STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005334	A. BUILDING: _____ B. WING _____	C 02/16/2023

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S 000	Initial Comments Investigation of Facility Reported Incident of February 1, 2023/IL156258.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)3)6) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident with a history of overstuffing his mouth with food was provided supervision and intervention during consumption of a peanut butter sandwich. The facility also failed to have a system in place to identify residents with swallowing precautions and failed to supervise two other residents on swallowing precautions during a meal service. This failure resulted in R1 experiencing a choking incident requiring the Heimlich maneuver and transportation to the local hospital. Hospital documentation showed R1 expired at the local hospital within an hour of the incident on February 1, 2023, at 3:55 AM. This applies to 3 of 5 residents (R1, R2, and R3) reviewed for accidents and supervision in a sample of 5. The findings include: 1. The facility's final report to the State Agency dated February 3, 2023, showed R1 came out of his room and approached the nurses' station and had obtained a peanut butter and jelly sandwich from nursing staff at 3:00 AM. R1 sat in a chair in front of the nurses' station and consumed the sandwich without difficulty while supervised. After	S9999		

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the sandwich was consumed, R1 then got up from the chair with the use of his rolling walker and ambulated to another chair down the hall close to his room and took a seat. NOD (Nurse on Duty) then noted R1 to be in distress and had abnormal movements to his arms and he began to fall over in the chair to the right, NOD and another nurse immediately ran to R1 as he was falling to the floor, per investigation this was at 3:05 AM. Staff immediately began abdominal thrusts to perform the Heimlich maneuver as they noted food particles to be on his lips, the NOD also attempted a finger sweep which resulted in her being bitten. Another staff member had alerted rapid response and notified 911 (emergency) services. Staff continue with life saving measures. Emergency services arrived and resumed care for R1. Emergency services left the facility with R1 and transported him to the Emergency Department. A follow up call was place to the Emergency Department; staff was notified that the resident expired at 3:55 AM.

On February 8, 2023 at 10:20 AM, V3 (LPN) said she was the nurse caring for R1 the night of the choking incident on February 1, 2023. V3 continued to say R1 had asked for a peanut butter and jelly sandwich. V3 said R1 was given a sandwich and he sat by the nurses' station to eat the sandwich. V3 said she could not see R1 while he was eating his sandwich.

On February 8, 2023 at 5:07 PM, V4 (LPN) said "[R1] came out of his room at about 3:00 AM on February 1, 2023, and asked for a peanut butter and jelly sandwich. [R1] sat in front of nurses' station where I could see him. I saw him take one bite of the sandwich. It was a huge, big bite. He ate over half of the sandwich in one bite. I did not say anything to him because he always eats

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like that. I did not know I had to say anything to him. Then, he got up from the nurses' station while holding the rest of the sandwich and walked to a chair across from his room. I watched him walk over there. The way he moved was weird, then he started falling out of the chair. He was turning blue. [V3] and I ran to him and turned him on his side, but he didn't respond."

A progress note dated February 1, 2023, at 7:04 AM by V4 showed, "Around 3:00 AM resident came to the nursing station and asked for a sandwich. He sat in front of the nursing station and had a bite. Then he moved and seated in a chair by [resident room - approximately 10 feet from the nursing station]. I notified the resident had hard time breathing, run to assist. When I got close, he fell out of the chair. [V3] and I tried to put on the side and checked if he was alerted but the resident couldn't respond. One of the nurses called [Emergency Services] when we tried to help the resident."

On February 9, 2023 at 11:29 AM, V16 (Deputy Coroner) said R1 died from choking on peanut butter.

Hospital documentation dated February 1, 2023, at 4:04 AM, by V23 (Emergency Room Physician) showed "75 year old male, history of hypertension, GERD (Gastroesophageal Reflux Disease), hyperlipidemia, schizophrenia presenting as a full arrest. Per EMS (Emergency Medical Services), patient seen walking in the hallway in his facility when they noted him choking on a peanut butter jelly sandwich. On their arrival, patient pulseless in PEA (Pulseless Electrical Activity). Three doses of epinephrine initiated in route without ROSC (Return of Spontaneous Circulation) ... Food debris noted in

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S9999	Continued From page 4 the oropharynx (back of throat) extending down towards the trachea ... Bedside cardiac ultrasound without any cardiac activity. Time of death at 0355 (3:55 AM)." Hospital documentation dated February 1, 2023, at 3:46 AM by V24 (Emergency Room Registered Nurse) showed "Peanut butter noted to be coming from Endotracheal Tube (breathing tube)." R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on November 25, 2020, with multiple diagnoses including schizophrenia, traumatic brain injury, GERD, and dry mouth. R1's MDS (Minimum Data Set) dated December 17, 2022, showed R1 was cognitively intact and required set up help and supervision from facility for eating. R1's care plan dated December 1, 2022, showed "[R1] at times over stuffs food in his mouth while eating." The care plan continued to show multiple interventions dated December 1, 2022, including "[R1] will take small bites." On February 8, 2023, at 4:01 PM, V2 said R1's care plan was in place due to a behavior R1 had of overstuffing his mouth with food. On February 9, 2023, at 10:57 AM, V2 said staff would know which residents have behaviors while eating by going through the resident's care plan. V2 continued to say staff would have to look in R1's care plan for the interventions he required while eating. V2 said R1 was not on the list of residents with dysphagia or the list of residents on aspiration precautions.	S9999		

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S9999	Continued From page 5 On February 9, 2023, at 11:13 AM, V10 (Certified Nursing Assistant/CNA) said she used to take care of R1. V10 continued to say she was unaware R1 had a behavior of taking big bites or overstuffing his mouth while eating. On February 9, 2023, at 8:58 AM, V15 (Speech-Language Pathologist/SLP) said if a nurse sees a resident overstuffing their mouth, the nurse should be telling the resident to spit the food out of their mouth. 2. On February 8, 2023, at 12:33 PM, R2 was seated in the main dining room. R2 had not received a meal tray yet. R2 was eating a cup of fruit. On February 8, 2023, at 12:44 PM, V9 (CNA) said staff had not provided R2 with fruit prior to R2 receiving her meal tray. V9 continued to say R2 had taken the fruit from another resident's meal tray, and staff were unaware and not supervising the resident until R2's meal tray was delivered. R2's EMR (Electronic Medical Record) showed R2 was admitted to the facility on May 9, 2022, with multiple diagnoses including psychosis, type 2 diabetes, dementia, depression, and hypertension. R2's MDS (Minimum Data Set) dated November 22, 2022, showed R2 had moderate cognitive impairment and required supervision with set up help for eating. R2's aspiration care plan dated February 1, 2023, showed "[R2] has potential for aspiration or choking related to advanced age, on therapeutic diet, mechanical soft, and current medical	S9999		

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condition (dysphagia, history of choking). Resident had choking episode 11-30-22. Speech therapy and swallow evaluation ordered." The care plan showed multiple interventions dated February 1, 2023, including "Aspiration precautions; encourage resident to eat slowly; cue resident to take small bites or small sips at one time; provide supervision and assist the resident as needed during meals."

R2's Order Summary Report dated February 14, 2023, showed an order dared December 14, 2022, for "LCS (Low Concentrated Sweets) diet, mechanical soft texture, regular/thin consistency."

A progress note dated November 30, 2022, at 6:39 PM, by V13 (Registered Nurse/RN) showed, "At 5:45 PM, noted resident having face red and choking episode, staff done the abdominal Heimlich, food came out, resident talked and coughing, resident was responsive and alert no shortness of breath was noted.

On February 9, 2023, at 8:58 AM, V15 (SLP) said R2 had a choking incident on November 30, 2022, and R3 had a second choking incident shortly after which led to R2's diet being changed on December 14, 2022, from regular consistency to mechanical soft.

On February 8, 2023, the facility provided an undated list titled, "ASPIRATION PRECAUTIONS LIST." R2 was identified on the list as having aspiration precautions.

On February 8, 2023, at 12:44 PM, V9 (CNA) said if a resident is on aspiration precautions it is written on their meal card. V9 said multiple residents with aspiration precautions eat in the main dining room at meals. V9 continued to say

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she does not know how to identify if a resident is on aspiration precautions if she did not deliver the resident's meal tray.

On February 9, 2023, at 2:47 PM, V19 (CNA) said she would work in the main dining room during meal service and assist with passing out resident meal trays. V19 said the only residents on aspiration precautions eat in the small dining room. V19 continued to say she does not have to supervise any of the residents who eat in the main dining room. V19 was not aware R2 has aspiration precautions and eats in the main dining room.

On February 9, 2023, at 2:49 PM, V20 (CNA) said she helps pass out trays in the main dining room during meal service. V20 continued to say the only residents who need to be supervised for swallowing sit in the small dining room. V20 said the CNAs do not have to supervise any residents who eat in the main dining room. V20 was not aware R2 has aspiration precautions and eats in the main dining room.

3. On February 8, 2023, at 12:26 PM, R3 was in the main dining room eating lunch. R3 was coughing while eating, no staff observed R3 or responded to R3. At 12:38 PM, R3 was putting three quarters of a piece of plain bread in his mouth. No staff observed R3 eating the bread. No staff intervened while R3 was taking large bites of bread, and no staff cued R3 to take small bites of his bread. R3's meal ticket showed "Aspiration Precautions."

R3's EMR showed R3 was admitted to the facility on December 2, 2020, with multiple diagnoses including schizoaffective disorder, chronic obstructive pulmonary disease, diabetes, and

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S9999	Continued From page 8 dysphagia. R3's MDS dated December 19, 2022, showed R3 was cognitively intact and required set up help only and supervision of facility staff for eating. R3's aspiration care plan dated February 1, 2023, showed "[R3] has potential for aspiration or choking related to advanced age and current medical condition (dysphagia)." The care plan continued to show multiple interventions dated February 1, 2023, including "Encourage the resident to eat slowly; Cue resident to take small bites or small sips one at a time; Assist the resident during meals and provide supervision." R3's EMR showed a diet order dated January 25, 2022 for "LCS diet, regular texture, regular/thin consistency." On February 8, 2023, the facility provided an undated list titled, "ASPIRATION PRECAUTIONS LIST." R3 was identified on the list as having aspiration precautions. On February 8, 2023, at 1:39 PM, V11 (CNA) said there is a list of residents on aspiration precautions at the nurses' station. V11 provided a list dated February 8, 2023, titled "Active Clients Filtered by Consistency: Mech (Mechanical) Soft." V11 provided a second list dated February 8, 2023, titled "Active Clients Filtered by Consistency: Pureed." V11 said these are the residents that require supervision when eating. R3 was not identified on either list. V11 was not aware the facility had another list titled "Aspiration Precautions List." On February 8, 2023, at 1:46 PM, when asked to identify which residents in the facility required	S9999		

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monitoring for aspiration precautions, V12 (LPN) said only those residents on pureed or mechanical soft diets. V12 was not aware the facility had another list titled "Aspiration Precautions List"

On February 8, 2023, at 1:58 PM, V13 (RN) said there is a list of which residents on aspiration precautions. V13 provided a list dated February 8, 2023, titled "Active Clients Filtered by Consistency: Mech (Mechanical) Soft." V13 provided a second list dated February 8, 2023, titled "Active Clients Filtered by Consistency: Pureed." V13 was not aware the facility had another list titled "Aspiration Precautions List"

On February 9, 2023, at 2:38 PM, V18 (RN) said she did not know which of her residents had aspiration precautions, and she would have to look in the computer. V18 continued to say it would show in the resident's diet order if the resident was on aspiration precautions.

R3's diet order did not show R3 had aspiration precautions.

On February 9, 2023, at 8:58 AM, V15 (SLP) said facility staff should be reminding R3 to eat slowly and take smaller bites. V15 continued to say facility staff should be supervising R3 while he eats.

"A"