STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002612	A. BUILDING: _____ B. WING _____	C 04/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DU PAGE CONVALESCENT CENTER	400 N COUNTY FARM RD PO BOX708 WHEATON, IL 60187

(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 Complaint Investigation Survey # 1572117/IL76644 Statement of Licensure Violations 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 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. Section 300.1030 Medical Emergencies 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:	S9999		

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S9999	Continued From page 1 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). These requirements were not met as evidenced by: Based on interview and record review the facility failed to notify the State Department of a resident's serious incidents and the facility also failed to develop policies and procedures to be followed during Pulmonary emergencies. This applies to 1 of 3 residents (R1) reviewed for choking incidents. R1 had a choking incident on 9/14/13. R1 expired on 9/14/13. The medical examiner/coroner certificate of death documented R1's cause of death as, "choked on a food bolus." The findings include: R1 was originally admitted to the facility on 2/17/1994 with multiple diagnoses which included vascular Dementia, GERD (gastroesophageal reflux disease) and muscle weakness. R1's quarterly MDS (Minimum Data Set) dated 7/1/2013 showed a BIMS (Brief Interview for Mental Status) score of "14" indicating that the resident is cognitively intact and would require set up help only for eating. R1's September 2013 POS (Physician Order Sheet) showed an order for general/ no salt packet diet. The same POS also showed an order for Do Not Resuscitate. R1's occurrence report dated 9/14/13 (8:00 AM) documents, "Around 8:00 AM, housekeeping alerted RN (registered nurse) that the resident did not look well. RN was present in the dining room area at this time. RN ran to patient (patient was found with head tilted back). At this time RN performed Heimlich maneuver. At this time resident expelled oatmeal and piece of prune. The resident then turned cyanotic in the face.	S9999		

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S9999	Continued From page 2 Rushed resident towards the crash cart where at this time patient was hooked to suction apparatus then given oxygen 10L (liters). Attempted to retrive SA02 (oxygen saturation) but pulse oximeter could not detect. Resident was then transferred to her room and placed into bed with HOB (head of Bed) 90 degrees. Oxygen given via mask. Neb tx (Nebulization treatment) given. Resident suctioned once more. Resident was noted biting the suction catheter. Resident was not verbally responsive but was alert. VS (Vital Signs) 130/100, 108 Apical pulse, 20, temp. 96.7. Resident was responding to treatment although the resident did have labored breathing at this time. 911 was contacted at 8:20 AM." "8:27 AM 911 arrived. 8:28 AM resident was noted to have no pulse, no respiration, no blood pressure, no breath sounds, 8:39 AM paramedics contacted their DR (doctor) to confirm time of death 8:39 AM." R1's Medical examiner/Coroner Certificate of Death showed that the resident expired on 9/14/13 at 8:39 AM with the cause of death as, "Choked on a food bolus." In an interview held on 4/23/15 at 3:00 PM, E1 (Administrator) and E2 (Director of Nursing) both stated that R1's incident of choking and subsequent death after the choking incident was not reported to the State Department. In an interview held on 4/23/15 at 4:00 PM in the presence of E1, E2 stated that the facility does not have a policy and procedure in place to address pulmonary emergencies such as choking. (B)	S9999		