| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145657 | A. BUILDING _____ B. WING _____ | C 12/11/2006 |

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| REST HAVEN WEST CHRISTIAN NURSING CENTER | 3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515 |

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| F 324 | Continued From page 11<br>certification, then they should not participate in any was in performing CPR, and instead should follow the facility code procedures by immediately notifying licensed and certified nursing personnel the resident needs CPR. The DON will review incident reports whenever CPR is performed to ensure only current staff CPR certification participate in CPR.<br><br>(3) Notice to paramedics of DNR status.<br><br>The DON and her designees will also inservice all RNs, LPNs and CNAs before beginning their next shift regarding the need to immediately inform paramedics upon their arrival if a resident has a DNR order.<br><br>The DON and her designee will review each incident report whenever CPR is performed to ensure the paramedics were informed upon arrival if the resident has a DNR order | F 324 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.1210a)<br>300.1210b)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) 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 | F9999 | | |

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| F9999 | Continued From page 12<br>to each resident to meet the total nursing and personal care needs of the resident.<br>Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act)<br><br>b)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.<br><br>These regulations are not met as evidenced by the following:<br><br>Based on interview and record review, the facility failed to supervise R10 who was identified on swallowing precaution. This failures resulted in R10's death on 09-20-06.<br><br>Findings include:<br><br>A review of R10's MDS (Minimum Data Set) dated 07-07-06 disclosed R10 was re-admitted to the facility on 01-16-06 with diagnoses that included CVA/Stroke (Cerebrovascular Accident) and Esophageal Reflux. The resident assessment tool also showed cognitively R10's decisions were poor, supervision was required,and R10 had limited ability in making concrete requests. R10 was also identified with a | F9999 | | |

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| F9999 | Continued From page 13<br>swallowing problem and was on mechanically altered diet. The Resident Assessment Summary dated 07-23-06 indicated R10 had a history of CVA with left hemiplegia with aphasia. The nutritional status Resident Assessment Summary dated 07-23-06 indicated R10 was on mechanically altered diet due to decreased swallowing ability.<br><br>A review of the hospital transfer form dated 01-12-06 reads: "Intake: Feeding Problems? Please feed patient. Other Problems and approaches: #4. Patient on soft mechanical with honey thick liquids, no concentrated sweets. Additional orders: DNR."<br><br>A review of the Speech-Language Progress Notes dated 09-16-06 through 09-20-06 disclosed a goal to decrease rate, decrease quality, clear mouth, swallow, clear throat and alternate liquids. On 08-26-06 the progress notes showed an objective to reduce impulsivity at meals with 3 cues per 30 minutes. R10's progress notes also disclosed R10 had remaining impairments in areas of comprehension of spoken language, cognitive/communicative functioning, expression of spoken language and impaired swallowing ability. A review of the swallowing instructions written for R10 read as follows:<br>* slow<br>* 1 bite/sip<br>* swallow<br>* clear throat<br>* drink between bites 2:1<br><br>In an interview with the Speech Therapist (E9) on 10-05-06 at 2:30 PM, E9 stated, "It was a challenge, he's very impulsive, needs a lot of re | F9999 | | |

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| F9999 | Continued From page 14<br>direction to slow down and chew..." E9 explained when a patient is placed on swallowing precaution, a red bag is placed on the back of the patient's wheelchair and a yellow placemat is use in the dining room to alert staff. E9 stated R10 was 80 years old.<br><br>On 09-20-06 the facility incident report disclosed R10 was in the dining room, became cyanotic and unresponsive and expired in the hospital emergency room.<br><br>A review of the 911 summary of events dated 09/20/06 showed: "called for subject (R10) choking. Found patient lying on floor in the dining room, with staff doing CPR (Cardio Pulmonary Resuscitation). Staff st. (stated) patient was eating and began choking and stopped breathing. Staff st. Heimlich maneuver was attempted multiple times. Pt. (Patient) assessed. Cardiac monitor initially shows agonal rhythm. Upon inspection of mouth with laryngoscope, found large amount of food in the esophagus and throat. Attempted suctioning airway with some success. Larger pieces of food removed with forceps. Approximately 3-4 larger chunks of food was removed with forceps. Airway suctioning was continued and removed smaller bits of food. CPR continued during this time. Cardiac monitor now showing asystole. Attempted intubation X 1, unable to view trachea due to food debris. Continued to suction and removed more food debris. Engine Crew arrived, pt. moved to automatic CPR device. After again confirming Asystole and no pulse, Device activated and CPR continued." The EMS narrative sheet reads: "On arrival at the hospital, upon reviewing pt. paper work from nursing home, EMS crew found a valid State DNR form. | F9999 | | |

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| F9999 | Continued From page 15<br>Per ER (Emergency Room) Physician, efforts cease."<br><br>In an interview, the Nurse in Charge (E10) said on 10-05-06 at 3:05 PM, "I went to the Nursing station (Jefferson) to call the kitchen. All the CNA's are(were) in there. I don't think there were nurses there. I'm not sure where they at... The CNA came to the nursing station and said R10 was choking. I found him sitting in his wheelchair unresponsive, head down. His brother was next to him. I was the one that started the Heimlich maneuver." This conversation was witnessed by the Nurse Consultant (E5).<br><br>On 10-27-06 at 12:30 PM R10's family member (Z1) was interviewed. Z1 claimed 2 -3 weeks before the incident they (Z1 and his wife) bought R10 white castle hamburgers (small size burger) and gave him one. Z1 claimed it almost choked R10. It clumped up and was too much for his esophagus. Z1 claimed "he was able to cough it out." Z1 said the doctor was in the facility and said he will adjust R10's diet and to continue with speech therapy and watch how he progresses.... Per speech therapist, R10 needs to be observed and to slow down and chew more. Z1 said, "I was told his speech needs to be strengthened and his swallowing. His swallowing (was) very poor and he eats fast. I wasn't trained to feed him. Never asked or told how... I'm afraid to be a part of that (feeding).... The day of the incident I arrived there 2 minutes before 6:00 PM, the tray was not there yet. I saw him sitting in the dining room.... I sat in my usual spot.... The staff served the tray. They set the tray down. They didn't cut or chop up anything. They didn't offer to feed him or cut the sandwich. He lifted the sandwich and bit. Every thing seems okay at that moment. He picked up a | F9999 | | |

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| F9999 | Continued From page 16<br>small piece of cake about 1/2 inch and ate it. I looked at him, he looked like he was in trouble, there was no expression in his face like he was trying to swallow. I got up and told 3 to 4 Aides. I told them he's having trouble breathing. They started pounding on his back for couple of minutes. The staff asked where E10 ( Nurse in Charge) was, said to call E10."<br><br>Z1 stated E10 was in the Nursing Station. When she arrived at the scene, she was the first one to initiate the Heimlich Maneuver. Then they called E12 (Male CNA) who lifted R10 from his wheelchair down onto the floor. Z1 said R10 was dead, not breathing and was blue. Then they called 911. Z1 vocalized "If I wasn't there, R10 will be dead in his plate. The facility was not equipped for this emergency procedure...."<br><br>The facility swallowing precaution policy and procedure with effective date of 01-01-04 and revised on 09-22-06 was reviewed and reads as follows:<br>Purpose: To identify the resident's that have been evaluated and have swallowing precaution noted.<br>Procedure:<br>(1) The Speech Therapist (S.T.) will evaluate the resident and recommend the diet order be modified in consistency. The physician will approve the diet change and write the order or sign the telephone order.<br>(2) The S.T. will provide a Red Bag with swallowing instructions for the resident.<br>(3) The dietary department will mark the diet card with "Yellow Placemat"<br>The red bag and yellow placemat will alert the staff of the swallowing precaution.<br><br>The final pathologic diagnosis autopsy report | F9999 | | |

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| F9999 | Continued From page 17<br>dated 09-22-06 reads as follows: (1) Asphyxiation secondary to obstruction of oropharynx, hypopharynx, larynx and trachea by partially masticated food. History/Final summary/clinical pathologic correlation: Post - mortem examination demonstrated partially masticated food obstructing the posterior pharynx, the pharynx, the hypopharynx, and trachea. Similar appearing partially masticated food was observed impacted in the esophagus at the level of the lower esophageal sphincter and within the stomach.<br><br>The immediate cause of R10's death was asphyxiation secondary to obstruction of the deceased's airways by partially masticated food.<br><br>(A) | F9999 | | |