STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

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ILLINOIS VETERANS HOME AT LASALLE	0044115	
Facility Name	I.D. Number	
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1015 O'CONOR AVENUE, LASALLE,ILLINOIS 61301		
Address, City, State, Zip		
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02630	JANUARY 8, 2010	
Reviewed By	Date of Survey	
NACED ENTER DEPONDE IN A PERSON OF 40 10 100 M. 17404	1.1615	
INCIDENT REPORT INVESTIGATION OF 12/8/09/IL45181	14647	
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.

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.

0044115

"A" VIOLATION(S):

340.1505a) 340.1910b)

Section 340.1505 Medical, Nursing and Restorative Services

a) The facility must provide the necessary care and services to attain of 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 shall be provided to each resident to meet the total nursing care needs of the resident.

Section 340.1910 Diet Orders

a) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.

These requirements are NOT MET as evidenced by:

Based on record review, interviews and observations the facility failed to serve a diet as ordered by the attending physician for 1 of 3 sampled residents. R1 choked in the dining room The facility failed to immediately call 911 according to facility policy. R1 died of asphyxia due to aspiration of a food bolus.

Findings include:

Incident Report dated 12/08/09 reads, "I (E7 Registered Nurse 2) was passing meds in the dining room when I heard (E3 Certified Nurse's Aide) call the kitchen and said they sent a resident (R1)

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the wrong diet. He (R1) was a mechanical soft and they sent a regular meat. A couple minutes later I heard someone say, 'He's choking'. I saw (R1) slumping in his chair gasping. We told him (R1) to cough but he just went limp. Heimlich was attempted by (E3), who was behind his (R1) chair. I was holding him (R1) up so he did not hit his head. (E5 Licensed Practical Nurse) asked if we needed help and she (E5) began the Heimlich and did 5 thrusts with no result. I had a V.N.A.C. (Veteran's Nursing Assistant Certified) call code blue. At this time (E5 and E3) and myself moved him (R1) on to the floor on his side. (E12 Nursing Supervisor) came in and started unconscious resuscitation. Suction was set up and (E5) to suction. (E5) removed a large amount of ground meat with a finger sweep and suction. 02 (oxygen) via ambu bag at 15 liters 02. Code was started and 911 called."

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On 12/29/09 at 10:40 A.M. E2 (Director of Nursing) stated that there was confusion during this incident and that there was about a 5 minute delay before 911 was called.

On 12/29/09 at 2:18 P.M. E6 (Nursing Supervisor) verified that she had called 911 about 4 minutes after the code blue was called, after there was some confusion as to whether or not 911 had been called. The 911 operator told E6 that this was the first they had heard about the incident.

Facility's Follow up to the Incident on 12/08/09 regarding (R1) reads, "On the above date, the Dietary Department food line 'checker', (E10 Cook 2), failed to check the lunch tray to see that the resident (R1) was served a mechanical diet. As a result, (R1) was served a general tray with regular meat. The tray was prepared and sat before the resident (R1); however, none of the CNAs (Certified Nurse's Aides) will admit to setting up the tray. We have narrowed it down to 2 possible CNA's: (E4 and E3). Another CNA entered the dining room and started feeding a tablemate to (R1). She stated that (R1) was not eating, so she gave him "a bite of meat." Then (E3) asked (E4) if (R1) was supposed to be on a mechanical diet. (E4) stated, "Yes." (E3) then called the dietary department at approximately 12:20 P.M., to send out a ground meat replacement. (E3) pushed the tray forward from the resident (R1), but the tray was still in reach of this resident. Dietary notes stated that the bowl of ground meat was 1/2 gone when it was returned to the kitchen. At 12:30 P.M. a code blue was called. (Local Emergency Ambulance Service report notes that the first call came in at 12:35 P.M. on 12/08/09) The Heimlich maneuver was attempted at the table unsuccessfully, thus (R1) was moved to the floor, wherein it was continued, and followed by attempts to suction. Large amounts of ground meat, and baked potato was removed manually and by suction. (R1) had no pulse at this time. (R1) was a DNR (Do Not Resuscitate), however since this was a choking incident, CPR (Cardiopulmonary Resuscitation) was initiated, but no air would go past the larynx into the lung. The ambulance and the EMT's (Emergency Medical Technician) arrived at approximately 12:45 P.M. and used a laryngoscope and long forceps to remove several larger pieces of meat from (R1's) larynx. He (R1) was pronounced dead at 12:55 P.M. The coroner came to observe the scene and then ordered an autopsy to be done."

On 12/29/09 at 2:18 P.M. E6 (Registered Nurse Supervisor) stated that the EMT's pulled out of R1's throat, 2 pieces of meat 1 and 1/2 to 2 inches in size.

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On 12/31/09 at 10:10 A.M. E12 (Dietary Manager 1) stated that both the cook (E9) and the checker (E10) did not do their jobs on 12/8/09, which resulted in R1 receiving the wrong diet tray.

E9 and E10 verified during interviews on 12/30/09 at 11:25 A.M., that they did not check the diet card to see if R1 was a mechanical soft diet.

R1's Nurse's Notes dated 10/31/09 at 12:00 P.M. read, "(R1) coughing and choking on meat. With staff encouragement res. (R1) spit out meat and was able to finish lunch without difficulty." R1's physician's telephone order sheet dated 11/23/09 reads, "NAS (No added salt)/ NCS (No concentrated sweets) 2 gram K+ (Potassium) Ground Meat."

(A)

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