (R1) at all times while (R1) was eating or drinking."

On 10/26/2020 at 11:55 A.M., V2/Director of Nurses stated,"Due to Covid-19 (R1) ate in (R1's) room. There was someone typically in (R1's) room, with (R1), during meals. Either a CNA or a Nurse, if the CNA were busy. (R1) had a long history of choking and needed to be monitored. Unfortunately, (V3/CNA) stepped out of the room (R1's) that night (10/10/2020)." V2 also stated, "(R1's) bread was to be chopped up and quartered, meat was ground. Bread was to be moistened with butter, jelly or gravy before it was served. (R1) had a history of dysphagia and choking on bread." At that same time, V2/DON verified R1's Care Plan and Speech Therapy recommendations were for a staff member to be present with R1 during all meals.

On 10/27/2020 at 9:15 A.M., V9/Company Dietician stated, "Mechanical soft diets are served sandwiches with soft breads, with the addition of added sauces or condiments. It makes them easier to swallow."

On 10/26/2020 at 12:47 P.M., V8/Speech Language Pathologist stated, "I saw (R1) for speech therapy after an incident of (R1) choking during a meal. (R1) had an almost obsession with eating his meals very quickly, literally shoving food into his mouth. I worked with (R1) and taught (R1) compensatory strategies for safe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008205	A. BUILDING: _____ B. WING _____	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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
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swallowing. I also educated the (facility) staff that (R1) would need to be supervised for all food and fluid intake with frequent reminders to slow his rate of consumption and to take smaller bites. It would never be safe for (R1) to eat without staff supervision."

The facility policy, Cardiopulmonary Resuscitation, dated (revised) 12/27/18 directs staff, "It is the policy of (the Company) that cardiopulmonary resuscitation (CPR) shall be initiated and maintained by qualified staff, in cases of recognized cardiac and/or pulmonary arrest to sustain or support or support a resident's cardiac and/or pulmonary function until advanced life support systems are available. Nursing personnel of this facility shall be certified in CPR within a reasonable time after hire but not to exceed 90 days."

The facility October 2020 Nurse Schedule and October 2020 CNA (Certified Nursing Assistant) for 10/10/2020 documents V6/Licensed Practical Nurse (LPN) and V3 and V10/CNAs were scheduled to work on the evening shift (2:00 P.M. 10:00 P.M.).

On 10/24/2020 at 2:30 P.M.,V3/CNA, V6/LPN and V10/CNA's employee files were reviewed for current CPR verification. No current CPR cards were present in each of the employee files. At that same time, V11/Business Office Manager verified that V3, V6 and V10 had no current CPR certification.

On 10/24/2020 at 3:00 P.M., V1/Administrator verified that no facility staff present on the 10/10/2020 evening shift had valid CPR certification when an incident occurred where a resident choked and subsequently expired, in the

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S9999	Continued From page 14 facility. The facility Resident Roster, dated 10/24/2020 and verified as correct by V2/Director of Nurses, documents 24 residents currently residing in the facility. (A)	S9999		