STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001135	A. BUILDING: _____ B. WING _____	C 11/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Final Observations LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.2040b) 300.2040d) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'	S9999		

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S9999	Continued From page 1	S9999		

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:
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:
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 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 300.2040 Diet Orders
b) 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.
d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record.

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S9999	Continued From page 2	S9999		

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident at high risk for aspiration and choking received the prescribed puree diet. This failure resulted in R2 receiving a mechanical soft diet. Further, the facility failed to provide supervision for a resident at high risk for aspiration and choking while eating. R2 choked while eating a chicken and noodle casserole entrée during the evening meal on 10/26/13. R2 lost her ability to cough or breathe, lost consciousness and expired on 10/26/13 from a cardiac arrest.
Findings:
R2 is a 58 year old resident with diagnoses that include Obsessive Compulsive Disorder, Schizophrenia, Dysphagia, and Mild Intellectual Disabilities. The Minimum Data Set dated 8/3/13 shows R2 eats independently with supervision and assistance with meal set up. The Care Plan for R2 dated 10/23/13 shows a physician order to change R2 ' s diet to puree related to the recent choking episode (no date listed). The care plan does not show eating or swallowing interventions in place for potential choking. The care plan dated 12/16/2010 for R2 shows she has a memory problem that causes her to have a great deal of difficulty remembering even the most basic of information. She often needs reminders of where she is and what she is doing here.
The hospital Emergency Department Record dated 10/26/13 documents, "R2 presents from the nursing facility. R2 was found choking at her

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S9999	Continued From page 3	S9999		

meal. EMS (Emergency Medical Service) arrived and was unable to intubate so the patient was bagged (ambu) ... A large amount of food debris was found in the airway, suctioned and then the patient was intubated ... The patient was difficult to bag, suctioned a lot of food debris from the tube, oral pharynx and from the airway ....The patient was asystolic the entire time. R2 was pronounced dead at 1800 (6 PM)."
A previous Hospital Emergency Department Record from 5/14/13 states, "R2 was sent in secondary to choking. R2 reportedly has her food pureed, however, her pizza puffs were not pureed today and she has been having swallowing issues for quite some time. R2 comes in today in obvious respiratory distress, unable to speak".
The Hospital Emergency Department Record on 4/10/13 states, "R2 who has a history of developmental delay and lives in a nursing home comes to the Emergency Department by ambulance after a choking episode. R2 states that she 'ate her burrito too fast'."
During interview on 10/30/13 at 3:25 PM, R6 stated she ate in the same dining room as R2 on the evening of 10/26/13. R6 stated, "I was not seated at her table, but had a direct view of her (R2). R2 has choked several times before while eating so I always kept an eye on her. R2 usually gets pureed foods but that night I noticed she received the same food as I did. It was a chicken and noodle dish, it was very thick and sticky, like peanut butter. She was eating, and then I noticed the panic in her eyes, I knew she was choking. I got up and went to her and called out loudly to E16 (Licensed Practical Nurse - LPN), he was at the nurses ' station. The CNA staff was not in the dining room. No one was around to help except E16 at the desk. E16 came into the dining room and started giving R2 the Heimlich."

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FAIRVIEW NURSING PLAZA	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S9999	Continued From page 4	S9999		

On 10/30/13 at 3:00 PM, E16 (LPN) stated, "R2 has a history of choking. That evening I was seated at the nursing station working on the computer filling out an incident report from a previous event". E16 stated, "I heard screaming from the resident in the dining room". E16 stated he responded and tried to get R2 to cough, and she could not speak. E16 stated he tried the Heimlich maneuver several times before she became unconscious. E16 stated he was not monitoring the residents eating, and was unsure where the CNA staff were at the time of R2's choking. E16 stated, "On Wednesday, 10/23/13, it was decided to put R2 back on pureed foods because she had choked on Monday 10/21/13". E16 stated, "I delivered the diet change slip to the kitchen staff and was sure she received a pureed diet on the 23rd".

On 10/29/13 at 2:05 PM, E12 (Speech Therapist) stated, "R2 has dysphagia because she gets very anxious, it ' s part of her behaviors. When she is anxious, she can start shoveling her food in very fast." E12 reviewed R2's choking history. E12 stated after a choking incident in April 2013, her diet was changed to mechanical soft. Then she had a second choking incident in May 2013 and they changed her diet to puree. R2 was very unhappy about the pureed diet, so a swallow evaluation was conducted in October 2013. On 10/7/13, the recommendation was for R2 to have a mechanical soft diet. E12 stated in a controlled situation when she is coached frequently to take small bites and slow down she could do well. E12 stated, "R2 choked on 10/21/13 after the mechanical soft diet was restarted. On 10/23/13, the staff and physician agreed it was in R2's best interest to change her diet back to puree with thin liquids." E12 stated R2 ate in a supervised dining area along with several other residents.

On 10/30/13 at 11:20 AM, E19 (CNA) stated she

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FAIRVIEW NURSING PLAZA	321 ARNOLD AVENUE ROCKFORD, IL 61108

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S9999	Continued From page 5	S9999		

was assigned to the second floor the evening of 10/26/13. E19 stated R2 always ate fast and needed to be encouraged to slow down and take small bites. E19 stated she served the tray to R2 that included chicken and noodles, vegetable, dessert, water and milk. E19 stated the beans were whole so it was not a puree diet. E19 stated R2 was served what the diet card said she should have. E19 stated she gave R2 the tray and left the room to go get another tray for the other residents at her table. E19 stated she thought E18 (CNA) was in the dining room when she left because someone was always to be in the dining room. E19 stated when she returned E16 (LPN) was in the room doing the Heimlich on R2. E19 stated R2 was on aspiration precautions because she had choked on her food before. E19 stated aspiration precautions included to monitor how they are eating and swallowing and to not let them put too much food in their mouth at one time.

On 10/30/13 at 9:35 AM, E18 (CNA) stated supervising the dining room meant to ensure there were no problems during the meal such as stealing other ' s food or inappropriate behaviors. E18 stated he was aware R2 had had problems with swallowing in previous months. E18 stated if he noticed someone choking he would encourage them to cough harder and get the nurse. E18 stated when he entered the assisted dining room with a meal tray; R2 was on the floor. E16 (LPN) and E5 (Registered Nurse - RN) were doing CPR for R2.

On 10/30/13 at 10:00 AM, E15 (Dietary Supervisor) stated nursing completes a "pink slip" for resident diet changes and sends it to dietary. The dietary staff will make the changes in the computer and a new meal card is printed. When the resident is ready to eat the CNA gives the resident their meal card and they hold it up for the

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S9999	Continued From page 6	S9999		

dietary staff to fill their tray. E15 stated she did not know who or when the diet change was entered in the computer for R2 on 10/23/13 because she was on vacation. E15 stated, "The diet clerk or the cook should make the changes when I ' m not here ". E15 stated she could not verify if the correct diet was on R2's meal card because she was taken out of the computer system by the time she returned from vacation.
On 10/30/13 at 12:20 PM, E2 (Director of Nurses - DON) explained her expectation of CNA staff monitoring the residents in the assisted dining room. E2 stated, "I am very rigid (with the staff) about monitoring residents. I expect the CNA staff to remain in the room at all times, and monitor how the residents are eating. Also to be watchful of what food the resident was served; they should be circulating in the room."
On 10/30/13 at 12:45 PM, Z5 (R2' s physician) stated, "The choking incident was the cause of her death; R2 did not have any underlying health conditions that would have caused her sudden demise."
The facility policy, "Supervision of Resident Nutrition" (undated) states,"Nursing personnel are responsible for assuring that residents are served the correct food tray. Prior to serving the food tray, the nurse aide must check the diet card to assure that the correct food tray is being served to the resident. Residents needing assistance in eating must be promptly assisted upon being served. Food and fluid intake must be observed by nursing personnel at each meal."
E1 (Administrator) was notified of the Immediate Jeopardy on 11/4/13 related to the facility's failure to supervise R2 on 10/26/13 while she was eating her evening meal. R2 choked, lost her ability to cough, or breathe, and became unconscious with asystole (no heart beat). She expired at 6:00 PM on 10/26/13.

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S9999	Continued From page 7 (A)	S9999		