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	145681	A. BUILDING _____ B. WING _____	C 7/9/04

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REST HAVEN CENTRAL	**13259 SOUTH CENTRAL AVENUE PALOS HEIGHTS, IL 60463**

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F9999	FINAL OBSERVATIONS Surveyor: 07081 Licensure Violation 300.1210a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial 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	F9999		

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F9999	Continued From page 10 personal care needs of the resident. 300.1210b)4) Personal care shall be provided on a 24-hour, seven day a week basis. 300.3240a) 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, staff interview, and record review, the facility failed to provide necessary supervision to one resident (R2) with swallowing difficulties during eating of a meal alone in his room. This resulted in R2 being found in the room without respirations in front of his meal tray on 6/2/04. Facility also failed to administer emergency care in a timely manner when the staff failed to promptly do the Heimlich Maneuver after finding R2 unresponsive in front of his tray. The Findings include: The medical examiner reference# 39 June 04 states the incident of 6/2/04 when R2 was found without respirations in his room with a tray in front of him and food hanging from his mouth was determined to be an aspiration of food bolus as the cause of death and the manner of death being an accident. Medical chart review documents R2 was a 69 year old readmitted on 5/29/04 after removal of a peg tube on 5/28/04. Physician's orders were for low sodium ,low potassium, 2200 calorie ADA diet with Nectar thick liquids. Siderails were ordered for bed	F9999		

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mobility related to left side weakness (flaccid), speech evaluation and treatment was ordered. Admitting diagnoses consisted of right below knee amputation of 5/26/04, CVA of left side-flaccid, and diabetic neuropathy.
Care plan notation stated to continue the careplan of the 5/15/04 admission for the 5/29/04 admission. MDS rap summary of area G1h .3 eating - indicates need for extensive assistance - approach: allow adequate time to eat; provide cues,encouragement. ADDRESS SPEED WITH WHICH HE EATS AND CUE AS NECESSARY (capital letter are documented in the care plan).

A Speech/swallowing evaluation was done on 6/1/04 and revealed that a chewing problem and swallowing problem was evident. Per documentation, " Patient exhibited symptoms of a mild to moderate oral dysphagia with suspected premature spillage with liquids and mild pocketing with solids in left lateral sulcus. Mild to moderate decrease in attention with impulsivity requiring mild cuing to decrease impulsivity before clearing stasis in left lateral sulcus. Symptoms of mild to moderate dysphagia were noted with decreased oral bolus formation and control, mild delays in swallow. Short term objective: patient will use safe swallow program to tolerate sips of thin liquids with verbal cues for decreased bolus-chintucks." The facility failed to cue and supervise R2's eating following the above guidelines and directions and left R2 alone in the room with his tray.

E7 (certified nurse aid) stated on 6/30/04 at 3:30pm "the incident occurred on the 1st Wednesday, 6/2/04. When I entered the hallway there were four trays to pass. It was after 5:30pm. I set up R2's tray first. I opened the tray and

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silverware and placed the overbed table in front of him as he sat up in bed. The back of the bed was up. He had a grill cheese sandwich. The grill cheese sandwich was already cut in half. The call light and phone was placed on the overbed table. After this, I went across the hall to pass the three other trays. I served one tray and on the way out of the room, a resident wanted to go to the toilet before I served her tray. So I assisted her to the toilet and then I went back to R2's room. R2 was sitting erect and I called out with no response. So I went closer and I couldn't see his chest rise and fall. I right then stepped out and called the nurse. R2 had eaten more than half of the sandwich. At the beginning of the shift, the nurse told me he was on my assignment list and that he was on a regular diet. R2 had come in over the weekend and I had only worked with him for three days. I had gone to the care plan and no special need was there except he needed assistance with everything such as dressing, eating, bathing. For eating for the past three days, I needed to prepare food so he can pick it up and put it in his mouth, put straw in shake, make everything convenient for him. R2 had gone to the dining room on 6/1/04 but was too tired from therapy on 6/2/04 so the nurse said to leave him in bed."
E7 left R2 unattended/unsupervised during the meal, did not cut the cheese sandwich into smaller bite size pieces and was not available to verbally cue R2 to slow the impulse to put more food in his mouth before clearing the mouth of prior bites of food. E7 did not have an updated care plan for review for swallowing precautions.

On 7/1/04 at approximately 12:30pm Surveyor toured the supervised dining area during the lunch meal with E4 (nursing supervisor). Eight residents

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F9999	Continued From page 13 (R1, R3, R4, R5, R6, R7, R8, R9) were identified to be receiving speech/swallowing therapy. Two of these eight residents were observed to not receive assistance nor supervision at the current meal (R4, R8). R4 was positioned at a back table with face away from staff and none of his food had been eaten. A straw was not observed in milk nor the shake and the tea bag was not placed in the hot water. The care plan/kardex stated provide cues and encouragement. E4 finally assisted R4 by opening the cartons and placing a straw in the beverages. R8 was positioned at a middle table with face away from staff, only 40% of her food was eaten and the ice cream had not been opened. R8 requested assist from E4 to open the ice cream. The speech therapist evaluation of 5/25/04 states R8 exhibits a mild deficit in bolus control. The care plan/kardex states staff need to cue resident to complete the meal which was not done. E6 (speech therapist) stated during interview on 7/1/04 at approximately 4pm, "I usually talk to the nursing staff regarding a swallow precaution. I felt R2 should be on swallow precautions. He needed verbal cueing. He had a left neglect and didn't always perceive food items on the left side . He needed cues for appropriate rate, bite size and cues to make sure he cleared any pocketing on the left side. R2's impulsivity was such that if he didn't get cues, chances are he would not finish the entire meal and there is risk for choking; but with the cues there is minimal chance for the choking. R2 was admitted on the weekend of 5/29 on a modified diet. R2 was put on a nectar thick liquids, but without swallowing precautions. R2 had been on swallowing precautions prior to this re-admission. Since I'm not here over the weekend, nursing does take on lots of initiative to	F9999		

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give appropriate diet and caution. I saw R2 on 6/1/04, the 1st day I returned back from holiday. I documented in the evaluation on 6/1/04, that R2 had chewing problems and swallowing problems. We have a checklist for swallowing precautions and I did not have a purple bag for the resident at that time, and R2 didn't already have one. I don't recall speaking with the nurses regarding the swallowing precautions to be initiated."
The facility's protocol for swallowing precautions state a purple bag will be placed on the back of the resident's wheelchair when the resident has been assessed to have a swallowing deficit. Instructions from the speech therapist will be placed in the purple bag for the staff to follow. However E6 stated, instructions were not placed in the purple bag nor did E6 give instructions to the nurses.

E4 was interviewed on 7/1/04 at 1pm. E4 stated "R2's condition had improved. His cognition, behavior, and appetite were on the upswing. I didn't have any fear of his need to be reassessed related to his ability to eat. The speech evaluation took place on 6/1/04. Speech communicates with nursing. They are then going to notify nursing of anything that nursing needs to be immediately aware of to properly care for the patient. That information is then communicated to the certified nurse aid and subsequent nursing shifts via reports.
I don't have any specific goals for eating sent from speech therapy to nursing (for R2). The information to assist R2 that is stated on the care plan did not get carried ver to the kardex for the CNA to review prior to feeding."
However, R2 had a peg tube removed on 5/28/04, six days prior to this incident and had only

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F9999	Continued From page 15 recently been given a thick liquid diet. E7 was interviewed on 6/30/04 at 3:30pm. E7 stated "E5 and Z2 (registry nurse) came into the room about the same time and they asked me what happened and I said , "he was eating". E5 looked at R2 and went out to call 911. Z2 instructed us to lay him down but the other CNA said if he's choking, we'd better sit him up. So we sat him up. Z2 started looking for food in his mouth and removed his dentures; by then the paramedics were in the room." E5 (RN) stated during interview on 6/30/04 at 1:30pm "that about 5:40pm, E7 stood outside R2's door and called for help. Myself and the other nurse responded. I first saw that R2 was not breathing, not blinking but I didn't check for a pulse. At that time I went to the desk to inform 911 that we had a respiratory arrest." Z2 stated during interview on telephone on 7/1/04 at 1:30pm "as I entered the room, I asked the CNA if she called for help and E7 stated something is wrong here. I called out R2's name with no response. It appeared R2 was not getting any good air, so I said lets reposition him. Once I got him in a reclining position, I was able to see a piece of food in his mouth. We repositioned the head again and just as I was about to remove the obstruction/food, the paramedics arrived. I made a clean sweep and was not able to remove any of the food. The first set of paramedics did try rescue breathing, but were unable to see the chest rise or fall. I do remember when the second set of paramedics arrived, they passed an instrument in the throat and removed food. It did look like the grill cheese sandwich served for dinner."	F9999		

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F9999	Continued From page 16 E7 found R2 unresponsive at approximately 5:40pm the CNA stood outside the door and called for help. Nurses responded a few minutes later. Z2 stated "I was passing medications and I continued with the medications for a resident that needed assistance until I was finished and then I answered the call. "The paramedics were already in the building and responded immediately after E5 was able to locate them. The facility Heimlich policy and procedure (7/03) states under procedure #1 #1-assess for adequacy of air exchange #2-Institute emergency code response #3-perform Heimlich maneuver..... #5-when a conscious choking victim becomes unconscious, if airway is obstructed: straddle victim 's thighs, place heel of one hand on abdomen in midline slightly above the navel and well below tip of xiphoid, place second hand on top of first hand, press into abdomen with quick upward thrusts; perform five thrusts..... R2 was described as unresponsive, with no signs of respirations, one nurse left the room and the other failed to institute emergency care after being unable to dislodge the food she saw in resident's mouth. E5 was interviewed on 6/30/04 at 1:30pm E5 stated "I was certified for CPR through May 04 for 2 years. I was certified for CPR through the American Heart Association at another facility. E5 stated I am not currently certified in CPR. I thought since I had more experience than the CNA, that I had to call 911. "E2 (director of nurses) was not able to present a current CPR card for E5 on 7/1/04 although the facility policy	F9999		

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F9999	Continued From page 17 states all licensed staff will be certified to perform CPR prior to resident contact.	F9999		