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
	IL6003198	A. BUILDING: ______ B. WING ______	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

(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
S 000	Initial Comments Complaint Investigation 2320065/IL154933 2320203/IL155140	S 000		
S9999	Final Observations Statement of Licensure Violations (Part 1 of 2) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.2040b)1)2) 300.2040c) 300.2040e) 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 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1	S9999		

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing,

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S9999	Continued From page 2	S9999		

activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

1) The resident's diet order shall be included in the medical record.

2) The diet shall be served as ordered.

c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is changed. Each change shall be ordered by the physician or dietitian. The diet order shall include, at a minimum, the following information: name of resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to the food service department, name of physician or dietitian ordering the diet, and the signature of the person transmitting the order to the food service department.

e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the

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S9999	Continued From page 3	S9999		

diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

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 requirements were not met as evidenced by:

Based on interview and record review, the facility failed to supervise a cognitively impaired resident during an evening dinner meal and follow a Physician's Diet Order for a Mechanically Altered Diet for one resident (R2). These failures results in R2 choking, requiring Cardiopulmonary Resuscitation and subsequently died. These failures have the potential to affect all twelve residents (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14) residing in the facility that receive a Mechanically Altered Diet for residents reviewed for diets received in a sample of 14.

Findings include:

The Facility COVID Policy, revised 11/7/22, documents the Residents on Transmission Based Precautions/TBP cannot participate in communal dining.

The Facility Dietary Policy/Cycle Menu, revised 4/21, documents: A Mechanical Soft diet is designated for individuals who have difficulty chewing but are able to tolerate a wide variety of foods; this diet is designed to permit easy chewing, ground meat and soft bread and cereal products; modifications in the diet need to be

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S9999	Continued From page 4	S9999		

individualized according to the Resident's needs; and diet ordered which are not found on the modified spreadsheets shall be referenced using the Diet Manual and have posted instructions in the serving area.

The Facility Room Trays Policy, dated 10/08, documents: It is the policy of the Facility that residents who choose not to or are unable to attend the dining room for meals will be served appropriate meals in his/her room.

Facility Diet Listing, dated 12/22/22, and provided on 1/4/22, documents that twelve residents receive a Mechanically Altered Diet (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13 and R14). The Facility Diet Listing documents R2's diet order as Regular, Thin Liquids with Finger Foods.

Facility Resident Council Minutes, dated 11/30/22, document that the Facility is under COVID precautions and Residents have been "eating in their rooms."

Facility Licensed Practical/LPN Nurse Job Description, undated, documents: The LPN responsibility is to assist in completing the nurse admission assessment on admission or assigned residents; participates in identification of problems on assigned residents; reviews Physician Orders on assigned Residents prior to care; demonstrates support of the philosophy of the nursing department by adhering to policies, procedures and established standards of nursing; and maintains current knowledge in present nursing practice area.

Facility Registered Nurse/RN Job Description, undated, documents: Must possess a general knowledge and understanding of the State and

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S9999	Continued From page 5 Federal laws as they pertain to long term care; completes the nursing admission assessment on admission or assigned residents per procedure utilizing proper techniques, tools and history and for caring for each resident; consults other departments as required or needed; reviews Physician Orders on assigned Residents prior to care and integrates therapeutic plans of care in collaboration with the Interdisciplinary Team. Facility Daily Assignment Sheet, dated 1/1/23, documents that V5 (Licensed Practical Nurse/LPN), V7 (Certified Nursing Assistant/CNA) and V8 (CNA) were scheduled on the A Hall (R2's Hall). V4 (Certified Nursing Assistant/CNA) was scheduled on B Hall. Facility Week at a Glance Menu, dated Sunday 1/1/23, documents that Salisbury Steak with Gravy, Asparagus, Bread/Margarine, Fruit of Choice, Gelatin and Milk were served for the evening dinner meal. Facility Admission History Report, documents that R2 admitted to the Facility on 12/14/22 and re-admitted to the Facility on 12/24/22. R2's Physician Order Sheet, dated 12/24/22, documents a Physician Diet Order for Mechanical Soft, Nectar Thick Liquids. R2's current Baseline Care Plan documents that R2 requires the assistance of one staff member for eating, has poor safety awareness, cognitive deficits, forgetful and poor mobility requiring staff assistance. The Care Plan does not document R2's Mechanical Soft Diet, Swallow Precautions or Nectar Thick Liquids. R2's Nutritional Assessment, dated 12/28/22,	S9999		

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S9999	Continued From page 6	S9999		

does not document R2's Physician Diet order of Mechanical Soft, Nectar Thick Liquids. The Nutritional Assessment documents Regular, Thin Liquids and Finger Foods.

The current Diet Order Form, dated 12/14/22, documents a Physician Diet Order of Regular, Thin Liquids. The Facility could not provide an updated Diet Order for the 12/24/22 admission.

R2's current Minimum Data Set, dated 12/18/22, documents that R2 requires one person physical assistance with eating.

R2's AIM for Wellness Assessment, dated 1/1/23 (no time), documents that R2 was found unresponsive. The AIM for Wellness documents "Approximately four minutes earlier (V4/Certified Nursing Assistant) readied (R2) for evening (PM) meal and set up tray. Called (V5/Licensed Practical Nurse) to Resident room per (V4) observed resident slumped over to the left of the bed, pupils fixed, no pulse or respirations. (R2) was lowered to the floor and Cardiopulmonary Resuscitation (CPR) initiated. Emergency Services (AMT) called, when arrived took over 'code.' Pronounced time of death at 6:42 pm."

R2's Nursing Note, dated 12/24/22 at 4:00 pm, documents that R2 admitted back to the Facility with a Physician Diet Order of "Thickened, Honey Liquids." The Nursing Note does not document the Mechanical Soft Diet Order. The Nursing Note documents that R2 is not able to use the call light and does require assistance of staff for Activity of Daily Living.

R2's Nursing Note, dated 1/1/23 at 6:07 pm, documents, "Approximately four minutes earlier (V4/Certified Nursing Assistant) readied (R2) for

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S9999	Continued From page 7 evening (PM) meal and set up tray. Called (V5/Licensed Practical Nurse) to Resident room observed resident slumped over to the left of the bed Pupils fixed, no spontaneous respirations, no radial pulse palpated, no apical heart tones. (R2) lowered to the floor and CPR initiated, Emergency Services (911) called." R2's Nursing Note, dated 1/1/23 at 6:20 pm, documents, "Emergency Services (AMT) here and took over 'code.' Called time of death at 6:42 pm." R2's Hospital After Visit Summary Record, dated 12/24/22, documents that R2's diet upon discharge is Mechanical Soft Restrictions and Nectar Thick Liquids. The After Visit Summary Record documents diagnoses including Right Ankle Fracture, Diabetes, Acute Encephalopathy, Hypoglycemia, Chronic Obstructive Pulmonary Disease, Acute Kidney Injury and Right Side Lucanar Stroke. The Emergency Services Report/EMS Report, dated 1/5/23, documents that on 1/1/23, EMS responded to a call that R2 was unresponsive and had a dinner tray delivered approximately 20 minutes prior and the staff found R2 unresponsive approximately ten minutes after the dinner tray was delivered. The staff denied R2 being sick recently or change in medications. The EMS Report documents there was noted emesis in R2's mouth and R2 required suctioning. The EMS Report documents that EMS relieved staff of CPR upon arrival to the Facility. R2's Preliminary Autopsy Report, dated, 1/6/23, documents the cause of death as Aspiration of food, with bits of food within the bilateral bronchi of the lungs and residual bits in the trachea.	S9999		

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S9999	Continued From page 8 On 1/4/23 at 3:35 pm, V4 (CNA) stated, "I was not assigned to that hallway, but they called a 'code' on the A Hall, so I started compressions. (R2) was already blue. (V7/CNA) and myself alternated CPR (Cardiopulmonary Resuscitation) for about fifteen to twenty minutes until the Paramedics arrived. V7 (CNA) delivered R2's room tray and said she cut up (R2's) food and started her eating, then went down the hallway to deliver more room trays, because the whole facility was on quarantine status and eating in their rooms, because of the positive COVID in the building." On 1/4/23 at 3:14 pm, V5 (Licensed Practical Nurse/LPN) stated, "I was (R2's) nurse on 1/1/23 at about 6:00 pm, for the evening meal. We were under quarantine, so all residents were eating in their rooms. (V7/CNA) told me that (V7) delivered (R2's) room tray and cut up the meat (Salisbury Steak) and gave her a bite, left (R2's) room, then delivered the other room trays down the hall. When (V7) came back up the hallway, after delivering the trays, (V7) noticed that (R2) was blue, so (V7) came and got me. I went down to (R2's) room and there were no respirations or pulse and R2 was already mottling at (R2's) neck. I looked in (R2's) mouth and did not see anything. We got her to the floor and (V4 and V7) started CPR (Cardiopulmonary Resuscitation), while I went and called Emergency Services (911). They arrived and took over and she was pronounced dead around 6:42 pm." On 1/20/23 at 3:14 pm, V13 (Certified Nursing Assistant/CNA) stated, "Everyone was talking about how (R2) got the wrong diet on 1/1/23. They served her the wrong food consistency; she got a Regular, Thin Liquid tray. She re-admitted	S9999		

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S9999	Continued From page 9	S9999		

back on 12/24/22, and had been getting Regular, Thin Liquids since 12/24/22. They never corrected her diet tray. I took care of her and when she came back on 12/24/22, she was confused on and off. When someone has a diet order of Mechanical Soft and Honey Thick Liquids, they should not be left in their room alone. We do not have enough staff to accommodate all those people being quarantined in their rooms that need assistance with eating. We normally only have about one or two people available to watch over the residents that need supervised with eating. None of the nurses or management staff help us, and it would be nice if they did."

On 1/4/23 at 4:51 pm, V11 (Dietary Manager) stated, "(R2) was served a Regular, Thin Liquid meal tray on 1/1/23. The meal was Salisbury Steak, broccoli, bread/butter and fruit cocktail. We substituted the broccoli for asparagus because no one like asparagus and we did not serve jell-o, because someone forgot to make it. My documentation shows that she (R2) is on a General, Regular Diet with thin liquids and finger foods."

On 1/4/23 at 2:20 pm, V1 (Administrator) stated, "The whole facility was eating in their rooms because we were in quarantine status because we had a positive COVID test. That is our protocol. (R2) was passed a room tray on 1/1/23 of Salisbury Steak, mashed potatoes and finger foods. She came to us around 12/14/22 and was sent out to the hospital and came back on 12/24/22. I know that four to five minutes went by from the time she received the wrong tray until V7 (CNA) went back and found her unconscious in bed. They performed CPR (Cardiopulmonary Resuscitation) and (R2) was pronounced dead at

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S9999	Continued From page 10 6:42 pm. I did not notify the Local Health Department, because I did not think (R2's) death needed to be. I thought it was a natural death." On 1/10/23 at 9:28 am, V1 stated, "After we looked at the COVID Policy, (R2) should have come out of her room for dining, only COVID positive should have stayed in their room for dining." On 1/10/23 at 9:28 am, V1 stated, "We did all of the audits and found that the Dietary Department was delivered the new diet order for (R2), but no one could find it, so (R2's) diet never got changed to the Mechanical Soft, Honey Thick Liquids. It is hard to cover all of the assuasive feeders with the amount of staff we have, especially when they are all room trays." On 1/10/23 at 3:07 pm, V12 (Coroner) stated, "The Death Certificate is not available yet. It will take about three weeks, but (R2's) death is ruled accidental and the cause of death is Aspiration of food. We performed an autopsy so that is what is delaying the Death Certificate. The autopsy showed Aspiration of food, with bits of food within the bilateral bronchi of the lungs and residual bits in the trachea. A lot of times if CPR is being performed in a forceful way, the debris gets 'stuffed deeper' into the airway, so that is why I performed an autopsy. The Emergency Services Report stated that (R2) aspirated and there was debris in the airway. (V9/R2's Physician) stated initially upon death, before the autopsy, that (V9) was leaning towards Aspiration as the cause of death." (Part 2 of 2) 300.690a)1)2)	S9999		

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S9999	Continued From page 11 300.690b) 300.690c) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. These requirements were not met as evidenced by: Based on interview and record review the Facility failed to notify the Department of an unexpected death for one (R2) of three residents reviewed for death in a sample of 14.	S9999		

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S9999	Continued From page 12 Findings include: R2's Hospital After Visit Summary Record, dated 12/24/22, documents diagnoses including Right Ankle Fracture, Diabetes, Acute Encephalopathy, Hypoglycemia, Chronic Obstructive Pulmonary Disease, Acute Kidney Injury and Right Side Lucanar Stroke. R2's AIM for Wellness Assessment, dated 1/1/23 (no time), documents that R2 was found unresponsive. The AIM for Wellness documents "Approximately four minutes earlier (V4/Certified Nursing Assistant) readied (R2) for evening (PM) meal and set up tray. Called (V5/Licensed Practical Nurse) to Resident room per (V4) observed resident slumped over to the left of the bed, pupils fixed, no pulse or respirations. (R2) was lowered to the floor and Cardiopulmonary Resuscitation (CPR) initiated. Emergency Services (AMT) called, when arrived took over 'code.' Pronounced time of death at 6:42 pm." R2's Nursing Note, dated 1/1/23 at 6:07 pm, documents, "Approximately four minutes earlier (V4/Certified Nursing Assistant) readied (R2) for evening (PM) meal and set up tray. Called (V5/Licensed Practical Nurse) to Resident room observed resident slumped over to the left of the bed Pupils fixed, no spontaneous respirations, no radial pulse palpated, no apical heart tones. (R2) lowered to the floor and CPR initiated, Emergency Services (911) called." R2's Nursing Note, dated 1/1/23 at 6:20 pm, documents, "Emergency Services (AMT) here and took over 'code.' Called time of death at 6:42 pm."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003198	A. BUILDING: ______ B. WING ______	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

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S9999	Continued From page 13	S9999		

Continued From page 13

R2's Preliminary Autopsy Report, dated 1/6/23, documents the cause of death as Aspiration of food, with bits of food within the bilateral bronchi of the lungs and residual bits in the trachea.

On 1/10/23 at 3:07 pm, V12 (Coroner) stated, "The Death Certificate is not available yet. It will take about three weeks, but (R2's) death is ruled accidental and the cause of death is Aspiration of food. We performed an autopsy, so that is what is delaying the Death Certificate. The autopsy showed Aspiration of food, with bits of food within the bilateral bronchi of the lungs and residual bits in the trachea. A lot of times if CPR is being performed in a forceful way, the debris gets 'stuffed deeper' into the airway, so that is why I performed an autopsy. The Emergency Services Report stated that (R2) aspirated and there was debris in the airway. (V9/R2's Physician) stated initially upon death, before the autopsy, that (V9) was leaning towards Aspiration as the cause of death."

R2's Facility Local Health Department Notification, dated 1/6/23 at 1:36 pm, documents notification of R2's 1/1/23 incident.

On 1/6/23 at 9:45 am, V2 (Director of Nursing/DON) stated, "I did not notifiy Public Health of the death."

On 1/10/23 at 9:45 am, V2 (DON) stated, "I was told on Friday 1/6/23, by 'Corporate,' not to send in a notification to Public Health, but I had already sent in the Initial earlier that day. I did not know that Public Health needed to be notified of R2's death, even though it was not anticipated or expected."

On 1/4/23 at 2:20 pm, V1 (Administrator) stated,

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S9999	Continued From page 14 "The whole facility was eating in their rooms because we were in quarantine status because we had a positive COVID test. That is our protocol. (R2) was passed a room tray on 1/1/23 of Salisbury Steak, mashed potatoes and finger foods. She came to us around 12/14/22 and was sent out to the hospital and came back on 12/24/22. I know that four to five minutes went by from the time she received the wrong tray until V7 (CNA) went back and found her unconscious in bed. They performed CPR (Cardiopulmonary Resuscitation) and (R2) was pronounced dead at 6:42 pm. I did not notify the Local Health Department, because I did not think (R2's) death needed to be. I thought it was a natural death." (A)	S9999		