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
	IL6008015	A. BUILDING: ____ 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 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
S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS
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

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

resident. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review, the facility failed to provide supervision to one of three residents (R7) reviewed for mechanically altered diets, in a sample of nine. This failure resulted in R7 requiring transport to the hospital after R7 was found unresponsive, and R7 subsequently died from choking on a bolus of food.

Findings include:

R7's Minimum Data Set, dated 11/24/15, documents R7 is severely cognitively impaired. This same form documents that R7 is ambulatory, and displays coughing 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.

R7's Care Plan Report, dated 12/1/14, documents R7 is on a restorative eating program related to the risk of choking, needing cues to eat at a slow pace, and reminders to chew food adequately before swallowing.

R7's Incident Report, dated 4/30/14, documents that R7 has a history of choking. This same form documents that on 4/30/14, R7 was sitting in the dining room when E16, Licensed Practical Nurse, heard R7 choking. E7 was assisted to a standing

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S9999	Continued From page 2 position and E16 began performing the Heimlich maneuver, which expelled the lodged food. This form also documents that R7 was given a peanut butter and jelly sandwich and a cookie by an unidentified Certified Nursing Assistant. The facility's investigation of R7's choking incident, dated 1/25/15, documents the following timeline for R7's location in the facility. At 7:15pm R7 was in R7's room At 7:45pm, R7 was in the patio room. At 8:00pm R7 was ambulating in the north hallway. At 8:20pm, R7 was sitting at a table in the facility's North Dining Table. 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 was coming out of (R7's) mouth. CPR (Cardiopulmonary Resuscitation) was initiated." Local hospital emergency room notes, dated 1/25/15, documents, "...On arrival, large amount of brownish material suctioned and on presentation intubated." This same form documents R7's time of death at 9:06 pm on 1/25/15. 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, "...the food appeared to be peanut butter." On 4/9/15 at 2:10pm, Z4, Speech Therapist, stated that R7 had two previous incidents of choking in the facility prior to R7's choking incident on 1/25/15. Z4 then stated, "(R7) was supposed to be supervised for all meals and the facility was not providing the supervision." Z4 also verified that after R7's choking episode on	S9999		

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S9999	Continued From page 3	S9999		

4/30/14, Z4 changed R7's diet from a mechanical soft to pureed.

On 4/9/15 at 1:00pm, Z5, Speech Therapist, verified that while R7 was at the facility, R7 required continuous staff supervision while eating.

On 4/9/15 at 1:00pm, E13, Licensed Practical Nurse, (LPN), verified that R7 would wander independently into other residents rooms, and R7 would take objects from these rooms. E13 stated, "(R7) was provided food in individual bowls and needed supervision while (R7) was eating." E13 also stated that R7 would eat meals too fast, and cough. E13 then verified that on 1/25/15 at 8:20pm, E13 was sitting at the north nurse's station and E13 saw R7 wandering around the dining room. E13 stated that night time snacks were sitting on the north nurse's station desk, within reach of anyone walking by, and the night time snacks included the following: pudding, applesauce, graham crackers, and peanut butter and jelly sandwiches. On 1/25/15 at 8:25pm, E13 stated E13 heard a loud thud and observed R7 on the floor.

On 4/9/15 at 1:40pm, E9, LPN, verified that R7 was ambulatory and would wander throughout the facility independently. E9 stated that night time snacks were left on top of the nurse's desk, and anyone walking by would have access to these snacks. E9 stated on 1/25/15 at 8:25pm, E9 heard E13, LPN, yell for help, so E9 ran to the north dining room. Upon entering the north dining room, E9 verified seeing R7 lying on the floor, with blue skin color and a faint pulse. E9 stated, "We started CPR (Cardiopulmonary Resuscitation) and called 911."

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S9999	Continued From page 4	S9999		

R7's Nurse's Notes dated 1/25/15 document that R7 was observed on the North Dining Room floor, cyanotic with no respirations, and R7 had bread, peanut butter and jelly coming out of R7's mouth.

On 4/9/15 at 2:10pm, E14, Dietary Manager, verified that R7 would eat too fast and needed reminders to slow down. E14 also verified that R7 would wander throughout the facility independently. E14 then stated, "(R7) would grab food, and (facility staff) would take it away from (R7)." E14 also stated that the facility's night time snacks consisted of pudding, applesauce, graham crackers, and peanut butter and jelly sandwiches. On 4/12/15 at 11:45am, E14 verified that a regular peanut butter and jelly sandwich is not an appropriate snack for R7.

(A)

300.690b)
300.690c)

Section 300.690 Incidents and Accidents
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional

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S9999	Continued From page 5	S9999		

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 toll-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 Ill. 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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S9999	Continued From page 6 was coming out of (R7's) mouth. CPR (Cardiopulmonary Resuscitation) was initiated." Local hospital emergency room notes, dated 1/25/15, document, "...On arrival, large amount of brownish material suctioned and on presentation intubated..." This same form documents R7's time of death at 9:06 pm on 1/25/15. 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, "There is no exact test, but the food appeared to be peanut butter." On 4/12/15 at 11:45am, E14, (Dietary Manager), verified that a regular peanut butter and jelly sandwich is not an acceptable snack for a person on a pureed diet. 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, even though the incident happened here, because (R7) passed away at the hospital." (AW)	S9999		

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