

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE PEORIA, IL 61604
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.1210b) 300.1210c) 300.3240a)</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review the facility failed to follow recommended supervision and verbal cues while eating for one resident (R1) with a history of choking. R1 was found unresponsive after being given a peanut butter sandwich and subsequently died as a result. R1 is one of four residents in the sample and 19 residents in the supplemental sample reviewed</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE PEORIA, IL 61604
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1 for mechanical diets.</p> <p>FINDINGS INCLUDE:</p> <p>R1's Resident Admission Information sheet documents that R1 was admitted to the facility on 12/22/11 with the following diagnoses: C6 Fracture, Chronic Back Pain, Diabetes Mellitus, Schizophrenia, Anxiety, Depression, Gastric Esophageal Reflux Disease.</p> <p>R1 had a documented history of choking as evidenced by nurses notes dated 4/17/13, when R1 was found sitting in the wheel chair in the hallway, not breathing. R1 was transferred to the local hospital Emergency Room where it was documented, " (R1) presents for choking episode at nursing home after being given a peanut butter sandwich as an evening snack at 7:30 P.M."</p> <p>R1's current care plan, dated 4/19/13 includes the following problems: "Swallowing problem: Resident choked on peanut butter sandwich." It also includes the following approaches: " Cut up resident's food in small bites and cue to place on middle of tongue. Cue resident to chew well. Watch for safe swallow before next bite..."</p> <p>R1's Nurses notes dated 4/28/14 document, " Noted resident ask CNA for a snack and CNA gave resident a peanut butter and jelly sandwich. Up in (R1)'s (wc) wheel chair by the shower room, near the nurse's station. The CNA gave (R1) the sandwich and went down to continue (to) pass snack to other resident. It took approximately 20 (min) minutes to pass and then the CNA had returned and noted resident was blue and gave a sternal rub and rub face. (R1) did not respond.Started CPR (Cardio Pulmonary</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE PEORIA, IL 61604
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>Resuscitation). 911 called. Police and rescue team arrived and took over CPR. Coroner arrived...(Physician) called. Coroner removed body out of facility."</p> <p>On 8/13/14 at 4:45 P.M., E9 CNA (Certified Nursing Assistant) stated, " On April twenty eighth, I worked second shift that night. I was assigned the snack cart. (R1) was sitting in (R1)'s wheel chair in B hall, down by the showers. (R1) said 'Can I have a snack?' I gave (R1) a peanut butter sandwich...I went down the hall with the snack cart and when I came back ten or twelve minutes later, (R1) was unresponsive. I yelled for the nurse and she started working on (R1). I feel really bad, Because (R1) had this same problem before with a peanut butter sandwich. No one ever told me (R1) couldn't have a peanut butter sandwich though."</p> <p>On 8/13/14 at 8:30 P.M., E2 DON (Director of Nurses) stated, "(R1) had two episodes of choking on a peanut butter sandwich, about a year apart. I don't know why the staff kept giving (R1) peanut butter sandwiches."</p> <p>R1's Medical Examiner/ Coroner Certificate of Death (date issued 6/25/14) lists cause of death as "aspiration of food bolus."</p> <p>(AA)</p> <p>300.695a) 300.695b) 300.695c)</p> <p>a) The facility shall maintain a file of all written</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE PEORIA, IL 61604
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.</p> <p>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. (Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to notify the Regional Office by telephone of the death of a resident resulting from an incident (R1). R1 is one of four residents reviewed for swallowing in the sample of four.</p> <p>FINDINGS INCLUDE:</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE ELMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3611 NORTH ROCHELLE PEORIA, IL 61604
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>R1's Nurse's Notes dated 4/28/14 documents that E9, Certified Nursing Assistant (CNA) gave R1 a peanut butter sandwich at 8:00 P.M. E9 then continued passing snacks and returned 20 minutes later and found R1 slumped forward in (R1)'s wheelchair, cyanotic. E10 (RN) Registered Nurse and E11 (LPN) Licensed Practical Nurse immediately began resuscitation efforts on R1. Local police, Emergency Medical Technicians and the Coroner arrived at the facility. R1 was pronounced dead at the scene.</p> <p>R1's Medical Examiner/ Coroner Certificate of Death issued 6/25/14 lists cause of death as, "Aspiration of food bolus."</p> <p>On 8/18/14 at 9:30 A.M., E1 (Administrator) stated, " I faxed (the Regional Office) the night (R1) passed away. I didn't call a report in."</p> <p>(AW)</p>	S9999		
-------	---	-------	--	--

IMPOSED PLAN OF CORRECTION

Sharon Health Care Elms
Complaint Investigation 1423527/IL71374
DATE OF SRVEY: August 19, 2014

300.1210b) The facility will ensure that necessary care and services are provided residents to
300.1210c) attain or maintain their highest practicable physical, mental, and psychological
300.3240a) well-being in accordance with each resident's comprehensive assessment and plan
of care. The facility shall provide adequate and properly supervised nursing and
personal care to each resident to meet the total nursing and personal care needs of
the resident.

Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This will be accomplished by the following:

1. A diet book will be set up for both the Nursing staff and Activity staff including copies.
2. All staff will be in-serviced on the book and its contents..
3. A Snack protocol for each diet is listed with options available.
4. The Speech Therapist will write specific recommendations for the residents that have certain interventions needed for safe eating and drinking.
5. Speech Therapist to in-service the nursing staff on techniques and definitions used for observation and cuing residents for safe eating and drinking.
6. Dietary Manager to audit all diet orders and Care Plans with these lists and approved their accuracy.
7. Dietary Manager will update all lists on a daily basis as diet orders are changed or new residents are admitted. On-going.
8. The Administrator and Director of Nurses will monitor Items I through VII to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within ten (10) days of receipt of this plan of correction.