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	IL6014518	A. BUILDING: _____ B. WING _____	C 10/10/2013

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)2)3) 300.3240a) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999		

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health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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. Restorative measures shall include, at a minimum, the following procedures:

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

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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

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:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care

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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 300.3240 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 are not in compliance as evidenced by:

Based on interview and record review, the facility failed to provide physical assistance and or supervision during meal-time as care planned for a resident with a known feeding deficit and the facility failed to inform the physician promptly of a resident's need for extensive physical assistance during meals and eating practices that placed the resident at risk of aspiration. As a result there were no physician orders for the care and treatment of this resident's feeding deficit and on 9/21/13 the resident (R1) choked on a 3-4 inch piece of hot dog while feeding while feeding himself and had to be sent to an area hospital where he was diagnosed with extensive anoxic brain injury related to cardiac and respiratory arrest.
This applies to one (R1) resident reviewed for Activities of daily living (ADLs) assistance.
The findings include:
R1 is a 45 year old resident originally admitted to the facility on 2/28/10. At the time of his admission R1 was alert and oriented. Admitting

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diagnoses include, advanced Multiple Sclerosis, depression, neurogenic bladder, anxiety, insomnia, psychosis, hyperlipidemia, and chronic encephalopathy.
According to a facility self-reporting incident sent to the state survey agency on 9/25/13, R1, while feeding himself in his room choked on a three inch piece of hot dog. At the time of the incident there was a Certified Nurse's Assistant/CNA (E8) in the room feeding R1's roommate. The facility report stated when the CNA heard R1 choking he ran to get a nurse. A code blue was subsequently called and CPR initiated. When the hot dog was removed from R1's airway he was found to be unresponsive. After being revived by paramedics R1 was taken by ambulance to an local hospital where he was admitted.
According to emergency department records (9/21/13) obtained from the treating hospital, R1 was diagnosed with cardiac arrest, acute respiratory failure, anoxic encephalopathy, aspiration pneumonia and severe metabolic acidosis. R1 has since been admitted to an unknown facility and placed on hospice care.
Review of multiple documents found in R1's medical record, including ADL functional assessment (9/9/13), Minimum Data Set (9/9/13), Dietary care plan (9/13), self-care deficit for eating care plan (9/9/13), Nursing admission/re-admission assessment (8/10/13) and Restorative nursing assessment (9/9/13) all indicated R1 required extensive physical assistance during meals.
On 10/1/13 at between 3:15 PM and 4:05 PM the nurse (E4) assigned to provide care for R1 stated during interview, "I have never known this resident to be fed by staff." E4 also stated he wasn't aware of R1's care plan that required R1 to received one person extensive physical assistance with meals.

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On 10/2/13 at 2:58 PM, the CNA (E8) who heard R1 choking stated during interview, when he heard R1 choking he was feeding R1's roommate behind a pulled privacy curtain. He stated he was never directed or assigned to feed or supervise R1 on 9/21/13. He stated R1 usually ate in his room alone and unsupervised.
On 10/1/13 at 4:13 PM, on interview the facility's Director of Nursing (E2) stated, "I just started in this facility. I' am not aware of his (R1) assistance with feeding." E2 stated, "For a resident who requires assistance with feeding her understanding is to have someone provide a hand over hand assistance from start to finish." E2 stated there was no formal list of residents requiring assistance with feeding who eat in their rooms. She also stated the facility had no policy or procedure for feeding residents in their room. During her investigation E2 stated she only spoke to the nurse (E4) assigned to R1 on the evening of 9/21/13 and read a written statement by the CNA (E8) present in the room feeding R1's roommate. There were no other interviews conducted although there were ten other nursing staff members working on the unit that evening. Following this incident, the facility did not implement any new policies or interventions to prevent future occurrences of residents choking while eating in their rooms. There are 11 other residents currently residing in the facility who require physical assistance with meals and eat in their rooms.
On 10/3/13 at 12:50 PM, R1's physician, stated during interview that he hadn't been informed by the facility that R1 required extensive assistance during meals. He volunteered additional information, stating he also was not informed by the facility, until recently R1 had a habit of "force feeding" himself large amounts of food at one time. He stated, " I saw the picture of the hot dog

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taken from his mouth. It was about 4 inches. " " It was obscene. " He went on to say if the hot dog would have been cut into a smaller piece R1 probably wouldn't have choked. The physician stated swallowing difficulty (dysphasia) can be a complication of advanced MS, the resident's primary diagnosis.
On 10/3/13 at 1:10 PM, the facility's in-house speech pathologist (E11) stated he had performed a dysphasia evaluation on R1 in January of 2012. He stated the results of the evaluation were R1 was capable of eating all food consistencies with thin liquids using a straw and following safe swallow strategies and aspiration precautions (90 degree position during meals and for 30 minutes after, chin tuck, double swallow and sips of thin liquids). E11 stated some time later he found out from CNAs and nurses R1 was not following aspiration precautions during meals. He stated he also heard the resident was putting large bites of food into his mouth, eating at a rapid rate and refusing to maintain appropriate positioning during meals. E11 stated, " Based on R1's non- compliance following safe swallowing strategies to avoid risk of aspiration; supervision during meals/assistance would be helpful to avoid aspiration risk.
On 10/2/13 at 12:45 PM, R1's Social Services Designee (E3) stated although she was assigned to R1 for the past three years and attended his care plan meetings, she was not involved in any formal or informal discussions regarding the safety of R1 eating in his room.
The facility's Acute change in condition policy (revised 1/6/12) states, "All interdisciplinary team members are expected to report and document symptoms/findings that may represent an acute change in condition." "Once it is determined there is an observed pattern of decline in the resident's health statue and it is significant, the nurse will

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S9999	Continued From page 7 contact the resident's physician and verbally report the changes in the resident's condition. (A)	S9999		