Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005698	A. BUILDING: ______ B. WING ______	C 03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORINGS OF ARLINGTON HEIGHTS	761 OLD BARN LANE ARLINGTON HTS, IL 60005

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S 000	Initial Comments Complaint Investigation #1893926/IL103456 Facility Report Investigation to Incident of January 31, 2019/IL109318 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure(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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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. Restorative measures shall include, at a minimum, the following procedures:
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 were not met as evidenced by:

Based on interview and record review the facility failed to assess and evaluate a resident with a condition change, failed to arrange for emergency transport to the hospital. These failures resulted in a delay in treatment. R2 expired on June 2, 2018.

This applies to 1 (R2) of 3 residents reviewed for quality of life in the sample of 8.

The findings include:

The ambulance report dated June 2, 2018

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showed a call was received from the facility at 9:27 AM. The ambulance arrived to R(2) at 9:55 AM. The report documents a crew was dispatched to the facility for "vomiting." Nurse states the (R2) has been vomiting since last night around five times. Nurse states the vomit was brown in color. (R2) vomited in front of the crew one time. Crew noted (R2's) vomit was bright red blood. Nurse insisted on changing (R2's) shirt and did. At 9:59 AM R2's blood pressure 72/36 and pulse 120. (R2) became unresponsive at 10:26 AM and did not have a pulse, CPR was started. Crew called 911 at 10:27 AM for assistance as crew consisted of two members.

The Physician's Order Sheets dated through May to June 2018 showed R2's diagnoses including long term use (current) use of antibiotics, atrial fibrillation, and chronic kidney disease. The P.O.S. showed he was receiving Coumadin (anticoagulant) and an antibiotic at the same time.

The Minimum Data Set assessment dated April 9, 2018 showed R2's cognition is impaired and requires extensive assist with activities of daily living.

The nursing home to hospital transfer form dated June 2, 2018 (without a time documented) by V15 (Registered Nurse) documents R2's reason for transfer he is having coffee ground emesis four to five times. "Informed resident was having emesis during the night shift." Appears brown in color, R2 did not have his medications or his breakfast this morning. The same report showed R2 has MRSA (Methicillin-resistant Staphylococcus Aureus) in his urine and completed his antibiotic.

The nurses notes dated June 2, 2018 by V15

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documents shown by V17 (Certified Nursing Assistant-CNA) (R2's) clothing protector appears to have dark brown emesis. (R2) continuing to spit/vomit brown/red colored liquid. No medications or breakfast given. V23 (Physician) notified and orders received to send to the local hospital .... (R2) continues to spit up orange/red liquid ... (R2) is a full code ... resident left the facility at 10:00 AM.

On March 19, 2019 at 12:40 PM, V17 (CNA) said he was R2's CNA on June 2, 2018. V17 said he worked a double shift that day and came in on the evening shift of June 1, 2018 at 11:00 PM. V17 said during the night shift he had to change R2's bedding because his bedding was stained with dark mucous. V17 said R6 threw up blood in the morning around 8:00 AM. V17 said he reported this to his nurse V15. V17 said R6 seemed weak that morning.

On March 18, 2019 at 9:26 AM V15 (RN) said if a resident is having coffee ground emesis it could indicate they are having gastrointestinal bleeding. Residents should get sent out by 911. Any nurse knows coffee ground emesis is abnormal and should be sent out right away.

On March 18, 2019 at 2:34 PM, V5 (RN) said if a resident has coffee ground emesis they should be sent out by 911. 911 is more equipped to handle this type of situation.

On March 19, 2019 at 12:30 PM, V15 said she was R2's nurse on June 2, 2018 when he was throwing up. V15
said she did not think she should have called 911 for R2. V15 stated, "I guess at the time I must have felt was not an emergency type of situation."

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On March 20, 2019 at 9:45 AM, V23 (Physician) said if a resident is on an anticoagulant (blood thinner) and an antibiotic they are at increased risk for severe thinning of the blood. V23 confirmed R2 was receiving both of these type of medications. V23 said if a resident is throwing up blood they should be sent out by 911 this is an emergency situation indicating they are actively bleeding.

R2's Medical Certificate of Death dated June 2, 2018 showed his cause of death was septic shock, aspiration pneumonia, and acute gastrointestinal bleeding.

The facility's Medical Emergencies policy dated revised on July 2017 states, "To prevent complications or deterioration if the residents status. All residents will receive timely assessment of care in the event of a medical emergency ..."

(A)
Licensure(2 of 2)

300.1210b)
300.1210c)
300.1210d)3)
300.3240a)

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

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' 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:
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 were not met as evidenced by:

Based on observation, interview and record review the facility failed to modify a resident's diet (R1) after showing signs and symptoms of aspiration. The facility failed to ensure staff supervised a resident (R3) at risk for aspiration during a meal. The facility failed to ensure staff could identify residents at risk for aspiration.

These failures contributed to R1 choking on January 31, 2019, requiring CPR (cardiopulmonary resuscitation), and hospitalization. R1 subsequently expired.

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This applies to 3 of 3 residents (R1, R3, R4) reviewed for safety and supervision in the sample of 8.

The findings include:

During this survey, R1 was unavailable for observation and interview as R1 was discharged from the facility on January 31, 2019.

R1's Physician Order Sheet dated December 30, 2018, showed R1 was prescribed a regular diet with thin liquids.
R1's Minimum Data Set dated January 6, 2019 showed R1 required supervision with one person assistance when eating.

R1's Nursing Home to Hospital Transfer Form dated January 31, 2019 at 7:00 PM showed, "Resident having dinner in dining room. Husband was yelling for help ...Resident choking, tried Heimlich maneuver but not effective and she lost consciousness ...Called 911 ...started chest compressions. Able to take some meat out of her mouth ..."
R1's Hospital Medical Admit Note dated January 31, 2019, showed, "Chief Complaint: Aspiration event ...Today, while in dining hall eating dinner she started to choke on her food, had LOC (loss of consciousness) and lost pulse momentarily ..."
On January 19, 2019 at 11:45 AM, V3 Assistant Director of Nursing (ADON) stated R1 was transferred to the hospital on January 31, 2019 and expired while hospitalized.
R1's hospital Discharge Summary dated March 7, 2019 showed R1 expired on March 7, 2019 with diagnoses including aspiration pneumonia.

On March 19, 2019 at 9:02 AM, V4 COTA stated, "On January 31, 2019 around 10:00 AM, I was

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working with (R1) when she started coughing while drinking water. (R1) said she felt like the "water went down the wrong pipe". I was concerned (R1) was aspirating so I reported it to the speech therapist (V10) and a nurse. I don't remember the nurse I talked too. I told (V10) about it but she (V10) stated she was leaving for the day and she would order a speech evaluation on (R1) the next day when she was back at work."

On March 18, 2019 at 2:00 PM, V10 (speech therapist) stated, "If there is concern that a resident is aspirating their food, the staff will notify me. I will fill out a telephone order for a speech evaluation and immediately downgrade the resident's diet until I can do the evaluation. On January 31, 2019, (V4/COTA) came to me and told me (R1) was coughing when drinking fluids. I was done for the day. (R1) was on my list to see and evaluate the next day ..." V10 SLP stated she did not modify or downgrade R1's diet or write an order for a speech evaluation for R1 prior to leaving work on January 31, 2019. V10 stated she did not speak with R1's nurse about R1's aspiration concerns prior to leaving work on January 31, 2019. On March 19, 2019 at 10:00 AM, V10 SLP stated, "After (R1's) episode on January 31, we should have downgraded (R1's) diet immediately and we didn't. We should have potentially modified her liquids too. I thought (V4 COTA) had reported her concerns to R1's nurse too. I should have made sure (R1's) diet had been downgraded before leaving work that day ..." V10 also stated, "I have never been allowed to make a list of residents, at risk for aspiration, to put up in the nurse's station to help keep staff informed. There is no system in place here to inform staff of who is at risk for aspiration other than word-of-mouth communication. Each

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resident's meal ticket shows what type of diet they are on but doesn't show who is at high risk for aspiration or what swallowing strategies should be used for each resident. I can't communicate this information verbally to every staff member."

On March 19, 2019 at 10:53 AM, V13 Certified Nursing Assistant (CNA) stated, "I noticed that the week before (R1) went to the hospital, she was having coughing episodes and trouble swallowing. I told the nurses about it ..."
On March 18, 2019 at 10:30 AM, V9 CNA stated, "I was in the dining room on January 31, 2019, when (R1) choked. I was the only staff member in the small dining room. I turned around and was looking at the tray cart. I had my back to (R1) when I heard (R5) yell out. I turned around and (R1) was blue and not breathing. I yelled for help ...The small dining room is where residents that need assistance or supervision while eating are placed in ...I was the only staff in the dining room when this happened with (R1) ... (R1) didn't need help eating or supervision."

On March 18, 2019 at R5 stated, "I'm (R1's) husband. I was seated next to her in the dining room when she choked. She started spitting up meatball and her lips were blue. She couldn't talk. I yelled for help ...She never came back from the hospital."
On March 18, 2019, V5 Registered Nurse (RN), V6 RN, and V7 CNA each stated they were working the night of R1's choking episode on January 31, 2019 but each stated they were not in the small dining room when the incident occurred. At 10:55 AM, V7 stated R1 "had no history of choking that I know of." At 10:52 AM, V6 RN stated, "(R1) did not need help eating or supervision." At 2:30 PM, V5 RN stated, "I didn't

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know (R1) very well. She had no history of choking that I know of."

R3's March 2019 Physician Order Sheet showed R3 has diagnoses including Parkinson's disease, dysphagia, and cerebral infarction with right sided hemiparesis/hemiplegia. R3's Order sheet showed R3 was prescribed a pureed diet with honey thickened liquids.
R3's Minimum Data Set dated January 9, 2019 showed R3 required limited assistance of one staff member when eating.

On March 18, 2019 at 8:18 AM, R3 was seated at a table in the small dining room, feeding himself pureed foods from his breakfast tray. No staff were noted in the small dining room.

On March 18, 2019 at 2:00 PM, V10 SLP stated, "(R3) had a swallow study done and is at high risk for aspiration ...He needs supervision while eating and on bad days, he needs assistance to eat ..."

R4's Speech Therapy Plan of Care dated March 6, 2019 showed R4 had diagnoses including dementia, cerebral infarction, and dysphagia. R4's Speech Therapy Plan of Care showed, "Pt choking incident observed by nursing and SLP on Saturday, 3/2/2019 on hard toast ...Recommended continue thin liquids and mech soft/ground solids at this time with standard aspiration precautions ..."

On March 18, 2019 at 12:55 PM, R4 was seated in the large dining room, eating a mechanical soft lunch. Two CNA's were in the dining room assisting other residents, with no staff providing swallowing cues or reminders to R4. At 12:59 PM, as V9 CNA was standing by R4's table, V9

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stated, "I don't know if (R4) has swallowing difficulty or is at risk for choking. I'm not normally in the big dining room."

On March 18, 2019 at 2:00 PM, V10 SLP stated, "(R4) had a near choking episode on a Saturday at breakfast so she had a swallow study done. She has dementia related dysphagia which causes a delay in swallowing and poor control of food in her mouth. (R4) needs supervision when eating with reminders to slow down and take more drinks ..."

On March 19, 2019, V2 Director of Nursing (DON), V3 Assistant Director of Nursing (ADON), V8 RN, V11 CNA, and V12 CNA each stated the facility did not have a consistent documented process in place to identify residents at risk for aspiration. At 9:00 AM, V8 RN stated, "We have no way of knowing who is at increased risk of aspiration unless symptomatic in our facility ..." At 10:50 AM, V12 CNA stated, "I would depend on the nurse to tell me who is at risk for aspiration. We don't have a list to identify residents at risk for aspiration or what swallowing strategies are needed ..." At 11:25 AM, V2 DON stated, "We don't have a list or quick reference to identify which residents are at increased risk for aspiration. Staff would have to get verbal report ..."

(A)