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
	IL6001697	A. BUILDING: _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE SNF	10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

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S 000	Initial Comments Complaint Investigation 2198913/IL140849 -	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b) 300.1210 c) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. These requirements are not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that supervision and monitoring of a resident with cognitive impairment and swallowing difficulties were implemented in preventing a choking incident for one (R1) of three residents reviewed for accidents and supervision. This deficiency resulted in R1 who was found unresponsive, with a piece of sandwich inside the mouth and subsequently died. Findings include: R1 is a 79 year-old, female, admitted in the facility on 07/12/14 with diagnoses of Unspecified Sequelae of Cerebral Infarction; Cerebral Infarction, Unspecified; Unspecified Dementia with Behavioral Disturbance; Alzheimer's Disease, Unspecified; Need for Assistance with Personal Care; Schizophrenia, Unspecified and Manic Episode, Unspecified. Physician Order Sheet (POS) dated 08/03/21 recorded R1's diet as no added salt, pureed texture. According to progress notes dated 08/09/21, R1 was found unresponsive in bed. A small piece of sandwich was found inside her mouth. Paramedics were called and came. R2 was	S9999		

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pronounced dead at 9 PM.

Death Certificate dated 10/18/21 documented R1's causes of death as follows: Asphyxia; Choking on food bolus.

On 12/13/21 at 2:50 PM, V3 (Assistant Director of Nursing) was interviewed regarding R1. V3 stated, "She had been here for a while in the facility. She was alert, oriented to time, place and person. She had behavior issues by going to other residents' rooms and pulling the lights. She is able to move her upper extremities and able to transfer self from bed to wheelchair. She is able to feed herself without supervision. I don't remember if she has any swallowing difficulties. She was able to eat with no issues. She eats in her room." V3 was asked about what happened to R1 on 08/09/21 when she was found unresponsive. V3 replied, that day, she was found unresponsive by V10 (Registered Nurse, RN) and I was informed. He (V10) called paramedics. I went to the room, she (R1) was lying on the bed, unresponsive. Paramedics were there but they did not take her to the hospital. They said they cannot do anything because she was a DNR (do not resuscitate) and expired. He (V10) told me that when he saw her, she was lying on the bed and unresponsive. V10 said she was sitting in the wheelchair roaming in the hallway 10 minutes before. I don't know if they intubated her or not, paramedics were in the room and said they found a small piece of food in her throat. She was not a feeder and needed tray set up only. We just leave the tray on the table and R1 eats her foods without staff supervision. She does not need a staff supervising her when eating.

On 12/14/21 at 11:15 AM, V4 (RN) was also asked regarding R1. V4 stated, "She was alert,

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oriented to person and place; and has to be redirected constantly. She had behaviors by going into other residents' rooms, would put herself on the floor and crawl and lie on the floor. She was able to feed herself. Staff needs to do a tray set up and she can eat independently without supervision. She does not need any supervision during eating. She eats in her room. Staff just need to give her the tray and she can feed herself without staff present. She needs to be redirected; she was not one on one. She does the behaviors on purpose; she does not need constant supervision due to behavior."

V8 (RN) also stated in an interview on 12/14/21 at 11:29 AM regarding R1. V8 replied, "She was alert, oriented to person, place and time. She was able to verbalize what she wants but she wanders from one room to another and in the hallway. She needs redirection, she had a lot of behaviors. She eats independently. I am not sure if she needs supervision during eating. Most of the time I do the treatment and can't remember."

Per MDS (Minimum Data Set) dated 07/13/21, R1's BIMS (Brief Interview for Mental Status) score was 2 which means severe cognitive impairment. Her functional status for activities of daily living (ADL) assistance indicated that she needs supervision from one person physical assist during eating. Her MDS also recorded: Section K100 - Swallowing disorder: A. Loss of liquids/solids from mouth when eating or drinking - yes.

Nutritional Risk Review dated 07/14/21 documented:
B. Oral Intake: Food
6. Signs and Symptoms of possible swallowing disorder - 2. Pocketing and/or drooling

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S9999	Continued From page 4 Care plan date initiated 01/05/18 documented: ADL self-care performance deficit related to Dementia - Intervention: Eating - supervision assistance one person physical assist. On 12/15/21 at 12:12 PM V17 (Dietary Technician) was asked regarding swallowing ability of R1, V17 stated, "She was alert, had a mechanically altered diet which is a pureed diet. She had some swallowing difficulties when she was eating. I do know she was verbal and had a diagnosis of Dementia. She was alert enough to feed herself but needed set up with her meals and needed supervision while eating. She had some difficulty with swallowing. She had drooled lots of foods indicating swallowing difficulties. She can only eat pureed foods and thin liquids. She did not have any sandwiches in her diet but pureed." V10 was asked on 12/14/21 at 12: 55 PM regarding R1's incident on 08/09/21. V10 verbalized, "That day, when I did my rounds from room to room I found her unconscious. I immediately called paramedics. She (R1) actually has a behavior - she likes to eat foods from other residents. She was not alert or oriented. I remember that she went to residents' rooms and ate their foods, she does that 10-15 times. I remember she steals foods from other residents. She cannot walk and uses a wheelchair and keeps on moving and moving around. I don't remember if she was a feeder, but she steals foods from other residents meaning she is able to eat by herself." Care plan date initiated 11/19/16 regarding impaired cognitive function/dementia or impaired thought processes. Intervention: Date initiated	S9999		

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S9999	Continued From page 5 09/21/16 - Cue, reorient and supervise as needed. Care plan date initiated 11/21/16 regarding at risk for a decline: I will be able to feed self after set up with supervision. Intervention: Monitor/document/report to MD (Medical Doctor) PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Care plan date initiated 06/05/18 regarding at risk for falls and injury due to decreased functional mobility skills, impaired cognition, poor safety awareness. Intervention: Resident (R1) requires frequent monitoring secondary to Dementia. V3 was asked regarding R1's behavior of stealing and eating other residents' foods. V3 mentioned, "She goes to other residents' rooms just to pull the bathroom call lights and said she did it purposely. I am not aware that she steals or eats other residents' foods. It was care planned regarding her room to room wandering. She needs to be redirected and educated because she is alert and oriented. She does not need supervision." There were no care plans formulated addressing R1's behaviors of going to other residents' rooms, stealing foods and eating the foods from other residents. On 12/14/21 at 3:08 PM, V16 (Nurse Practitioner) was asked regarding R1. V16 stated, "She was not alert and oriented. She had memory impairments. She had a CVA (Cerebrovascular Accident, Stroke). She also had psychiatric issues. She does not talk. I am not aware of her behavior of going to other residents' rooms. I	S9999		

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don't know. She passed away. When they called me, they found like a food in her mouth. She was unresponsive, a DNR and was declared dead. Most of the CVA residents are on aspiration precautions. Staff needs to do supervision on residents at least every two hours, do rounds to make sure that residents are safe, no falls and alive. Staff are also expected to know their residents, their care plans and other medical information."

Facility's policy titled "Policy and Procedure Safety and Supervision of Residents" dated 9/2021 documented in part but not limited to the following:
Policy Statement
Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

Policy Interpretation and Implementation
Resident-Oriented Approach to Safety
1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents.
2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS.
3. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents.
4. Implementing interventions to reduce accident risks and hazards shall include the following:
   a. communicating specific interventions to

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S9999	Continued From page 7 all relevant staff; d. ensuring that interventions are implemented; and e. documenting interventions 5. Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently Systems Approach to Safety 1. The facility-oriented approaches to safety are used together to implement systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. (A)	S9999		