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Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.
c) These written policies shall include, at a minimum the following provisions:
2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

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

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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:
1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).
c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements.
d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement.

Section 300.1210 General Requirements for Nursing and Personal Care
a) The facility must 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 assessment and plan of care. 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.
b) General nursing care shall include at a minimum the following and shall be practiced on

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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 300.2040 Diet Orders
b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.

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)

Based on observation, record review,and interview, the facility failed to perform appropriate emergency response measures for 1 of 1 residents(R10) who was found gasping for air at the dinner table. Facility staff failed to put the unconscious victim on the floor to attempt rescue procedures, failed to have staff knowledgeable in the correct procedures for a suspected choking victim, and failed to have policies and procedures detailing direction for emergency response measures. R10 was found in a wheelchair dead by paramedics responding to the emergency call. Thirty two other residents are assigned to eat in this assisted dining room. In addition, the facility failed to adequately supervise and monitor 1 of 1 residents on a pureed diet during meal time (R1). Facility failed to ensure that peach slices were not accessible to R1. R1 ingested a peach slice

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and was found choking in the assisted dining room. EMS (emergency medical service) personnel suctioned a peach chunk out of R1's throat which had totally occluded the airway. R1 expired several days later at a local hospital.

Findings include:

1) Facility's incident report dated 7-6-05 regarding incident of 7-2-05 states "Resident (R 10) found at table slumped over and cyanotic. Heimlich maneuver performed and guest suctioned. Clear saliva retrieved. AMT (Ambulance Transport) arrived and hooked resident to defibrillator, and guest found to be straight lined. Resident code status DNR (Do Not Resuscitate) and paramedics ceased treatment. Coroner ruled as medical death." This report was completed by E2, Director of Nursing (DON).

The emergency response notes dated 7-2-05 for this incident state "nursing home staff state they think the patient choked while eating dinner. They attempted the Heimlich maneuver several times and then attempted to suction the patient... Patient pulseless, non breathing and has a valid DNR present. Monitor asystole (cardiac standstill -absence of contractions of the heart)."

The coroner's report states "at autopsy a plastic butter container was found completely sealing off airway. Preliminary cause of death: Asphyxia by aspiration (plastic butter container)."

On 7-14-05 at 11:00 a.m., Z6, paramedic stated when they arrived at the facility the evening of 7-

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2-05, R10 was found unresponsive sitting in a wheelchair. They placed R10 on the floor and hooked him to the monitor. The monitor read that R10 was in asystole, having no pulse and no blood pressure. Z6 stated R10 had a device on his wrist which facility staff said was an automatic blood pressure cuff which was reading a blood pressure of about 170/80. Z6 said another paramedic stated "that can't be-he has no pulse."

On 7-6-05 at 3:00 p.m., E6, LPN (Licensed Practical Nurse) stated R10 was moved from the main dining room to the assisted dining room because he would get confused and would need help at times. E6 stated R10 received a regular consistency diet and had been doing "fine". E6 continued that R10 used a wheelchair and was able to feed himself with set up assistance. On 7-2-05 during the supper meal, E6 cut up R10's spaghetti and broccoli and asked a CNA, E16 to help feed R10 since he was not wearing his dentures.

On 7-7-05 at 10:35 a.m., E16 said she did not feed R10 on 7-2-05 stating he was sitting by himself and feeding himself.

On 7-6-05 at 3:20 p.m., E18, CNA (Certified Nursing Assistant) stated that after most residents were done with supper on 7-2-05, and they were starting the take residents to their room, she approached R10 who had his head down, drooling and gasping for breath. E18 called R10's name and gently shook his shoulder with no response. E25, LPN was called over to assist. E25 lifted R10's head back and then did the Heimlich maneuver once or twice from behind R10 who was sitting in his wheelchair. E25 and

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E18 transported R10 from the assisted dining room to the nurses station keeping his head tilted back. E25 suctioned R10 with no results and repeated the Heimlich maneuver again while R10 was in the wheelchair. E18 went and found the automatic blood pressure cuff for E25 and got a reading. E18 stated EMS (Emergency Response System) arrived, put R10 on the floor and was told by E25 that R10 was a DNR. EMS then put a monitor on R10 and "there was nothing-he was gone."

On 7-8-05 at 11:30 a.m., E24, CNA stated she saw R10 at supper before the incident. R10 was coughing so she gave him a drink, made sure he was OK and went on. About 5 minutes later she observed E18 and E25 wheeling R10 to the nurses station in his wheelchair. R10's head and wheelchair were tilted back and E25 was yelling for suction. E25 proceeded to do the Heimlich maneuver several times with R10 in his wheelchair and E25 standing in front of R10. E 25 stated that R10 was choking. E24 observed R 10 to be unconscious and unresponsive. R10's blood pressure and pulse were taken several times with an automatic digital cuff with readings found. A manual cuff and stethoscope were not used. E24 found information that R10 was a DNR that was verified by E6, LPN. E24 stated E 25 continued to suction while she tried to perform the Heimlich maneuver from the front while R10 was still in the wheelchair as per E25's instructions. E18 said "can't we put him on the floor?" and E25 stated "hell no - don't move him out of that chair." E24 stated she was taught to put an unconscious victim on the floor for the Heimlich and to also continue first aid until help arrives. E24 stated that when the paramedics

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arrived, E25 instructed E24 to "stop" so they wouldn't think they were doing CPR (Cardio Pulmonary Resuscitation.) Upon arrival, paramedics immediately put R10 on the floor and hooked up a monitor or defibrillator. E25 then told paramedics "you can't do that , he's a DNR." The paramedics quit treatment when they were presented with the DNR. The paramedics at one point asked staff why R10 had not been placed on the floor.

E24 (during same interview on 7-8-05 at 11:30 a. m.) stated R10 was eating at a table by himself that night. E24 stated he received a regular diet but thinks he may have needed a mechanical soft since he had coughed on his food several times recently. When asked if she had notified Nursing or Dietary of this, she stated no because the other CNAs stated they already had. When asked about use of the automatic blood pressure cuff, E24 stated it is not always accurate and she does not trust its readings.

On 7-7-05 at 2:15 p.m., E25, LPN stated on 7-2-05 she was in the back assisted dining room passing medications and monitoring the supper meal. E25 stated a CNA called her over to R10 stating he was not breathing. When E25 went over to R10, she thought he was choking since he had food on his lap and his dentures were out . E25 looked in his mouth, tilted his head back and performed the "Hemlock" (Heimlich maneuver) once from behind while R10 was in his wheelchair. E25 stated he was breathing, his hands were blue but not his face and he was unresponsive. E25 yelled from the assisted dining room to E6 to call 911 and see if R10 was a no code. E25 stated they took R10 to the

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nurses desk to suction him and applied oxygen at 5 liters. E25 performed the Heimlich maneuver two more times from the front while R10 was in the wheelchair. E25 explained that she pushed in and up below the chest from the front, stating that was OK since R10 was in a wheelchair and the in and up movement was what was important. E25 took R10's blood pressure with an automatic blood pressure cuff stating she charted her reading in the nursing notes but did remember he had a blood pressure and a pulse of 112. E25 stated she liked using the automatic cuff since it stores all the readings. When E25 suctioned R10 , she got only clear saliva. When EMS arrived, they put R10 on the floor and hooked him to a monitor. E25 stated the monitor gave the "heart rate of 61 that then dropped till he was gone." The paramedics told E25 they had to shock R10 but E25 said no he's a DNR. E25 stated R10's color went from blue to pink before he was put on the floor then went pale after he was laid on the floor.

R10's nursing notes made by E25 and dated 7-2-05 at 10:48 state "at 6:49 PM 911 was here had heart monitor machine said it stop. At supper time CNA came to nurse due to res [R10] was blue color and slumted [slumped] over in W/C [wheelchair] head bent down. I tilled [tilted] his head back res grasp [gasp] for air and started breathing I hemlock [Heimlich] him to see if he was choking no food came up he have food in his lap already I suctioned him only slavia [saliva] same up and V/S [vital signs] 100/60 pulse 112 when 911 got here res had weak thready pulse of 61 color of blue gone and res is pale and warm heart monitor on and res strag. [straight] line while on the floor with 911 at his side..."

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F9999	Continued From page 32 The coroner's report of 7-2-05 states "They (EMS) stated upon their arrival, (R10) was found still in his wheelchair, and he was asystole, no carotid pulse, urinated, and unresponsive. The fire dept. placed him on the floor and ran a strip on the decedent while the nursing home simultaneously had an automated BP (blood pressure)/Pulse monitor hooked up, showing the decedent had a BP and pulse of 70, while the fire dept. was getting a reading of asystole on their EKG/ Defibrillator." The coroner also interviewed E25, LPN. Report states "that (R10) was seen in the dining room, sitting in his wheelchair at a table, with his head down (chin against his chest) with his lips and arms turning blue. When she raised his head, he took gasping breaths and she saw food in his lap on his legs, so she assumed he was choking. She reports seeing saliva coming from his mouth. She attempted the Heimlich maneuver while (R 10) was still sitting in the wheelchair, but soon decided it would be better to use suction, so (R 10) was left in the wheelchair and taken to the nurse's desk where the suction machine was mounted to the crash cart, and suction was conducted. (E25) reports nothing more than saliva was suctioned from (R10's) airway. Oxygen was started, but the decedent had a DNR order, so no further actions were taken, other than the call to 9-1-1." R10's physician order sheet for July 2005 states R10 is to have a regular diet with low salt. Per interview with E2, Director of Nursing on 7-7-05, no speech evaluation or notes could be found for this year. R10's care plan dated 6-29-05 states "	F9999		

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resident requires assistance with all ADLs (activities of daily living), resident has full dentures that fit poorly. Resident refuses to wear dentures at times due to his cognitive decline. Dietary Manager notes dated 4-5-05 states "does require tray set up at times...dietary manager will...and monitor daily."

During interview on 7-7-05 at 3:15 p.m., E22, Dietary Cook stated the menu for the night of 7-2-05 was spaghetti, broccoli, pears, milk, bread and butter. E22 stated the butter used comes in small individually covered containers.

On 7-6-05, during the lunch meal butter was served to residents in small individual round covered containers. One resident was sitting at R10's assigned table facing the wall eating lunch by herself.

On 7-12-05 at 2:45 p.m., Z5, family friend who visited R10 almost daily stated R10 was often seated at a table by himself in the back dining room facing a wall. The seating arrangement for the assisted dining room shows R10's table to be a U shaped table pushed against a wall leaving the three residents assigned to the table to be facing the wall. R10 seating arrangement was confirmed by E18, CNA during interview on 7-6-05 at 3:20 p.m.

On 7-14-05 at 9:45 a.m., Z7, visitor stated she is at the nursing home almost every day during lunch time and sometimes during the supper meal. Z7 stated she had often seen R10 sitting alone at a table pushed against the wall, with his back to the dining room facing the wall. Z7 stated a resident told her that during supper on 7-

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F9999	Continued From page 34 2-05, she noticed R10 was gasping for air but could not get anyone's attention to help. Z7 also related the CNA's often are "playing around" when feeding residents, "talking and yelling to each other across the dining room and laughing." Z7 went on to say "they should be talking to and watching the residents." On 7-8-05 at 12:30 p.m. Z4, Education Coordinator of the American Red Cross was interviewed. Z4 stated the rescue procedure for an unconscious victim and/or unconscious choking victim is to lay the victim prone, check for air by giving two breaths, if no air goes in, give 15 chest compressions, look in victim's mouth and then repeat steps again until air goes in. When asked about giving abdominal thrust to an unconscious victim in a wheelchair standing in front of the victim, Z4 stated she had never heard of that method and it was not a part of their training to do it that way. On 6-21-05, when E3 asked to supply emergency response policies and procedures, the policy for the Heimlich maneuver and seizures was supplied. Again on 6-28-05 and 7-7-05 emergency response policies were requested from E3. No additional policies were supplied. On 7-12-05, the facility's policy and procedure book was reviewed. No policy that gives direct instruction for what to do with an unconscious victim in a wheelchair who is suspected to have choked could be located. The facility supplied a list of staff who need CPR/ choking rescue course update. Five of the eight nurses listed as having working hours scheduled for July 2005 have not had updated training in	F9999		

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F9999	Continued From page 35 CPR. Two nurses are scheduled to work the night shift and neither have updated training listed. 2) Facility's incident report for incident of 5-25-05 states "55 year old female was sitting at the table for evening meal. Staff noted she was in distress and appeared to be choking. Heimlich performed with no return. Oral cavity suctioned with no return. 911 called. Resident transferred to hospital." Emergency response form dated 5-25-05 for this resident, R1 states ".. upon arrival found patient laying on floor. Staff stated that patient was eating and had a seizure...upon arrival patient had a weak radial pulse that disappeared shortly after... After suctioning patient was found to have a chunk of peach completely occluding her airway. Her airway was cleared with forcepts... CPR (Cardio Pulmonary Resuscitation) was done throughout up to the point when patient regained vitals...Patient transported to (local hospital) and released in care of ED (emergency department) staff." R1's hospital discharge summary dated 6-11-05 states R1 "was admitted on 5-25-05 ... status post cardiopulmonary arrest and grand mal seizure. The patient had sustained severe encephalopathy secondary to anoxia...she ultimately expired on 6-3-05." R1's physician's order sheet for May 2005 lists her diet as pureed with honey thick liquids. R1's care plan dated 3-15-05 states R1 needs assistance with activities of daily living... requiring supervision and set-up help for eating. An	F9999		

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F9999	Continued From page 36 update added 5-23-05 states "to feeder table, resident cycling refusing to feed self." R1's speech therapy evaluation dated 7-28-04 states R1 has a diagnosis of Dysphagia. This assessment states "resident demonstrates a moderate to severe oral and pharyngeal dysphagia." Recommendation was to continue current diet of pureed with honey thick liquids and gastrostomy-tube feedings. On 6-21-05 at 11:15 a.m., E2, Consultant Nurse acting as Director of Nursing stated R1 had a choking/seizure event which led to her hospitalization. E2 stated she was unsure what happened. E2 stated that R1 was on a pureed diet, and per her investigation, R1 was served the appropriate diet that evening. E2 stated there were regular peaches on R1's table but she did not know how R1 got them. E2 stated now all residents with pureed diets sit together and diet cards are triple checked for accuracy. On 6-21-05 at 1:00 p.m., E5, Registered Nurse stated she worked the night of 5-25-05. E5 stated a CNA called her to the assisted dining room stating R1 was having a seizure. E5 thought R1 was choking, not having a seizure. E 5 observed some sliced peaches sitting near R1 on the table and thought maybe she ate one and choked. E5 and E6, Licensed Practical Nurses (LPN) performed the Heimlich maneuver numerous times before R1 started to seize. E5 helped lower R1 to the floor and was preparing to suction her when the paramedics arrived and took over. E5 stated R1 is to have a pureed diet. E5 also stated R1 was physically able to reach and feed herself peaches.	F9999		

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	146073	A. BUILDING _____ B. WING _____	C 07/18/2005

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F9999	Continued From page 37 E6 related on 6-21-05 at 3:00 p.m., that on the evening of 5-25-05, R1 was choking, She and E 5 attempted the Heimlich maneuver with mouth sweep numerous times without results when R1 went into seizures. 911 had been activated and the paramedics arrived and took over. E6 stated R1 did have a pureed food tray in front of her that night but regular peaches were sitting near her on the table. E6 stated R1 had the capability to feed herself and could have consumed the peaches nearby although she has never witnessed R1 taking other residents food before. E6 did not know if anyone was supervising R1 during the meal. During interview on 6-22-05 at 2:25 p.m., E17, CNA (Certified Nursing Assistant) stated on the night of 5-25-05 she observed E7, CNA standing on the right side of R1 in the assisted dining room when E7 called for help stating something was wrong with R1. The nurses responded and started doing the Heimlich maneuver. E17 stated she "heard" from another CNA that E7 had fed R 1 regular peaches. E17 stated she did observe regular peaches sitting to the right of R1. E17 stated R1 was physically able to reach for other resident's food but she had never witnessed it. She also stated R1 has not wanted to eat at all lately. E17 stated R1 did not always sit at a table with other residents receiving only pureed food. E17 stated on several occasions she has had to send back food for a pureed diet because the food was not pureed. During interview on 6-23-05 at 3:10 p.m., E7 CNA, stated during the supper meal on 5-25-05, she was sitting at a table across from R1 feeding	F9999		

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F9999	Continued From page 38	F9999		

another resident when she heard a choking sound. She called to the nurse for help who responded and performed the Heimlich maneuver numerous times without success. E7 stated earlier in the meal, she had observed R1 digging in a bowl of sliced peaches placed on the table. After the choking started, E7 observed that some of the peaches were now gone from the bowl. E7 stated R1 was feeding herself that night and no staff were present at that table. E7 also stated all the pureed diets received sliced peaches on their trays that night. E7 did not serve R1 her tray nor did she know who had served the tray. E7 did not say why she did not remove the sliced peaches from the pureed trays.

On 6-23-05 at 1:00 p.m., E16, CNA stated she was working in the assisted dining room on the night of R1's incident. E16 observed E7, CNA feeding R1 at another table. E7 later came back to E16's table and said "I told them I fed her a peach and that she was choking, but they said she was having a seizure." E16 stated that E7 was new but did not know if she still in orientation or not.

During interview on 6-21-05 at 2:30 p.m., E20, CNA stated she was working the night of 5-25-05 but did not witness the incident. E20 did state that earlier in the meal, a resident sitting near R1 who also was to receive a pureed diet was given regular peaches. E20 stated she returned those peaches to the kitchen but did not observe the table after that. E20 was unsure if anyone was supervising R1's table during the meal.

During interview on 6-17-05 at 2:15 p.m., E12 stated she did not observe the incident on 5-25-

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F9999	Continued From page 39	F9999		

05 but did state that staff do not always sit at the table that R1 sits at during meals.

On 7-14-05 at 9:45 a.m., Z7, visitor stated she comes to the facility almost daily to visit another resident and is present for the lunch meal and sometimes supper. Z7 stated they could use more help in the assisted dining room. Z7 states "the CNA's play around when feeding resident talking and yelling to each other across the dining room and laughing. They should be talking to and watching the residents."

On 7-15-05 at 9:00 a.m., E27, former Social Service stated when she monitored the assisted dining room, she found CNA's at times not assisting residents with meal setup such as opening milk cartons and buttering bread or with feeding residents who needed help. E27 also stated sometimes incorrect diets were served from the kitchen or the CNA's would give the wrong diet to the wrong resident.

During interview on 6-21-05 at 2:30 p.m., E8, Dietary Manager stated she was not there the night of the incident but stated her staff said they had served the correct diets that evening. E8 stated the two kitchen staff working had been at the facility for several weeks and had finished their orientation period.

During interview on 6-22-05 at 3:00 p.m., Z1, R1 physician stated that a choking episode such as choking on a peach medically could have lead to anoxia and cardiac arrest eventually leading to R 1's death.

E3, new Director of Nursing (DON) and E2,

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F9999	Continued From page 40 Consulting Nurse,were asked to provide their policies and procedures dealing with supervision during dining, None were provided.	F9999		