STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145486	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE SPRING VALLEY	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

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F 000	INITIAL COMMENTS Facility Reported Incident Investigation of 9/21/20/IL127176. A Partial Extended Survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor/supervise an altered diet with swallowing deficits that required staff supervision for one (R1) of three residents reviewed for dietary supervision in a sample of three. This failure resulted in R1 experiencing a choking episode leading to the death of R1. These failures resulted in an Immediate Jeopardy. While the Immediate Jeopardy was removed on 9/29/20, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of protocols and oversight visits. Findings include: R1's State of Illinois Certificate of Death Certificate, dated 9/24/20, documents R1's 9/21/20 cause of death, as "Asphyxiation and	F 689	Aperion Care Spring Valley Provider # 145486/0053611 Cycle Date: October 1st, 2020 Survey Date: October 1st, 2020 Survey Type: FRI of 9/21/20/IL127176 Plan of Correction F689 Please accept the following as the facility's credible allegation of compliance. The Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice: R1 expired and was pronounced at the facility by EMS. All residents diets were reviewed by	10/1/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/09/2020

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F 689	Continued From page 1 choking on a sandwich." On 9/29/20 at 1:27 pm, an Immediate Jeopardy was identified to have begun on 9/21/20 when staff failed to follow care plan interventions for supervising and monitoring R1 while eating a peanut butter sandwich. On 9/29/20 at 1:27 pm, V1 (Administrator) and V2 (Director of Nurses/DON) were notified of the Immediate Jeopardy. Facility Job Description for Certified Nursing Assistant/CNA, undated, documents: that the primary purpose of the job description is to provide residents with nursing and personal care under the supervision of a Charge Nurse to safeguard the health, safety and welfare of all residents of the facility, in accordance with the directions of supervisors, including Administrator, Director of Nursing, Charge Nurse and Rehabilitation Director, in order to assure the highest degree of quality care is maintained at all times. As a CNA, you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties; to carry out assignments for resident care including feeding; be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty; and to follow established safety precautions when performing tasks. Facility COVID 19 Communal Dining Guidelines, documents that the Facility Guidelines for Phase One (1) are that communal dining is not recommended but may be considered on a limited and modified basis and that dining services should be served in resident rooms.	F 689	Director of Nursing and Dietary Manager and residents with altered diets were identified. How will the facility identify other residents having the potential to be affected by the same deficient practice: Those residents with altered diets have been identified and they will continue to be monitored during meal and snack time. Random auditing of staffing levels will be completed to ensure proper amount of supervision during dining and snacks. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All staff were immediately in-serviced on altered diets and proper supervision according to Aperion Care Policy and Procedure. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Random auditing of staffing levels will be completed weekly or as needed by DON or designee for 3 months. Residents who require supervision will be supervised in the hallway during meal and snack times weekly for 3 months. Observations noted during monitoring will be discussed with the QA Committee. Concerns will be discussed among the members, a plan of action is devised, and past plans of actions evaluated by Quality Assurance Committee, for 3 months or as	

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F 689	Continued From page 2 On 9/22/20, at 2:26 pm, V3 (Dietary Manager) stated, "We are in Phase One with dining." On 9/22/20, at 3:25 pm, V2 (Director of Nursing/DON) stated, "We cannot go to Phase Two until the County COVID numbers fall below ten percent for two consecutive weeks, so all residents eat in their rooms. Some residents that require supervision for altered diets will eat in their doorway, or if they require feeding, then a Certified Nursing Assistant/CNA will go to their room and feed them." R1's Dietary Initial/Quarterly/Annual Notes, dated 9/8/20, document that R1 readmitted to the facility on 9/7/20 with a diagnoses including Dysphasia, Dementia with Behavioral Disturbance, Metabolic Encephalopathy and Pneumonitis due to Inhalation of Food and Vomit. The Notes also document that R1 was on a Mechanical Soft diet and required Supervision Assistance with eating. The Notes also document that R1 was to receive a pudding snack at 2:00 pm. R1's Dietary Assessment, dated 9/9/20, documents a swallowing issue of "Holding food in mouth/cheeks or residual food in mouth after meals." R1's Speech Therapy Plan of Care, dated 9/8/20, documents that R1's current level of swallow function as "Patient utilizes swallow strategies/precautions in fifty percent of the trials." and that R1 was receiving Speech Therapy for swallowing dysfunction and/or oral feeding. R1's Speech Therapy Note, dated 9/9/20, documents that V6 (Speech Therapist) reviewed aspiration precautions with R1 and R1 "Did not	F 689	needed. Date of Completion: 10/1/2020	

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follow strategies for small bites and slow pace given maximum prompting in any trials."

R1's Speech Therapy Note, dated 9/14/20, documents that "Certified Nursing Assistant (CNA) reported to (V6) that (R1) had been 'chugging' drinks during lunch and that (V6) noted occasional coughing from down the hall while patient was eating lunch. Patient independently recalled swallowing strategies during review but becomes impulsive at times and will not use."

R1's Speech Therapy Note, dated 9/15/20, documents that "Nurse expressed concerns about increased coughing during meals and coughing up phlegm. Nurse notes that patient eats and drinks with quick pace outside of therapy sessions" and that R1 was inconsistent with implementation.

R1's Speech Therapy Note, dated 9/18/20, documents that concerns were reported "About increased coughing and wet quality of coughing to nurse."

R1's current Care Plan documents: to place R1 in common area for snacks due to potential behavior with Dementia; to cue, reorient and supervise as needed for cognitive function related to Dementia; to provide and serve diet as ordered and that snacks will be consumed safely; and to monitor and report signs of Dysphagia, pocketing, choking, coughing, holding food in mouth and several attempts at swallowing.

On 9/22/20, at 3:15 pm, V12 (Resident Assistant) stated, "The resident's get snacks from the kitchen at 10:00 am, 2:00 pm and 7:00 pm. They usually come out with their names on them."

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On 9/22/20 at 3:18 pm, V11 (Certified Nursing Assistant) stated, "Whoever is the float, hands the snacks out. The snacks come out with assigned stickers and the resident room number. If someone is a special diet and they do not want their snack, we have to ask the nurse before giving an alternate."

On 9/22/20, at 2:15 pm, V4 (Certified Nursing Assistant/CNA) stated, "I came onto shift on 9/21/20 at 2:00 pm and immediately started handing out the 2:00 pm snacks to the residents on (R1's) hall. R1 got a peanut butter and jelly sandwich about 2:50 pm or 2:55 pm. She did not have a snack with a dietary label on it, so I gave her the peanut butter and jelly sandwich as she requested. I continued to pass snacks down the hallway, to the other residents, and at about 3:05 pm, (V7/Physical Therapy Assistant) came to me and told me to get a nurse because R1 was choking. I ran and got V8 (Licensed Practical Nurse/LPN). About 10 to 15 minutes went by from the time I gave her the sandwich until the time she she was observed choking. I did not see her choking until (V7) came and got me and was not aware that she had been experiencing any swallowing issues."

On 9/22/20, at 2:00 pm, V7 (Physical Therapy Assistant/PTA) stated, "I was doing therapy with another resident right across the hallway from (R1). On 9/21/20, at about 3:05 pm, I happened to look out the doorway and (R1) did not look right at all, I could tell something was wrong. I ran across the hallway to check on (R1) and asked if (R1) was okay, and (R1) told me, in a whisper, 'I am choking.'" I kind of panicked and set her forward and pounded on (R1's) back. I then got

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(V4/CNA) and told (V4) that (R1) was choking and (V4) went and got (V8). Then the nurses took over."

On 9/22/20, at 2:24 pm, V8 (Licensed Practical Nurse/LPN) stated, "On 9/21/20, at about 3:05 pm or 3:10 pm, I was alerted by (V4) that (R1) was choking. We immediately started the Heimlich Maneuver. It was very difficult to do because (R1) was a large lady. I did scoop (R1's) mouth and throat and had a small amount of bread and peanut butter on my glove afterwards. Then (R1's) skin became discolored, (R1) went unconscious and I did not feel a pulse, so we laid (R1) on the floor and began Cardio Pulmonary Resuscitation/CPR and suctioning to try and expel the debris and establish an airway until the paramedics came. It was unsuccessful and the paramedics declared her expired at 3:36 pm."

On 9/22/20, at 1:50 pm, V13 (Registered Nurse/RN) stated, "On 9/21/20, a little after 3:00 pm, I was in my office on C Hall and overheard something going on down the hall. I came out of my office and saw the crash cart and a couple nurses down the hallway by (R1's) room. They were performing the Heimlich and then (R1) went unresponsive and they lowered (R1) to the floor and started CPR. (R1) was on speech therapy for swallowing issues. (R1) did not sit in the supervised dining room because of COVID, we sat (R1) in the doorway of (R1's) room for meals and snack time."

On 9/23/20, at 3:30 pm, V13 (RN/Minimum Data Set/MDS Nurse) stated, "(R1) was supervision for meals according to the documentation from staff for the MDS. There are two CNA's down the hallway and sometimes a float but not all

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resident's can be supervised at all times during meals and snacks."

On 9/22/20, at 2:26 pm, V3 (Dietary Manager) stated, "Resident that are feeders or supervision are not sitting in the dining room due to COVID. I know (R1) was working with (V6/Speech Therapy). She was working on getting on a regular diet and back on thin liquids. (R1) needed reminded to slow down because she was a fast eater. We individually label the snacks with resident names and also send out extra for alternatives. We base who gets a snack on if that resident tells me they are hungry between meals, or if I have orders or recommendations from Dietician, Speech Therapy or the Doctor. The CNA's should know the resident's diets."

On 9/22/20, at 2:07 pm, V8 (Speech Therapist) stated, "(R1) was a readmission after multiple hospitalizations for Aspiration Pneumonia, Urinary Tract Infections and Encephalopathy. (R1) has been mechanical soft diet through all of those admissions and we trialed thin liquids. (R1) was always in the Supervised Dining Room prior to COVID restrictions because (R1) needed supervision. I believe (R1) was to be receiving a pudding snack at 2:00 pm and not a peanut butter sandwich. (R1) still had recommendations for supervision with swallowing, (R1) was impulsive and needed reminders to slow down. I observed (R1) eating in the doorway to (R1's) room multiple times and even saw (R1) coughing.

R1's Nursing Note, dated 9/15/20 and 9/18/20, does not document notification or monitoring of R1's swallowing and coughing issues per V6's (Speech Therapist) notes. R1's Medical Record dated 9/15/20 through 9/18/20, does not

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document coughing or choking monitoring of R1 per V6's recommendation.

On 9/22/20, at 3:12 pm, V2 (DON) stated, "We always gave (R1's) food in the doorway of the room because she was impulsive with her eating. (R1) did not always need supervision because she would sometimes do alright by herself. We always had two CNAs on the floor. The CNAs did pass snacks and did have to care for other residents, so they could not continually monitor (R1) but were still on the hallway. When the snacks were being passed, the nurse was always on the floor doing medication pass."

On 9/22/20, at 10:55 am, V5 (Medical Director) stated, "(R1) has been in and out of the hospital multiple times over the last few months for Dysphagia, Aspiration Pneumonia, Encephalopathy and other infections. When (R1) is sick (R1) gets weaker and requires more supervision with cares. I would think that if a resident is supervision for meals and on a mechanical soft diet that a peanut butter and jelly would require supervision with staff watching (R1) eat. Supervision technically means that a staff member should be right there with the resident or it can be a major problem."

The surveyor confirmed through observation, interview and record review the facility took the following actions to remove the Immediate Jeopardy:

1. All residents's diets were reviewed by V2 (DON) and V3 (Dietary Manager) and residents with altered diets were identified. Completion date 9/25/20.

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2. All staff were immediately in-serviced on altered diets and proper supervision according to the facility's Policy and Procedure. Completed by V2 (DON) and V3 (Dietary Manager). Completion date 9/25/20 and ongoing.

3. Direct Care Staff will be in-serviced on supervision for all dining and snacks of altered diet residents. Completed by by V2 (DON) and V3 (Dietary Manager). Completion date 9/29/20 and ongoing.

4. Staffing will be monitored and reviewed daily by V2 (DON) or designee in morning meeting to ensure there is adequate staffing for supervision during meal and snack times. Completion date 9/29/20 and ongoing.

5. All snacks will be labeled to identify appropriate diet restrictions. V3 (Dietary Manager) will be responsible for labeling. Completion date 9/29/20 and ongoing.

6. Random auditing of altered diets will be completed by V2 (DON) or designee weekly or as needed for three months. Completion date is ongoing for three months.

7. Random auditing of staffing levels will be completed weekly or as needed by V1 (Administrator) for three months. Completion date is ongoing for three months.

8. Observations noted during monitoring will be discussed with the Quality Assurance (QA) Committee. Concerns will be discussed among the members, a plan of action is devised and past plan of actions evaluated by QA Committee for three months or as needed. Completion date is

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F 689	Continued From page 9 ongoing for three months or as needed.	F 689		