STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS

ILLINOIS VETERANS HOME AT MANTENO — 0042218
Facility Name — I.D. Number

ONE VETERAN'S DRIVE, MANTENO, ILLINOIS 60950
Address, City, State, Zip

NOVEMBER 9, 2006
Reviewed By — Date of Survey

INCIDENT REPORT INVESTIGATION OF 11-7-06
Type of Survey — Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

340.1560 a) Section 340.1560 Nursing Personnel

a) There shall be sufficient number of nursing staff and auxiliary personnel on duty each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents.

This requirement is not met as evidenced by:

Based on record review and interviews, the facility staff failed to adequately supervise one resident (R2) while the resident was in the dining room on 11/07/06. Staff failed to monitor and supervise R2 according to his care plan and the resident choked on food while eating and died as a result.

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(Cont'd) Findings include:

The record of R2, a 57 year old male admitted to the facility on 9/13/06 with diagnoses of Huntington's Chorea, Dementia and memory loss, was reviewed. The record of R2 contained a "Pre-Admission Information" sheet that stated, "...he must be watched while eating...He has had a problem at lunch and choked because he put too much turkey sandwich in his mouth." R2's record contains a nursing note dated 10/4/06 at 11:00AM that states, "...concerned with member eating too fast. Puts a lot in mouth at a time...OT recommends to divide double portions into two trays, less food at one time." R2's record contains a "Swallowing Precautions" sheet which states, "Assist as needed to decrease rate of presentation...small bites...recommend regular diet with chopped meat to decrease choking risk...small bites...slow rate of eating...supervise at meals...moderate dysphagia." The record contains the following physician's orders: on 10/10/06 stating, "Slower rate feeding." on 10/5/06 stating, "Swallowing Evaluation." and on 10/6/06 stating divided plate and weighted teaspoon at meals." R2's record contains an, "Interdisciplinary Plan of Care" stating, "choking risk, eats fast, needs supervision."

An interview was conducted with E3, the charge nurse, on 11/9/06 and again on 11/16/06. E3 stated that the choking incident with R2 took place at approximately 12:45 PM on 11/7/06. E3 stated that E4, a Certified Nurse Assistant, came to get her stating R2 was choking; she called 911 and went to evaluate the member. E3 stated that when she arrived in the dining room she administered the Heimlich maneuver until the member became unconscious, and then she lowered him to the floor. E3 stated that she cleared R2's mouth of what looked like bread and attempted to give ventilations, but no air passed into the member's lungs. E3 stated that at this time E1 responded to the "code" called and brought the suction machine. E3 stated that R1 suctioned R2's mouth and then administered oxygen via the "Ambu-bag." E3 stated that cardio-pulmonary-resuscitation (CPR) continued, then the ambulance came and they stated that E2 did not have a pulse or heart rhythm and CPR was discontinued. E3 stated that the Deputy Coroner took pictures of R2 and interviewed the staff. E3 stated that there were 4 staff members in the dining room at the time of the choking incident. E3 stated that at that lunch seating there are approximately 27 members eating lunch.

In an interview with E4, a CNA, on 11/16/06, she stated that R2 was at a dining table with other members but no staff person. E4 stated that she did not know that R2 was to be supervised during meals and that he should only take small bites at a time. E4 stated that R2 had a turkey sandwich for lunch the day of the choking incident.

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(Cont'd) In an interview with E7, an Licensed Practical Nurse, on 11/9/06, she stated that she heard someone shout "he's choking", she then saw R2 running across the dining room, when he went back to sit down he was waving his arms about and it was difficult to do the Heimlich maneuver but two CNAs were attempting it. E7 stated that she called 911 and brought oxygen to the member. E7 stated that she knew that R2 was to be supervised at meals, but stated she did not know if he was supervised that day. E7 stated that the food material taken from the resident's mouth looked like bread and turkey.

In an interview with E1, the Director of Nursing, she stated that she did not know if R2 needed supervision with meals.

The Kankakee County Coroner's Office preliminary autopsy findings stated, "1. Aspiration of food bolus" and the preliminary opinion states, "Asphyxia, aspiration of food bolus."

(A)

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IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: ILLINOIS VETERANS' HOME AT MANTENO
DATE AND TYPE OF SURVEY: 11/09/06, INCIDENT REPORT INVESTIGATION OF 11/07/06

340.1560 a) Section 340.1560 Nursing Personnel

a) There shall be sufficient number of nursing staff and auxiliary personnel on duty each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents.

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions for the employees involved. Policies and procedures for assistance of residents with eating that are identified to be at high risk for choking and food aspiration in their assessment and care plan will be developed and/or revised as necessary to ensure residents receive appropriate supervision and monitoring from facility staff during meals.

II. A review of all residents eating assistance needs will be conducted to identify any special supervision or monitoring needs.

III. All nursing and direct care staff will be in serviced on implementation of appropriate and adequate supervision of residents during meals, staff responsibilities for communication of resident supervision needs, and the consequences of failure to provide needed care and the monitoring of residents in accordance with facility policy for eating assistance.

IV. Documentation of in-service training will be maintained by the facility.

V. The Administrator and Director of Nurses will monitor Items I through IV to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of the Imposed Plan of Correction.