STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015630	A. BUILDING: _____ B. WING _____	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEKALB COUNTY REHAB & NURSING	2600 NORTH ANNIE GLIDDEN ROAD DEKALB, IL 60115

(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 Facility Reported Incident of May 24, 2023 IL161058 Facility Reported Incident of June 15, 2023 IL161055	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.3240 a) 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 300.3240 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 are not met as evidenced by: Based on observation, interview, and record	S9999	**Attachment A** **Statement of Licensure Violations**	

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review, the facility failed to protect a resident from theft of their personal property, for 1 of 3 residents (R1) reviewed for misappropriation of resident property, in the sample of 10. This failure resulted in the resident becoming distressed, crying, refusing to eat meals, and not wanting to be around other people.

The findings include:

R1's Admission Record, printed by the facility on 6/21/23, showed she had diagnoses including Parkinson's disease, generalized anxiety disorder, dementia, osteoarthritis, malignant neoplasm of pharynx, secondary malignant neoplasm of brain, major depressive disorder, and personal history of antineoplastic chemotherapy and irradiation.

R1's ADL (activities of daily living) care plan, with a revision date of 6/14/23, showed she required limited one assist of staff for dressing, personal hygiene, toileting and transferring to and from bed, wheelchair, and toilet.

R1's facility assessment dated 6/13/23, showed she was cognitively intact and required extensive assist of one staff member for dressing, toileting and personal hygiene.

R1's Progress Note, dated 5/24/23 at 9:00 AM, showed, "Patient voiced concern this morning, POA (Power of Attorney), MD (Medical doctor) notified. DON (Director of Nursing) and Administrator aware for further follow up." R1's Progress Noted, dated 5/24/23 at 4:06 PM, showed, "Resident is very distressed, crying, refused both meals related to missing items."

R1's Missing Item Report, dated 5/24/23, showed

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S9999	Continued From page 2 at 7:10 AM that morning, R1 reported a diamond ring and a $50.00 gift card from a local store missing. The form showed R1's room was checked, the wing was checked. The bathroom and shower room, the dining room, the soiled laundry room, and the room and unit garbage were checked. The form showed dietary, laundry and housekeeping staff were notified. The form showed the items were not found. A note in R1's medical record, initialed by V24 (CNA/Ward Secretary) showed V23 (R1 significant other) gave R1 a ring that was silver with a green stone on 5/12/22. The facility's investigation into R1's missing items was reviewed. The investigation showed the ring, and the $50.00 gift card were not found, no staff member admitted to taking the missing items, and the police were notified. The facility's Visitor's Register was reviewed showing R1 did not have any family or other visitors from 5/21/23 until 5/24/23 at 10:01 AM (after the items were reported missing). On 6/20/23 at 9:43 AM, R1 was in her room, sitting in her wheelchair. R1 was alert and oriented. R1 had a spiral band around her left upper arm that had a key attached to the spiral band. R1 said she went to bed one night and when she woke up the next morning, her ring and her $50.00 gift card from a local store were missing out of the top drawer of her nightstand. R1 said the ring had a diamond and an emerald in it. R1 said her partner of 40 years gave her the ring, and her family gave her the gift card. R1 said she used to wear the ring on her hand, until she almost lost it in the sink one day. After that, she started keeping it locked in her nightstand. R1 said she always kept the ring and the gift certificate locked in the top drawer of her	S9999		

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S9999	Continued From page 3	S9999		

nightstand and the key on a band around her arm, even when she was sleeping. R1 pointed to the spiral band around her left upper arm with the key attached. The key ring was made of a sturdy metal-like material that would not easily come off the band. R1 said she never takes the key off the spiral band. R1 said the night before the items were missing, she had the band around her arm and the key chain was on the band. R1 said the day she reported the ring and gift card missing, she woke up and she was in the bathroom getting ready. R1 said the CNA (Certified Nursing Assistant) that helped her get ready kept going in and out of the bathroom, to R1's room (which R1 thought was weird because no one has ever gone in and out of the bathroom so many times while getting her ready). R1 did not know the name of the CNA. R1 said after she got cleaned up and dressed, she noticed the key was not on the spiral band around her arm. R1 said every morning she would check in her top drawer of her nightstand to make sure the ring was still in there. R1 said she reported to staff that she could not find her key. R1 said they found her key on her bedside table next to her box of tissues. R1 said she looked in the top drawer of her nightstand, and that morning the drawer was not locked, and her ring and the gift card were not in there. R1 said she reported the ring and gift card missing. R1 said no one from the facility has talked to her about the missing items since she spoke to the police officer, the day she reported them missing. As R1 was telling what happened, she appeared upset, and tears were welling up in her eyes. R1 removed the spiral band from around her left arm and unlocked the top drawer of her nightstand. The box that used to have the ring in it was in the top drawer. The box was empty. The cardboard that the gift card used to be attached to was also in the top drawer. The gift card was not attached

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to the cardboard and was not found in the top drawer of R1's nightstand. After showing the empty box and cardboard, R1 locked the top drawer of the nightstand and was observed pulling on the top drawer to ensure it locked correctly. R1 said she always checked to make sure it locked correctly. On 6/21/23 at 9:45 AM, R1 repeated the process of unlocking the top drawer, locking it back and checking to ensure it locked correctly when she was showing the earrings that matched the ring she was missing.

On 6/20/23 at 12:10 PM, V1 (Administrator) said he interviewed staff, and no one admitted to taking R1's missing items. V1 added he has never had an employee admit to taking a resident's items, in all the places he has worked. V1 said the police were called regarding R1's missing items. V1 said the police officer spoke with him and with R1. V1 said the police officer did not interview any staff members. V1 said the officer filed a report and told him if any of the local pawn shops report a ring with that description being pawned, he would let V1 know.

On 6/20/23 at 12:20 PM, V8 (Certified Nursing Assistant-CNA) said she was informed by third shift staff about R1 missing a couple dollars. V8 said she told them they needed to report it to the nurse. V8 said she talked to R1 that day, and she was really upset and depressed about the missing ring, and did not want to be around anyone. V8 said she told R1 to let her know if she needed anything. V8 said R1 kept everything that was important to her locked up, and the key on a key ring that she took everywhere with her. V8 said she has never seen R1 try to take the key off the key ring.

On 6/20/23 at 12:42 PM, V9 (Registered

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Nurse-RN/House Supervisor) said she was told by a CNA about R1's missing items. V9 said she went to R1's room and filled out the missing item form, then notified the DON (Director of Nursing), Administrator, R1's POA (Power of Attorney), R1's doctor and the police. V9 said R1 said she keeps the drawer to her nightstand locked. V9 said that morning, the scrunchie (spiral band) was on her arm, but the key was on her bedside table. V9 said R1's family verified they bought her a gift card for her birthday, and R1's significant other verified he bought her a ring. V9 said R1 is alert and oriented and answers questions appropriately. V9 said she had no idea what might have happened to the missing items.

On 6/20/23 at 1:08 PM, V11 (RN) said R1 reported the missing items to her. V11 said no staff reported it to her. V11 said R1 said it happened on the overnight shift that worked 5/23/23-the morning of 5/24/23. V11 said she reported it to V9 (House Supervisor) right away. V11 said she was not aware R1 had these items until she reported them missing.

On 6/20/23 at 2:19 PM, V15 (CNA) said she worked the night shift into the morning on 5/23/23-5/24/23, the day R1 reported the ring and money missing. V15 said R1 takes herself to the bathroom, staff help dress her and make her bed. V15 said V14 (CNA) went into R1's bathroom and got her ready. V15 said she went in and made R1's bed and took R1's trash out of her room, while R1 was in the bathroom getting ready. V15 said about 10 minutes later, V14 told her R1 said she could not find the key to her nightstand, and the key was not on her bracelet (spiral band). V15 said she went into R1's room to check, and the key was on R1's bedside table. V15 said V14 had gone back into R1's room after because R1 had

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turned her light on again. V15 said she asked V14 why R1 had turned her light on again, because that was unusual for her to turn her light on that often in the morning. V15 said V14 told her R1 said she could not find her ring and three dollars. V15 said V14 told her the three dollars was found, but not the ring.

On 6/20/23 at 2:04 PM, V14 (CNA) said when she went into R1's room on the morning of 5/24/23 to help her get dressed, R1was already in the bathroom, sitting on the toilet. V14 said she helped R1 put her shirt on and her deodorant on. V14 said the scrunchie band was on R1's arm when she assisted her, however, she does not know if the key was on the band or not. V14 said she did not leave the bathroom to go into R1's room, because R1's clothes and everything she needed was already in the bathroom when she went in. V14 said she went into R1's room after that because R1 had turned her light on. V14 said R1 told her she was missing three dollars and a ring. V14 said R1 told her she found the three dollars, but did not find the ring.

On 6/21/23 at 8:38 AM, V23 (R1's significant other) said he gave the ring to R1 about a year prior for her birthday. V23 said it was an emerald ring with a diamond in it. V23 said he bought it from a local jeweler. V23 said the facility has not spoken to him about the missing ring. V23 said R1 kept the ring in her locked nightstand.

On 6/21/23 at 10:21 AM, V22 (R1's daughter/POA-Power of Attorney) said R1 received the gift card for her last birthday. V22 said V23 gave R1 the ring last year. V22 said R1 used to wear the ring all the time. V22 said no one from the facility has spoken to her regarding any updates on the missing items since they first

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S9999	Continued From page 7 informed her that they were missing. On 6/21/23 at 9:01 AM, V24 (CNA/ Ward Secretary) said V23 told her over a year ago he gave R1 a silver ring with a green stone. V24 said she wrote it down on a piece of paper and put it in R1's medical record. V24 said she also informed the nurse on duty about the ring. V24 said R1 is "with it" and faithful about keeping it locked in the top drawer of her nightstand. V24 also said R1 always keeps the key with her. V24 said V22 and R1 are very honest and good on their word. On 6/21/23 at 10:17 AM, V20 (CNA that worked the second shift on 5/23/23) said R1 requires a lot of help getting dressed in the morning, however in the evening, unless R1 asks for help, staff do not do much for her to help get her ready for bed. V20 said she is not aware if the key was on the spiral band around R1's arm when she laid down on 5/23/23 because she did not ask for help. At 1:30 PM, V25 (CNA) said she worked the second shift on 5/23/23. V25 said she did not assist R1 with getting ready for bed because R1 was independent. V25 said she does not recall if the band was around R1's arm or not when she went to bed. On 6/21/23 at 9:32 AM, V16 (CNA) said R1 always kept the top drawer of her nightstand locked and the key on her spiral band. The band was always on her arm. V16 said she has never seen R1 take the key off the band. On 6/21/23 at 9:40 AM, R1 said she got into bed about 6:00 PM on 5/23/23. R1 said she always gets into bed around that time. R1 said she would lay in bed and watch television for a while before she went to sleep. R1 said the top drawer of her nightstand was locked that night and the key was on the band around her arm. R1 said she always	S9999		

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S9999	Continued From page 8 checks the drawer to make sure it locks correctly. On 6/22/23 at 3:08 PM, V1 (Administrator) said R1 is "sharp". V1 said R1 did all the right things by keeping the drawer that her valuables were in locked, and always keeping the key with her. The facility's Abuse Prevention /Detection Program policy and procedure, with a review date of November 2021, showed "II Resident Treatment: A. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of resident property." The policy defines misappropriation of resident property as follows: Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. (B) 2 of 2 300.610 a) 300.1210 b) 300.1210 d)3) 300.3240 a) 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	S9999		

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S9999	Continued From page 9 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 care needs of the resident. 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. 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 are not met as evidenced by: Based on interview and record review, the facility failed to reassess a resident for change of diet after losing dentures, and failed to supervise residents in the dining room at mealtime for 1 of 3	S9999		

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S9999	Continued From page 10 residents (R4) reviewed for choking. This failure resulted in R4 choking in the dining room on 6/15/23 and expiring at the hospital on 6/15/23. The findings include: R4's face sheet showed he was admitted to the facility on 1/31/22, with diagnoses to include Parkinson's Disease, Diabetes Type 2, Atherosclerotic Heart Disease, hypertension, muscle weakness, vascular dementia with behavioral disturbance, and personal history of peptic ulcer disease. R4's facility assessment dated 4/13/23 showed he had moderate cognitive impairment and required no help or staff oversight while eating. R4's most recent dietary assessment, completed by V10 (Registered Dietitian), was dated 1/20/23 (approximately 5 months from survey date), and the "dentition" section was not completed. R4's most recent Dietary Resident Interview, completed by V26 (Dietary Manager), was dated 1/23/23, and only addressed resident preferences for food. R4's June 2023 physician order sheet showed an order dated 3/9/23 for, "General diet, regular texture, thin consistency." R4's Care Plan initiated on 2/17/22 showed, " ... I have dentures. I fail to take them often when performing oral care on myself, I have my upper denture. I have a history of throwing my bottom partial out in the garbage or leaving them in a napkin at my table when I eat meals ... I am inquiring about receiving a new pair of dentures ... Diet as ordered. Consult with dietitian and change if chewing/swallowing problems are noted ...	S9999		

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S9999	Continued From page 11 Revision on 4/27/23 ... I require mouth inspections every shift with cares. Report changes to the nurse ..." R4's Care Conference Note, dated 4/27/23 at 2:30 PM, showed, "Care conference held this afternoon with resident in attendance and POA (Power of Attorney) (V28) in attendance via phone call in ... POA expressed concerns with missing items that this writer is following up with management and nursing staff on items listed. POA requesting a sign be placed on table to remind resident if he has his dentures or not prior to leaving the dining room due to continued forgetfulness of dentures at mealtimes. Informed unit clerk to perform this request. POA states she contacted dentist ..." R4's Social Services Note entered by V27 (Registered Nurse/Restorative Nurse), dated 4/28/23, showed, "Writer and SSD (Social Services Director) search resident's room looking for misplaced lower dentures, but were unsuccessful in finding them. Resident believes he wrapped them in paper towels. Education provided regarding placing dentures in denture container. Resident is eligible for new dentures in September 2024 ... Resident and POA notified ..." R4's Health Status Note entered by V18, LPN (Licensed Practical Nurse), dated 5/25/23 at 2:10 PM, showed, "Returned with P.N. (progress note) to return to the dentist next week for another fitting of his lower dentures. No date and time provided yet." R4's Health Status Note entered by V9 (Registered Nurse/House Supervisor), dated 6/13/23 at 11:36 AM, showed, "Conducted phone conference with POA, (V28, R4's daughter) and	S9999		

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S9999	Continued From page 12 (V29, R4's son) ... Made aware of dental appointment for lower dentures for Monday (6/19/23) that (V29) will take patient to, written on Calendar for staff/talked about how to prevent patient from losing them again ..." The facility's 6/15/23 menu showed, "Waffles and Fried Chicken with syrup ..." R4's 6/15/23 meal ticket from the dietary department showed R4 was served fried chicken and waffles. R4's 6/15/23 nursing progress note entered by V12, LPN, showed, "18:15 (6:15 PM) Resident in dining room eating dinner when his tablemate called out "Nurse I think he is choking" this writer was assisting another resident and turned and saw resident seated in chair, bending forward and holding on to the table. I moved in front of resident, his eyes were open, skin pink and he was unable to speak, I could hear some shallow inspiratory gurgles, at which time I explained to the resident I was going to perform back blows and the Heimlich maneuver. I did 5 back blows without success and kneeled behind resident and tried 5 abdominal thrusts without success. I checked resident's mouth and couldn't see any food, checked carotid pulse which I could feel and repeated this sequence without success. Resident was awake and small inspiratory breaths could be heard and carotid pulse could be felt. I had (V19, CNA- Certified Nursing Assistant) take over 5 abdominal thrusts while I called 911 at 18:18 (6:18 PM) and then house supervisor for assistance. Pulse checks, mouth checks and 5 back blows and abdominal thrusts were continued until (V17, House Supervisor) arrived at 18:20 (6:20 PM) which time he took over and EMS (Emergency Medical Services)	S9999		

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had arrived at 18:25 (6:25 PM). EMS took resident out of the facility at 18:50 (6:50 PM) POA (Power of Attorney) #1 called at 18:51 (6:51 PM) and message left to call back. POA#2 was updated at 18:53 (6:53 PM). DON (Director of Nursing) and ADON (Assistant Director of Nursing) notified. Daughter POA #1 called back at 20:05 (8:05 PM) asking what had happened? All questions answered, stated she had to perform the Heimlich on her father when they went out to eat before and stated that the family hadn't gotten his bottom dentures back from the dentist yet ..."

The facility's seating chart for R4's dining room provided by V2, DON (Director of Nursing), dated 6/15/23, showed R4 shared a dining table with R8, R9, and R10. R8's facility assessment assessment, dated 5/23/23, showed she has no cognitive impairment. R9's facility assessment, dated 4/18/23, showed she has no cognitive impairment. R10's facility assessment, dated 5/23/23, showed he has no cognitive impairment.

On 6/21/23 at 8:48 AM, R8 said, "(R4) sits to the left of me at the table. We were served waffles and chicken that night. He had been coughing quite a bit lately. He would cough and cough until he got past the spell. I'm a retired nurse so I've been watching him over the past weeks start coughing more and more while he was eating. He had just put a piece of chicken in his mouth and started coughing right away. I said '(R4) can you talk to me??' He shook his head 'no'. I use a walker, but I left it behind and hurried out to the nurse's station and went into that area. The nurse was walking into the little room behind the nurse's station and I said 'Come Come, (R4) is choking!' She put down what she was doing and she went into the dining room to talk to him; he couldn't talk. She got another nurse to come in and the

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two of them were doing the Heimlich. I think when he started coughing he inhaled deep and the chicken went further down. They got a male nurse and called the ambulance. Now there were 3 or 4 of them and they got (R4) onto the floor at that time. (R4) was already changed to an ashen color by then; it was too late for him. The paramedics got there with their equipment and we were ushered out of the dining room. He didn't have his bottom set of teeth. He put a piece of chicken in his mouth and just started gasping. It went so fast there was hardly any time to do anything properly. (R4's) coughing was getting worse as the weeks went on. I noticed he was having difficulty eating for at least the last 2-3 weeks because he kept coughing and having more difficulty with his food. He could always get it out before though, but this time was different. He had been missing his bottom teeth for at least a couple of weeks, but I can't say for sure how long. When this happened, he had his upper set of teeth in. There is only 1 table between our table and the exit. I didn't look to see if there were staff in the other part of the dining room before I went out to the nurse's station to get the nurse, but I know nobody else came to the table to help before I got back with the nurse. It was obvious he was having a lot of difficulty. If there was staff in there, I think they must have just thought he was having another coughing spell. He was in serious trouble this time."

On 6/21/23 at 1:27 PM, R9 said, "I was a table mate of (R4), but I had left the table before he actually choked and died. Everyone else was still at the table. (R4) was coughing a lot during meals and food would fall out of his mouth during meals. (R8) said nobody came over when he first started choking."

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S9999	Continued From page 15 On 6/21/23 at 1:30 PM, R10 said, "I was in the dining room when (R4) choked. His hands were up by his throat and spit came out of his mouth. Two staff came and did the Heimlich but the food was too far down. He had been coughing more during meals. He didn't have bottom teeth." On 6/20/23 at 10:35 AM, R5 said, "I eat in the dining room. They don't have as much staff as they should. They serve everyone and then they disappear. If we need something there isn't anyone to go get it. It's a major concern because you look around and they have all left. It concerns me because there should be at least one person there to help. I go to resident council meetings and its been brought up a couple times in there." The 6/15/23 nursing daily schedule and assignments showed V12, LPN (Licensed Practical Nurse), V13, CNA (Certified Nursing Assistant), and V16, CNA, were assigned to R4's hall, and V20, CNA, assigned as a "dining room float". On 6/20/23 at 1:52 PM, V12, LPN, said, "I was in the back of the dining room. I heard someone say 'Nurse I think he is choking'. It was (R8) that was speaking. (R8) was standing there with her walker. He was sitting and holding onto the table. I walked around to the front and he appeared in distress. His mouth was open and he was making gargling noises. I told him I was going to try to help. I did back blows and squatted behind him and did the Heimlich but it was not successful. I heard a little bit of breath sounds, but it was not getting better. The CNA secretary (V19) was nearby, so I asked her to take over so I could call 911 and get the supervisor who is bigger and stronger than I am to come and help. I was hoping they could do it better since my hands	S9999		

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kept slipping. He stayed in the chair because I didn't want to lay him down with the thick sludgy liquid that was in his mouth. (V17, CNA Supervisor) took over the abdominal thrusts and I started moving people. The paramedics were here quickly. After a little bit I think EMS (Emergency Medical Services) had to start CPR (Cardiopulmonary Resuscitation). When I called the family to let them know what happened, I think it was the daughter that told me about the bottom dentures. I'm not sure how long he was without his bottom dentures ... I remember seeing on the nursing clipboard that he did not have his bottom dentures. I don't know how long ago that was. We would definitely have a discussion on downgrading his diet, but it was my understanding that the family was working on getting him another set of dentures."

On 6/20/23 at 2:59 PM, V13, CNA, said, "It was dinner time. There were 2 of us and we only have 1 resident we need to feed. We also had a resident who was sick and stayed in their room. While my partner was in the dining room feeding the resident who needs assistance, I went into the room of the resident that was sick because I knew my partner was going to be in the dining room. I don't think V16, CNA, was in there when he started choking because I think it was literally the beginning of feeding."

On 6/21/23 at 10:54 AM, V16, CNA, said, "I had been taking residents back after the meal. I toileted a resident and then came back. (V12, LPN) was in the entryway to the dining room passing medications when I left to go to the resident's room. When I returned to the dining room (V12) told me what was going on and the paramedics were already here. When I came out of the room I saw paramedics working on (R4). I

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was trying to get everyone out of the dining room ... He had a regular diet with regular liquids, no precautions. I did not know he didn't have bottom dentures. I feel they probably should have changed his diet if he didn't have any bottom teeth. I didn't notice him having trouble eating when I was in there. The nurse told me he didn't have bottom dentures after the incident. They took his top denture out when they were giving him the Heimlich. After that I went into his room to see if his bottom dentures were in there, they were not in his room and his denture cup was empty."

On 6/21/23 at 11:30 AM, V20, CNA (assigned as dining room float), said, "I was at work in the facility at the time of (R4's) incident but I was nowhere near where (R4) was. I was in a room at the end of another hallway with a resident who was actively passing. The dining room I was attending that day is also not the dining room where (R4) eats."

On 6/21/23 at 10:44 AM, V19, CNA/Ward Secretary, said, "I was finishing my day up and getting doctor envelopes ready for the next day when I heard someone yell 'help'. I don't know who said it, I just headed that way as soon as I heard it. I was reaching that table and I saw the nurse behind (R4's) wheelchair trying to do the Heimlich. I don't recall seeing other staff in there, but my focus was on the commotion. I took over the Heimlich maneuver because the nurses usually have phones. She was calling 911. While I was doing the Heimlich I could hear a wheezing sound which was why I kept doing the Heimlich. I checked his mouth and it was no chunks coming out of his mouth. I did maybe 20 thrusts and in between checking the mouth. By that time, (V17, House Supervisor) got there and he is a bigger

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man so he took over the doing the Heimlich. Emergency personnel arrived and took over; the emergency personnel transferred him to the floor. I oversee the people sitting out by the nursing station eating and answer call lights on one of the other halls. I had been down answering a call light and when I arrived back is when I heard someone yell for help."

On 6/21/23 at 11:08 AM, V18, LPN, said, "He was going out to appointments to get dentures repaired. He went out for a fitting and he wasn't happy with how they fit, so he was supposed to go back for another fitting. He had his upper denture, but I don't think he had a lower denture. Without dentures, we would make sure his food was cut up. I don't know if we would do a diet change, we would probably ask him if he had trouble chewing. He was alert and oriented with some confusion and forgetfulness. I would imagine we asked him if he was having trouble eating. Dietary aides are responsible for cutting up the resident's food, the CNAs are a backup."

On 6/20/23 at 12:50 PM, V9, RN (Registered Nurse), said, "I know he was supposed to go for an appointment coming up. At times he would forget to put in his upper dentures and we would remind him. I know I talked to the family, and they were taking him to the dentist appointments to get his lower dentures replaced. I'm not sure how long it had been since he had his lower dentures. We would usually do a speech evaluation and they would determine his needs. He did not have any choking incidents that I was aware of prior to this."

On 6/20/23 at 1:15 PM, V11, RN, said, "If we have a resident misplaced dentures, I would definitely have the diet changed for that day

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because it would be hard for them to macerate without teeth. I would fill out a missing item list, we would call the family and start getting the ball rolling on either getting the dentures replaced, or getting a diet change."

On 6/20/23 at 12:21 PM, V7, RN, said, "(R4) had an upcoming dentist appointment." V7 checked the calendar and found an appointment had been scheduled for R4 to go to the dentist to get his lower dentures on 6/19/23.

On 6/20/23 at 11:52 AM, V5 (Therapy Program Manager) said, "(R4) has not been on therapy services for a long time. He has not been on speech therapy. It's been awhile."

On 6/21/23 at 9:50 AM, V5 said, "(R4) wasn't seen for speech therapy since 2016. We document a screening on every resident in the facility every 30 days. To do a screening, we speak with the resident and staff. We don't document anything other than a screening was done, unless we feel they need services. No staff told me he was missing his bottom dentures. It was a rumor he was taking his dentures out. It would only make a difference to me if he was having difficulty eating. Most of our residents have adapted to eating without their dentures. If it was bothering him or if staff would notice he was having difficulty, they would let the nurse know, and the nurse would get a referral for Speech Therapy to evaluate. Our "screenings" are not a hands-on thing, we only interview."

On 6/20/23 at 1:23 PM, V10, Registered Dietitian, said, "I receive a list from the kitchen when I come in. I document my visits in the dietary progress notes in the electronic record unless its an initial or an annual assessment which I put

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under the assessment section. I was not informed that (R4) had lost his dentures. If I had been told, I would have referred him to speech therapy and downgraded his diet to mechanical soft. If his whole bottom teeth are missing, he would be having a harder time chewing and moving food around. I would look at that as a safety issue with choking. (V26, Dietary Manager) is in a meeting every morning and puts the list together of residents for me to see. I'm available by phone at if they have something urgent they can call."

On 6/21/23 at 11:34 AM, V21 (Speech Therapist Consultant) said she does not work at this facility usually, but does work for the same company that comes to his building. V21 said she was in the facility on Monday, 6/19/23, to do an in-service on swallowing, diets, dentures, when to get an evaluation, and sitting upright.

On 6/21/23 at 1:50 PM, V26 (Dietary Manager) said, "In the evening we have a night time cook and 4 aides. On the evening of (R4's) choking incident, there were no dietary staff present in the dining room because they had already finished up in (R4's) dining room, and had moved on the other dining room. I found out his dentures were missing back in either March or April during a care plan meeting. At that care plan meeting we talked about him taking his dentures out and wrapping them in a napkin and putting them in his pocket."

The facility's April 17, 2023 Resident Council Meeting Minutes showed, "... A few residents expressed concern about the amount of staff in the dining rooms." The facility response directly under the concern showed, "Care needs for each resident are evaluated and seating charts are adjusted as needed to ensure the proper level of

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S9999	Continued From page 21 care for each resident. Occasionally CNAs are pulled away to assist other residents that have care needs during meal times." The facility's May 15, 2023 Resident Council Meeting Minutes showed, "...One resident stated that on occasion they have a hard time finding someone to provide extra assistance in the dining rooms..." The facility response directly under the concern showed, "Dining room floats have been assigned to help residents that return to their rooms early. Staff are being re-educated to be sure that someone remains in the dining room to assist the remaining residents..." The facility's policy reviewed March 2006 titled Resident's Meal Time showed, "It is the policy of the Nursing Department of (the facility) that all unit staff nursing personnel shall be available to assist in the feeding of the resident during their meal times. Nursing staff are to schedule their breaks accordingly..." The facility's policy with review date of March 2006 titled Resident's Meal Time that showed, "It is the policy of the Nursing Department of (the facility) that all unit staff nursing personnel shall be available to assist in the feeding of the residents during their meal times." The facility's undated policy and procedure showed, "Nutrition Policy ... Comprehensive Assessment, Residents will be assessed for nutritional status and risk factors on admissions, annually, and as condition warrants ...The assessment will be completed by the licensed dietitian in accordance with accepted clinical practice ..." (AA)	S9999		

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