STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001044	A. BUILDING: _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON CARE CENTER	1201 NORTH ALTON LEBANON, IL 62254

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S 000	Initial Comments Complaint Investigation 1941879/IL110409	S 000		
S9999	Final Observations Statement of Licensure Violations: (Findings 1 of 2) 300.610a) 300.1210b) 300.1210d)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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)

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide continual abdominal thrusts to open an obstructed airway, failed to initiate CPR (cardiopulmonary resuscitation) once the resident became unresponsive and failed to activate emergency medical procedures per facility policy for 1 of 1 residents (R2) reviewed for CPR in the sample of 8. This failure resulted in R2's aspiration and death.

Findings include:

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S9999	Continued From page 2	S9999		

The web site, entitled "patient.info/doctor/choking-and foreign-body-airway-airway-obstruction-fbao (Foreign Body Airway Obstruction)" and entitled "Choking and Foreign Body Airway Obstruction (FBAO)" written by Dr. Roger Henderson, 04/19/16, documents, "Choking is the physiological response to sudden obstruction of the airways. FBAO causes asphyxia and is a terrifying condition, occurring very acutely, with the patient often unable to explain what is happening to them. If severe, it can result in rapid loss of consciousness and death if first aid is not undertaken quickly and successfully. Immediate recognition and response are of the utmost importance. Choking due to inhalation of a foreign body usually occurs whilst eating. Severe Obstruction - This is indicated by: The victim not being able to breathe or speak/vocalize. Wheezy breath sounds. Attempts at coughing that are quiet or silent. Cyanosis and diminishing conscious level. The victim is unconscious. Choking is a risk whenever food is consumed. FBAO represents a true medical emergency in adults, with a mortality rate of just over 3 % (percent). MANAGEMENT - Adults. In severe obstruction in a conscious patient: Stand to the side and slightly behind the victim, support the chest with one hand and lean the victim well forwards. Give up to 5 back blows between the should blades with the heel of your other hand (checking after each if the obstruction has been relieved). If unsuccessful, give up to 5 abdominal thrusts. Continue alternating 5 back blows and 5 abdominal thrusts until successful or the patient becomes unconscious. In an unconscious patient: Lower to the floor. Call an ambulance immediately. Begin CPR (even if a pulse is present in the unconscious victim)."

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S9999	Continued From page 3	S9999		

The Adult First Aid/CPR/AED (Automated External Defibrillator) ready reference guide from the American Red Cross (undated), Copyright 2011, page 4 documents, in part, "UNCONSCIOUS CHOKING, chest does not rise with rescue breaths. After checking the scene and the injured or ill person: 1. Give rescue breaths, re tilt the head and give another, rescue breaths 2. Give 30 chest compressions. If the chest still does not rise, give 30 chest compressions. TIP: Person must be on firm, flat surface. Remove CPR breathing barrier when giving chest compressions. 3. Look for and remove object if seen. 4. Give 2 rescue breaths. If breaths do not make the chest rise - repeat steps 2 through 4. If the chest clearly rises - CHECK for breathing. Give care based on conditions found, CPR - No breathing. 1. Give 30 chest compressions. 2. Give 2 rescue breaths. 3. Do not stop. Continue cycles of CPR. Do not stop CPR except in one of these situations: You find obvious signs of life, such as breathing, an AED is ready to use. Another trained responder or EMS (Emergency Medical Services) personnel take over. You are too exhausted to continue. The scene becomes unsafe."

Facility Policy revised on 04/11/13 and Reviewed 12/21/17, documents, "Airway Obstruction - Abdominal Thrust Maneuver: It is the policy to maintain a staff trained in the assessment and treatment of a resident with an obstructed airway due to aspiration of a foreign body. All employees shall be trained within a reasonable length of time after initial employment and as needed thereafter, in the following procedure for airway obstruction management. 1. Assess for extent of obstruction. If resident is able to speak or cough, or if wheezing is audible, resident may have a partial obstruction--continue to observe. If

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S9999	Continued From page 4	S9999		

resident is unable to cough or speak, or is clutching the neck between thumb and index finger, the resident has an obstructed airway. 2. Call out for help. 3. Perform the Abdominal Thrust Maneuver. a. Stand behind the resident. b. Place arms around the resident abdomen between the naval and rib cage. c. Grasp one fist with the other hand and place the thumb side of the fist against the resident's abdomen. d. Press in with quick, forceful inward and upward thrusts. e. Repeat thrusts until the obstruction is relieved or the resident becomes unconscious." The Policy further documents, "6. Should the resident become unconscious, supporting the head and neck, lower the resident to the floor and continue the Abdominal Thrust Maneuver for an unconscious victim. a. Activate the emergency medical service system. b. Open the airway with the head/chin lift. Assess for breathlessness. If no breath, place the ambu bag or shield over the resident's mouth and nose, attempt to administer two rescue breaths. The policy and procedures of the facility are not intended to replace sound clinical judgment in the delivery of health care and are not intended to replace the prevailing standard of care. c. If unable to ventilate, straddle the resident's thighs. d. Place the heel of one hand on the resident's abdomen midline and between the navel and Xyphoid process. e. Thrust inward and upward quickly 5 times. f. Assess for dislodgement of the foreign body. g. Repeat procedure until the obstruction is relieved or the emergency medical team arrives and takes over. 8. Inform the physician and family. 9. Document date, time, and all occurrences in the medical record."

R2's Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated 09/26/17 and signed by the Nurse Practitioner on 09/26/17,

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S9999	Continued From page 5	S9999		

documents in part, "B. Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed: use oxygen, suctioning and manual treatment of airway obstruction."

R2's Death Visit Report (Hospice report), dated 03/03/2019 at 12:00 PM, documents, "Significant observations, Interventions and/or comments: Pt (patient) aspirated, Heimlich performed multiple times unsuccessfully."

R2's Triage Note, dated 03/03/2019 at 5:53 PM, documents in part, "Call Detail: Caller (V12) states that patient (R2) aspirated at dinner. Heimlich given and a 'few chili beans' dislodged, however, pt. went limp and died while Heimlich being given."

There is no documentation in R2's medical record the Emergency Medical Service (i.e. 911) was notified.

R2's Certificate of Death, dated March 03, 2019, documents in part, "CAUSE OF DEATH a. ASPIRATION," and the Certificate further documents approximate interval between onset and death being, "MINUTES."

On 03/21/19 at 12:12 PM, V16, Certified Nurse's Aide (CNA), stated on 03/03/19, R2 got up from the meal. R2 started walking past V19, CNA, and R2's breathing was "gurgling." V16 stated she left the unit to get the nurse (V12). V12 arrived and started to perform the Heimlich on R2. V12 then stopped the Heimlich, left the unit and returned with V14, LPN. V16, CNA, stated V14 started to perform the Heimlich and "nothing could be done." V16 further stated that R2 was

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S9999	Continued From page 6	S9999		

unresponsive and that both nurses (V12 and V14) put R2 back to bed and then R2 stopped breathing shortly after she was put into bed.

On 03/21/19 at 2:10 PM, V19, CNA, stated she was working with V16, CNA, on 03/03/19 when she noted R2's cheek bones turning "really red," because she was sitting next to V16 at the dining room table. V19 stated the nurse, V12, was on another unit at that time. V19 recalls V12 and V14 performing the Heimlich on R2 and recalls at some point R2 "was not breathing," V19 recalls V12 and V14 discussing R2's time of death and who to call.

On 03/20/19 at 2:40 PM, V12, LPN, stated on 03/03/19 at about 5:50 PM, she was on another unit (Hen House Dining Room) and not on the secure unit where R2 resided. V12 stated V16 and V19 were on the secure unit and that residents were in the dining room finishing up their dinner. V12 further stated R2 was served a regular diet. V12 stated one of the aides (V16 or V19) came to the dining area off the unit to inform her that R2 was "choking." V12 stated when she arrived to the unit, she noted R2 with a "red face," her respirations were labored, and she was talking (normally non-verbal). V12 stated she performed the Heimlich and might have gotten a "little phlegm." V12 said R2 was still standing upright, attempting to walk down the hall, and both CNAs (V16 and V19) were holding onto R2, and she (V12) continued to do the Heimlich. V12 then stated she sat R2 down in a chair and left the unit to get another nurse (V14, LPN). When V12 and V14 returned to the unit, she believes V14 did about 8 thrusts and "(R2) didn't have any respirations or any vital signs."

On 03/21/19 at 11:20 AM, V14, LPN, stated when

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S9999	Continued From page 7	S9999		

he arrived to the unit he did the Heimlich on R2 and wasn't sure how many thrusts were given, but knows it was greater than 5. V14 further stated R2 then remained flaccid, and not breathing, she remained unresponsive. V14 also stated V16 and V19 moved R2 from the "regular chair" to a wheelchair and they took her to her room and put her to bed.

Nurse notes on 03/03/19 at 5:50 PM document, "Resident respirations decreased, placed resident in w/c (wheelchair) and laid in bed with HOB (head of bed) elevated to make comfortable. Resident a DNR (do not resuscitate) and Hospice."

Nurse notes on 03/03/19 at 6:05 PM document, "No respirations or pulse obtainable."

V12, LPN, stated on 03/19/19 at 3:20 PM that (R2) Resident was Hospice, "We did not call an ambulance or do CPR."

V14, LPN, stated on 03/21/19 at 11:20 AM, "She was a Hospice and DNR, we did not do CPR or call an Ambulance."

On 03/21/19 at 9:34 AM, V1, Administrator, stated the expectation for staff if a resident is choking and not able to get anything expelled during the Heimlich Maneuver, that she would hope they would call an ambulance.

On 03/26/19 at 10:21 AM, V23, Interim Medical Director, stated he would expect the Heimlich Maneuver to be performed on a resident that is choking and for EMS to be summoned. CPR to be initiated should a resident become unresponsive if suspected of choking and no longer breathing. V23 also stated he is aware R2

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S9999	Continued From page 8 cause of death being that of Aspiration. (AA) (Findings 2 of 2) 300.690a)b)c Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. 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. 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	S9999		

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S9999	Continued From page 9	S9999		

occurrence.

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to notify the Department of a serious incident in a timely manner for 1 of 3 residents (R2) reviewed for change of condition, in the sample of 8. This failure resulted in R2's aspiration and death.

Findings Include:

On 3/20/19 at 1:03 PM, V1, Administrator, stated that R2 had "aspirated," and died at the facility. V1 stated she did not report the incident to IDPH and that nurses fill out a Quality Care Report that is put into Quality Assurance and not available to the surveyor. V1 also stated that she admits to sending previous choking incident reports to IDPH and she didn't report this choking incident for R2 on 03/03/19.

On 03/20/19 at 1:20 PM, V1 stated it is against company policy to give IDPH the Incident/Accident Log and/or the incident report for R2 with regarding to a choking incident on 3/03/19.

R2's Death Visit Report, dated 3/03/2019 at 12:00 PM, documents, significant observations, Interventions and/or comments: Pt (patient) aspirated, Heimlich performed multiple times unsuccessfully.

On 4/01/19 at 11:42 AM, V1 stated that the facility doesn't have a specific policy with regard to reporting specific incidents and the facility follows regulation on reporting incidents.

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S9999	Continued From page 10	S9999		

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