Illinois Department of Public Health

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IPLE CONSTRUCTION		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	NG:	CON	MPLETED
	IL6008015		B WING			С
11.0008013		J D. WING_		04/	/13/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	Y, STATE, ZIP CODE		
RIVERS	HORES HLTH & REHA			RCIAL STREET		
			LES, IL 6	1341		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	DRE	COMPLETE
		<u> </u>	1/40	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIALE	DATE
59999	Final Observations		00000			
00000	T IT COUNTY ALIONS		S9999			
	STATEMENT OF LI	CENSURE VIOLATIONS				
4	300.1210b)					
	300.1210c)					
900	300.1210d)6)					
	300.3240a)					
	•					Wilder + the myogra
	Section 300.1210 Ge	eneral Requirements for				
	Nursing and Persona	al Care				
	h) The facility shall n	rovide the necessary care				
	and services to attain	or maintain the highest				
	practicable physical	mental, and psychological				
	well-being of the resi	dent, in accordance with				
	each resident's comp	prehensive resident care				
	plan. Adequate and p	properly supervised nursing				
	care and personal ca	re shall be provided to each				
	resident to meet the t	total nursing and personal				
	care needs of the res	sident.			-	
	a) Each direct core					1
'	be knowledgeable ob	iving staff shall review and out his or her residents'				
- Anna Anna Anna Anna Anna Anna Anna Ann	respective resident ca	out his or her residents.				
•	Copodito resident ca	are plair.				
	d) Pursuant to subsec	ction (a), general nursing				
(care shall include, at	a minimum, the following			diam's	
á	and shall be practiced	on a 24-hour.				į
8	seven-day-a-week ba	sis:				
	5 \ A II					
16) All necessary preca	autions shall be taken to				l
a	issure that the reside	nts' environment remains			and the same of th	
8	is free of accident ha	zards as possible. All			997	
+1	nat each resident	all evaluate residents to see			and the same of th	1
a	and assistance to prev	eives adequate supervision				l
4	me application to pref	vent accidents.		AttachmantA		
S	ection 300.3240 Abu	se and Neglect		Attachment A		I
	111111111111111111111111111111111111111	sila riogioti	TAPA PERSONAL PROPERTY AND ADDRESS OF THE PERSON	Chatamant of Lieuwanna Millett		ĺ
а) An owner, licensee.	administrator, employee or		Statement of Licensure Viola	uons	
a	gent of a facility shall	not abuse or neglect a			William Works	
	ent of Public Health	-3,00.0				1

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTI	DIE CONCEDUCTION			
AND PLAN OF CORRECTION			IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDIN	G:		MELETED	
		IL6008015		B. WING		04	C 04/13/2015	
-	NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY	, STATE, ZIP CODE	***************************************		
	RIVERSI	HORES HLTH & REHA	B CTR 578 WEST		CIAL STREET			
ľ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1				
	PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
	S999 9	Continued From pag	ge 1	S9999				
	1	resident. (Section 2-	-107 of the Act)					
	-	THESE REGULATION EVIDENCED BY:	ONS WERE NOT MET AS					
		failed to provide sup- residents (R7) review diets, in a sample of R7 requiring transpo	and record review, the facility ervision to one of three ved for mechanically altered nine. This failure resulted in rt to the hospital after R7 was and R7 subsequently died blus of food.					
		Findings include:					T D CONTRACTOR OF THE PROPERTY	
		This same form docu ambulatory, and dispi	erely cognitively impaired.					
	ſ	1/31/15, documents F Mental Retardation, D	Sheet, dated 1/1/15 through R7's diagnoses to include: Dementia with agitation, and deflux Disease. This same current diet order as ed diet.					
	r	elated to the risk of c	restorative eating program hoking, needing cues to eat					
	th d d	nat R7 has a history o ocuments that on 4/3 ining room when E16	dated 4/30/14, documents of choking. This same form 60/14, R7 was sitting in the by Licensed Practical Nurse, was assisted to a standing					

nois Department of Public Health

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If continuation sheet 3 of 7

Illinois Department of Public Health

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T ()(0) 1 11 11 7			
		OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY
			A. BUILDING:		COV	COMPLETED	
IL6008015		B. WING _			C 04/13/2015		
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	Y, STATE, ZIP CODE	1 07.	13/2013
			570 W.T.O.		RCIAL STREET		
	RIVERSI	HORES HLTH & REHA	B CTR MARSEIL				
ŀ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1			
l	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR	RECTION	(X5)
١	TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR	HOULD BE PPROPRIATE	COMPLETE DATE
L					DEFICIENCY)		
	S9999	Continued From page	ge 2	S9999			
				-			
		maneuver which ev	gan performing the Heimlich				
		form also document	pelled the lodged food. This s that R7 was given a peanut				
		butter and jelly sand	wich and a cookie by an				
		unidentified Certified	Nursing Assistant				
			Training / toolstaint.				A COLUMN A C
		The facility's investig	ation of R7's choking				
		incident, dated 1/25/	15, documents the following				
		timeline for R7's loca	ation in the facility. At 7:15pm				
		R7 was in R7's room	At 7:45pm, R7 was in the				
		patio room. At 8:00pi	m R7 was ambulating in the				
	4	north nailway. At 8:20	Opm, R7 was sitting at a				
		table in the facility's N	North Dining Table.				
		On 1/25/15 at 8:26pn	n P7's Nurses Notes				
		document "(R7) obsi	erved on floor in NDR,				
		(north dining room), o	cyanotic, no respirations.				
		Upon assessment, br	read, peanut butter and jelly				
	1	was coming out of (R	7's) mouth. CPR			To the second se	
		(Cardiopulmonary Re	suscitation) was initiated."			and the state of t	
						MAAAAAA AA	
		Local hospital emerge	ency room notes, dated				1
	1	1/25/15, documents,	"On arrival, large amount				
	(of brownish material s	suctioned and on				
		presentation intubated	d. This same form				
		1/25/15.	of death at 9:06 pm on				
		,, a. O/ 1 O;					
	1	On 4/9/15 at 3:15nm	Z6, Coroner, verified that			(Mary and Association)	1
	F	R7's cause of death w	as aspiration of a food				
	b	oolus. Z6 also stated,	"the food appeared to be				
	þ	eanut butter."					
	-						
	C	On 4/9/15 at 2:10pm, .	Z4, Speech Therapist,				
	S	tated that R7 had two	previous incidents of			Of an ideal	
	C	hoking in the facility p	prior to R7's choking			and the state of t	
	ir	ncident on 1/25/15. Z	4 then stated, "(R7) was				
	S	upposed to be superv	vised for all meals and the			Alle Andrews	
	į ta	acility was not providir	ng the supervision." Z4				
	а	iso verified that after	R7's choking episode on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		1 OF CORRECTION		A. BUILDIN	/G:	СОМ		
	IL6008015		B. WING_		l l	C 13/2015		
	NAME OF	PROVIDER OR SUPPLIER	STREET AD	יייייייייייייייייייייייייייייייייייייי	/ OTATE 312 0 0 0 0	1 04/	13/2015	
			E70 ME0		Y, STATE, ZIP CODE RCIAL STREET			
	RIVERS	HORES HLTH & REHA		LES, IL 6				
	(X4) ID	SUMMARY STAT	TEMENT OF DEFICIENCIES					_
	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLETE	
	170		DEITH THE IN CHANATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
	S9999	Continued From page	TA 3	S9999				-
				29999				
		soft to pureed.	d R7's diet from a mechanical					
		On 4/9/15 at 1:00pm	ı, Z5, Speech Therapist,					
		verified that while R7	was at the facility, R7					ı
		required continuous eating.	staff supervision while					
		On 4/9/15 at 1:00pm	, E13, Licensed Practical					ı
		Nurse, (LPN), verifie	d that R7 would wander				4 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
		independently into ot	her residents rooms, and R7					l
		would take objects fr	om these rooms. E13 stated,					l
		needed supervision v	ood in individual bowls and while (R7) was eating." E13			and the same of th		
		also stated that R7 w	ould eat meals too fast, and			and the state of t		
		cough. E13 then ver	ified that on 1/25/15 at			MACA AND AND AND AND AND AND AND AND AND AN		
	8:20pm, E13 was sitting at the north nurse's station and E13 saw R7 wandering around the					A CALL		
		dining room. E13 stat	ted that night time snacks					
		were sitting on the no	orth nurse's station desk.					ĺ
		within reach of anyon	e walking by, and the night					ĺ
		applesauce graham	the following: pudding, crackers, and peanut butter					
	COMPANY OF STATE OF S	and jelly sandwiches.	On 1/25/15 at 8:25pm, E13					
		stated E13 heard a lo	ud thud and observed R7					
		on the floor.						
	The state of the s	On 4/9/15 at 1:40pm.	E9, LPN, verified that R7					
		was ambulatory and v	vould wander throughout the					
		facility independently.	E9 stated that night time			MATERIAL PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS		
		anvone walking hv wo	op of the nurse's desk, and ould have access to these			nd to the state of		
	:	snacks. E9 stated on	1/25/15 at 8:25pm, E9			And Annual Control		
		heard E13, LPN, yell f	or help, so E9 ran to the					
		north dining room. Up	oon entering the north dining					
		vith blue skin color an	ing R7 lying on the floor, and a faint pulse. E9 stated,					
		We started CPR (Car	diopulmonary					
		Resuscitation) and cal		and the state of t			1	
	1		l l	1		i		

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Illinois Department of Public Health

	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	E SURVEY
AND LEAN OF CONNECTION		IDENTIFICATION NUMBER:		G:	CON	E SURVEY IPLETED
		IL6008015	B. WING			С
NAME	OF DEOVIDER OF SUSPICE		<u> </u>		04/	13/2015
NAME	OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVER	RSHORES HLTH & REHA			CIAL STREET		
			LES, IL 61:	341		
(X4) II PREF	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
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				DEFICIENCY)	DATE
S999	Ontinued From page	ge 4	S9999			
	R7's Nurse's Notes	dated 1/25/15 document that				
	R7 was observed or	the North Dining Room floor,				
	cyanotic with no resi	pirations, and R7 had bread,				
	peanut butter and je	lly coming out of R7's mouth.				The first section of the section of
	Verified that P7 would	, E14, Dietary Manager,				
	reminders to slow do	d eat too fast and needed own. E14 also verified that				
	R7 would wander thr	oughout the facility				
	independently, E14 t	hen stated, "(R7) would grab				
	food, and (facility sta	ff) would take it away from				
	(R/)." E14 also state	d that the facility's night time				1
	snacks consisted of	oudding, applesauce,			Manada and page	
	sandwiches On 4/11	d peanut butter and jelly 2/15 at 11:45am, E14 verified				
	that a regular peanut	butter and jelly sandwich is				
	not an appropriate sn	ack for R7				
					VI AVAILA	
	(A)					
	300.690b)					
	300.690c)					
	Section 300 600 Incid	onto and A - side :				
	Section 300.690 Incides b) The facility shall no	tify the Department of any				
	serious incident or acc	cident. For purposes of this			700	
	Section, "serious" mea	ans any incident or accident			- Carlotte C	
	that causes physical h	arm or injury to a resident				1
	c) The facility shall, by	fax or phone, notify the				1
	Regional Office within	24 hours after each				
	incident or assident or a	accident. If a reportable				
	incident or accident re-	Suits in the death of a				
	law enforcement nursu	all, after contacting local part to Section 300.695,				
	notify the Regional Offi	ce by phone only. For the				
	purposes of this Section	n, "notify the Regional			THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PR	

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A. BUILDING:	(3) DATE SURVEY COMPLETED
IL6008015 B. WING	C 04/13/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
RIVERSHORES HLTH & REHAB CTR 578 WEST COMMERCIAL STREET MARSEILLES, IL 61341	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY	BE (X5) COMPLETE ATE DATE
Continued From page 5 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 notify the Department's tol-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. (Source: Amended at 37 III. Reg. 2298, effective February 4, 2013) This requirement is not met as evidenced by : Based on record review and interview the facility failed to report a fatal choking incident to the State Agency for one of three residents (R7) reviewed for mechanically altered diet in a sample of nine. Findings include: R7's Minimum Data Set, dated 11/24/15, documents R7 is severely cognitively impaired, ia ambulatory, and displays coughing and/or choking episodes during meals or when swallowing medications. R7's Physician Order Sheet, dated 1/1/15 through 1/31/15, documents R7's diagnoses to include: Mental Retardation, Dementia with agitation, and Gastro-Esophageal Reflux Disease. This same form documents R7's current diet order as follows: general pureed diet. On 1/25/15 at 8:26pm, R7's Nurses Notes document, "(R7) observed on floor in NDR, (north dining room), cyanotic, no respirations. Upon assessment, bread, peanut butter and jelly	

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TATE FORM Sees 2FD911 If continuation sheet 6 of 7

Illinois Department of Public Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E CHOVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		CON	(X3) DATE SURVEY COMPLETED	
		A. BOILDIN	G			
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		IL6008015	B. WING _		04/	13/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		, , , , , , , , , , , , , , , , , , ,
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RIVERS	HORES HLTH & REHA		LES, IL 61			
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	i			
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION	(X5)
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			03333			
	was coming out of (R7's) mouth. CPR				
	(Cardiopulmonary R	lesuscitation) was initiated."				
	Local bassital amount					
Annual magazin	1/25/15 document	gency room notes, dated				
	brownish material a	"On arrival, large amount of				
	intubated "This car	uctioned and on presentation me form documents R7's				
	time of death at 9:06	S nm on 1/25/15				7
	time of additi at 0.00) pin on 1/20/13.				
	On 4/9/15 at 3:15pm	, Z6, Coroner, verified that				
	R7's cause of death was aspiration of a food					
	bolus. Z6 also stated	I, "There is no exact test, but				
	the food appeared to	be peanut butter."				
	On 4/12/15 at 11:45a	nm, E14, (Dietary Manager),				
	verified that a regular	r peanut butter and jelly				
	sandwich is not an ac	cceptable snack for a person				
	on a pureed diet.					
	On 4/9/15 at 11:10am	5 E1 Administrator (C.)				
	On 4/9/15 at 11:10am, E1, Administrator, verified that E1 did not call or fax the State Agency to report R7's choking incident. E1 stated, "I did not					
	report this incident of	ven though the incident				
	happened here, beca	use (R7) passed away at				
	the hospital."	dase (117) passed away at				
	(AW)					1
						İ
					TO THE COLUMN TWO IS NOT THE COLUMN TWO IS N	
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linois Department of Public Health

Attachment B Imposed Plan of Correction

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Rivershores Health & Rehab Center DATE AND TYPE OF SURVEY: April 13, 2015 Complaint Investigations: 1521827/IL76276

300.1210b) 300.1210c) 300.1210d)6) 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 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)
- b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
- e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

This will be accomplished by:

- I. Conduct QAPI Audits for residents with cognitive impairment, on mechanically altered diets and at risk for choking.
- II. Provide education for nursing staff including but not limited to; supervision of residents during meals, including those on mechanically altered diets, supervision and maintaining snacks to minimize risk.
- III. Review and monitor the process ensuring supervision and assistance with meals and snacks, including policies and procedures will be completed. Make revisions as clinically indicated.
- IV. QAPI committee shall review existing policies and procedures concerning supervision at meal times and snack times, and to formulate or revise any needed policies and procedures that facility staff will follow. This committee will ensure that the facility's policies and procedures address at a minimum, the following items.
 - A. Recognition of situations that could be interpreted as potential harmful to residents;
 - B. Proper reporting procedures for staff to follow;
 - C. Techniques to be utilized in the facility's internal investigation of the situation.
- V. The Administrator and Director of Nurses will monitor Items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of the Imposed Plan of Correction.

5/6/2015/ljk

Attachment B Imposed Plan of Correction