| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145307 | A. BUILDING _____ B. WING _____ | C 08/28/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GROVE OF LA GRANGE PARK | 701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526 |

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| F 323 | Continued From page 4<br><br>E15 (nurse's aide) was interviewed on 08/22/13 at 3:34pm about the same choking incident. E15's written statement in part is, "I (E15) was walking out of my (E15's) room and I (E15) seen R5 in R5's wheelchair and R5 was eating a cake donut. Me (E15) and my (E15) co-workers realized R5 was choking. So, the nurse informed my co-worker (E17) to give R5 some water, so, E17 gave R5 some thickened water from the nurse cart."<br><br>On 08/28/13 at 10:38am, Z2 (physician) was interviewed via telephone about the incident. Z2 stated, "It's possible that if the circumstances described that R5 ate a donut, then choked on the donut. If that fact is certain, it's ascertain to be true. Then it's possible the donut caused respiratory deterioration. As a physician, we like to keep our differential diagnosis open and consider other possibilities such as Arrythmia and vaso-vagal response to an event leading to vomiting and aspiration." | F 323 | | |
| F9999 | FINAL OBSERVATIONS<br><br>Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and | F9999 | | |

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| F9999 | Continued From page 5<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. Restorative measures shall include, at a minimum, the following procedures:<br><br>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:<br><br>6) All necessary precautions shall be taken | F9999 | | |

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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 300.3240 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 Regulations were not met as evidenced by:

Based on record review and interview, the facility failed to provide adequate, safe and acceptable monitoring for one resident (R5) reviewed for adequate supervision. The lack of monitoring resulted in an avoidable incident of another resident (R2) giving (R5) a donut with no staff intervention; and (R5) choking on it and being sent out emergently to the hospital. R5 was identified as having problems eating regular textured food.

Findings include:

On 07/15/13 at 7:05pm, R5 was noted to be coughing on a donut that R5 had received from a peer (later to be determined as R2). R5 coughed up and spit out the donut; the remainder of the donut was removed from R5's hand. Resident appeared fine with no distress noted. The

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Resident was given liquids which were tolerated well. Resident was taken to room by RN to access further. Upon entering room, resident became cyanotic. Code Blue called; 911 notified, according to the facility incident report form.
The final report, (occurrence resolution) stated, resident admitted to LaGrange Hospital with diagnosis of cardio-respiratory arrest. Patient was intubated and placed on ventilator. On July 20th, resident's family decided to remove patient from ventilator. Resident expired at (Z5/hospital) on July 20 th.

The accompanying nurse's notes written by E16 (nurse) indicated the same information as above with additional details which were the liquids given to R5 was thickened and RN initiated Heimlich maneuver.

The E11 (nurse) and E16 (nurse) were seated in the nurse's station when the incident occurred; the incident took place outside the nurse's station in the hallway.

A review of the most recent Nutrition Assessment presented by the facility (annual) is dated 02/05/13 which indicated R5 had chewing problems.
Minimum data Set (MDS) date 05/03/13, section K. swallowing/nutritional status depicts R5 receiving Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food. thickened liquids).

The current physician order (07/01/13 - 07/31/13) is for Pureed and Nectar Thick Liquids.

A review of (hospital records/Z5) Progress Notes page 36 of 483 states in part, the patient is a 79

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year old with bipolar disorder and diabetes who was admitted from Z6 ( facility) on 07/15/13. R5 was eating a donut when R5 choked and had a respiratory leading to cardiac arrest. Upon arrival to emergency room R5 was noted to have fixed and dilated pupils, not breathing over vent. R5 was placed on hypothermia protocol.

The Medical Examiner/Coroner Certificate of Death stated, date of death is July 20, 2013 and the cause of death part 1. a. Complications of Asthma b. Choking on Food Bolus.

Review of a hand written interview dated (07/17/13) by E17 (nurse's aide) who is no longer employed by the facility is, "walk out of room 304. Look at resident, R5 were coughing informed the nurse. I (E17) was told to give R5 water, I (E17) did. R5 spit donut out of R5's mouth. R5 look ok A couple of seconds went by and we could tell something was still wrong with R5, so informed the nurse again."

E4 (nurse aide) was interviewed on 08/20/13, at 4:50pm, about the choking incident involving R5. E4's written statement as written in part is, " I (E4) wasn't working on the third floor, was on the first floor. The two aides I (E4) know that were working on the third was E15 (nurse aide) and E17 (nurse aide).

E11 (nurse) was interviewed via telephone on 08/22/13, at 11:03am, about the choking incident. E11's statement as stated in part is, "I (E11) don't work that often, but I (E11) do remember that they were giving R5 thick liquids in R5's cup. This usually means that person have difficulty swallowing. I (E11) was inside the nurse's station untill I (E11) came out for choking

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incident. No, I (E11) didn't see any resident with any donuts. The documentation was done by (E16) nurse who was R5's nurse for the day. I (E11) never saw R2 give R5 a donut until I (E11) went to R5 when someone said R5 was choking. E15 (nurse aide) said, R5 was choking, that's when I (E11) got up went over to R5. When R5 was in the hallway, R5 was trying to cough up whatever R5 had in R5's mouth."

On 08/22/13 at 12:04pm, E16 (nurse) was interviewed via telephone about the incident. E 16' s' statement as stated in part is, "I (E16) was assigned to R5 on the day R5 choked. R5 should not have that donut because R5 was on a mechanical diet with nectar thick liquids. I (E16) was in the nurse's station with E11 (nurse), but I (E16) didn't see anyone give R5 a donut that's because the nurse's station counter is high and the medicine carts are on the corner. R5 was blocked by the counter top and medication carts. I (E16) am assuming R5 got the donut from another resident (R2)."

08/22/13 at 2:21pm, E13 (nurse's aide) was interviewed via telephone about the incident. E13's statement as stated in part is, "R2 has been known to try to give R5 regular water, R5 has to have thick water. We (staff) have actually had to stop R2 from trying to give R5 water is what I've (E13) seen. R5 was on a pureed diet. Myself (E13) and E15 (aide) was in the room with another resident. When we (E13 and E15) made it back to the nurses station, R5 was already choking. One of the other nurse's aide (E17) alerted the nurses that R5 was choking. E11 (nurse) and E16 (nurse) were in the nurse's station, E11 came out. R5 was not far from the room, but there were medication carts there. So,

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| F9999 | Continued From page 10<br>maybe, that's why they (E11 and E16) didn't see."<br><br>E15 (nurse's aide) was interviewed on 08/22/13 at 3:34pm about the same choking incident. E15's written statement in part is, "I (E15) was walking out of my (E15's) room and I (E15) seen R5 in R5's wheelchair and R5 was eating a cake donut. Me (E15) and my (E15) co-workers realized R5 was choking. So, the nurse informed my co-worker (E17) to give R5 some water, so, E17 gave R5 some thickened water from the nurse cart."<br><br>On 08/28/13 at 10:38am, Z2 (physician) was interviewed via telephone about the incident. Z2 stated, "It's possible that if the circumstances described that R5 ate a donut, then choked on the donut. If that fact is certain, it's ascertain to be true. Then it's possible the donut caused respiratory deterioration. As a physician, we like to keep our differential diagnosis open and consider other possibilities such as Arrythmia and vaso-vagal response to an event leading to vomiting and aspiration."<br><br>(B) | F9999 | | |