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
	IL6014666	A. BUILDING: ________ B. WING ________	C 05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ST CHARLES	850 DUNHAM RD ST CHARLES, IL 60174

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S 000	Initial Comments Complaint Investigation #1973727/IL112435	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.1210b) 300.1220b)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 resident to meet the total nursing and personal care needs of the resident. 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,	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.3240 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 evidencded by:

Based on interview, and record review the facility failed to supervise a resident at risk for aspiration during a meal. This failure resulted in R1 having a choking episode during the evening meal on May 21, 2019, requiring Heimlich maneuver. R1 subsequently died.

This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.

The findings include:

R1's Face Sheet dated March 23, 2019 showed R1 had diagnoses to include: Alzheimer's disease, gastro-esophageal reflux disease and cerebellar ataxia.

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R1's Speech Therapy evaluation and treatment plan dated April 26, 2019 shows a new onset of dysphagia in the oropharyngeal phase. R1 was referred to speech therapy due to a new onset of dysphagia placing the patient at risk for aspiration, dehydration, pneumonia, malnutrition and weight loss. Patient demonstrating oral pocketing and decreased mastication (chewing) of regular solids. Patient is currently on regular solids, and thin liquids. R1 had a dysphagia work up which showed a swallowing disorder involving the oral phase and pharyngeal phase. R1's Speech therapy note dated May 20, 2019 shows, R1 was seen for skilled speech therapy for dysphagia treatment at the evening meal of mechanical soft diet and thin liquids. R1 required moderate verbal cues for use of rate control and small amounts.

R1's Minimum Data Set dated March 20, 2019, shows R1 cognition is severely impaired with a BIMs (Brief Interview for Mental Status) score of 7. R1 requires limited assistance of one staff member for eating.

The facility's Incident Report dated May 23, 2019, showed the resident (R1) began having difficulty breathing during dinner, assessed as choking and staff intervened with the Heimlich maneuver. Paramedics took over care and the resident was breathing via nonrebreather with her eyes open on the stretcher while being moved through the front door.

On May 23, 2019 at 8:42 AM, V15 (Assistant Chief Deputy Coroner) stated R1's autopsy was performed on May 22, 2019. The preliminary cause of death was aspiration of a food bolus.

On May 22, 2019 at 11:21 AM, V1 (Administrator)

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and V2 (Director of Nursing) reported there was an incident the night before where R1 was sent to the hospital. Around 5:45 PM, R1 was in the assisted dining room with other residents and staff. R1 had an episode and the staff responded and did the Heimlich. The staff thought she was choking. R1 was gasping, her dentures were removed. A small amount of meat was expelled. R1 continued in respiratory distress. At the same time an ambulance service was returning a resident to the facility from an appointment. They asked the staff if they needed help, the nurse said yes. They placed a nonrebreather mask on and someone went to call 911. When R1 left the building, she was still breathing, and her eyes were open. She was taken to the local emergency room. R1 arrested and they attempted to intubate but were unsuccessful. R1 had a valid DNR- Do Not Resuscitate order. They stopped resuscitation and R1 was pronounced dead at the emergency room.

On May 22, 2019 at 11:52 PM, V3 (CNA- Certified Nursing Assistant) stated R1 was able to feed herself. She used her fingers and her spoon. R1 would "gobble" her food and we would have to tell her to slow down. Sometimes she would, other times she would not. V3 stated she was working the night of the incident. She was on hydration duty in the assisted dining room. She was passing beverages in the assisted dining room. She gave R1 her drinks. She was alone at the table. Then she turned her back to R1 and passed the drinks to the next table. V3 stated then a resident tried to leave the dining room and she went over to bring the resident back to the dining room. When she turned around she saw R1 turning blue. V3 noticed the tray in front of her. V3 asked R1 if she was okay and R1 did not respond. V3 said she tried the Heimlich and R1

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did not respond. V3 then called out to V4 (CNA) that R1 was choking. They stood R1 and did the Heimlich. The guy in the kitchen (V12) ran for help. We were able to get a little piece of meat out but not much. The nurses (V6 and V7) came. There were some EMS here and they did the Heimlich. R1 was drooling and then some of her color came back. The nurses took out her dentures. They put her on the gurney. The EMS put oxygen on R1. She was wheezing and then they took her out.

On May 22, 2019 at 2:15 PM, V7 (Registered Nurse) stated she was R1's nurse the night of the incident. V7 stated R1 eats in the assisted dining room because R1 has swallowing issues and needs to be supervised when she eats. R1 can feed herself but requires cueing to slow down because she tends to eat too much and too fast. The night of the incident she was in another resident's room. The resident had just been brought back via ambulance from an appointment and V7 was checking her in. V7 stated she heard someone screaming for help and she went out of the room. She saw R1 standing and V4 performing the Heimlich maneuver. R1 was breathing and she had red punch running out of her mouth. V7 stated she took over for V4 and performed a few abdominal thrusts. Someone took over for her and she removed R1's dentures. V7 stated she did not see any food in her mouth. V7 reported when V3 and V4 were doing abdominal thrusts some meat came out. V7 stated the EMS personnel came over to help and said they were paramedics. V7 stated R1 was breathing but wheezing at the time. EMS did some more abdominal thrusts. R1 was put on the stretcher and EMS started oxygen with a nonrebreather mask. R1 breathing was easier.

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On May 22, 2019 at 11:43 AM, V6 (Licensed Practical Nurse) stated R1 eats in the assisted dining room. She needs to be supervised. R1 can feed herself. When R1 sees her food, she starts to "gulp it right away and doesn't wait for staff. The staff are to sit at the table to feed her and monitor her. The night of the incident she was in the main dining room. She heard they needed assistance in the small dining room. When she arrived R1 was standing and they (CNAs) were doing the Heimlich. R1's nurse V7 was trying to get her dentures out. The paramedics were in the building and they saw us and came over to help us. At that point V6 left to make copies for the transfer.

On May 22, 2019 at 4:02 PM, V8 (CNA) stated she worked the night of the incident but did not see the incident. She was on hall trays and was running late to pass them. V8 stated R1 was able to feed herself. R1 ate fast and everyone had to tell her to slow down. V8 said you would tell her to slow down and she would go back to "scarfing down" her food.

On May 22, 2019 at 3:43 PM, V9 (CNA) stated R1 ate in the assisted dining room. She needed supervision with eating. Someone had to sit at the table when she ate. V9 stated he worked the night of the incident. V9 stated R1 was sitting with her back to him when she was eating. He could not see what she was eating. There was no staff at the table when she was eating. V3 started yelling, "She's choking, she's choking!" V3 started doing the Heimlich. Then there was ambulance person who took over to do the Heimlich. "R1 expelled a piece of meat and it came flying out unto the table."

On May 22, 2019, V10 (Restorative Nurse) stated

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R1 ate in the assisted dining room because she required cueing when she was eating. R1 ate fast. R1 was at the "feeder table". We would tell her to slow down when she was eating. At times we would need to put our hand on hers and remind her to slow down and at times we needed to feed her. V10 stated there should be a CNA at the table when she and her table mates were eating. If no one was there she (R1) would "gobble it quickly, so a CNA needed to be there when she got her food." V10 stated someone needed to be at the table to prevent possible aspiration, not just for her but the others at the table.

On May 22, 2019 at 12:46 PM, V5 (Speech Therapist) stated R1 was referred to speech for difficulty with swallowing. R1 eats quickly. V5 stated she performed a bedside swallow evaluation and the testing showed R1 had difficulty with chewing. R1 doesn't chew her food well. R1 was eating and swallowing quickly and not chewing her food. R1's diet was changed to mechanical soft. R1 was to always be supervised when eating. She was to be monitor and cued to slow down by myself and the staff. R1 was given a plate guard and covered cups to prevent spilling. R1 was to be supervised for the rate at which she ate. She required constant eye contact by staff. The staff monitoring her should not have been occupied with other tasks and had direct eye contact with her to monitor the rate at which she was eating.

R1 has a telephone order dated April 17, 2019 for speech therapy to evaluate and treat. R1's diet texture is to be adjusted as appropriate. A telephone order dated April 26, 2019 for skilled speech therapy 4 times a week for 4 weeks for swallowing.

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R1's Care Plan Meeting Note dated March 18, 2019 shows R1 is " ...being monitored in small dining room; she uses a covered cup and plate guards at each meal related to her eating fast ..."

R1's Nurse Note dated April 17, 2019 showed, R1 was "seen by dietician; recommended speech therapy to evaluate and treat and adjust diet texture as appropriate."

On May 22, 2019 at 3:20 PM, V11 (Dietician) stated R1 was eating in the assisted dining room for the past few months. The change was made by the restorative nurse. R1 was being impulsive and eating "really fast." She was told by nursing that R1 was having difficulty with eating and swallowing. She made a referral to speech therapy. Speech made a recommendation for mechanical soft texture.

R1's Dietician Note dated April 17, 2019 showed, "V11 (Dietician) was informed that R1 is having issues chewing/swallowing bread. Per CNA resident eats fast and chews very little. (R1) Eats in the ADR (Assisted Dining Room) for supervision. Diet: Regular. Nursing staff questioning if the diet should be downgraded to mechanical soft ..." R1's Dietary Recommendation dated April 17, 2019 shows a request for speech therapy to evaluate and treat and adjust diet texture as appropriate. R1's Diet Requisition Form dated May 1, 2019 shows a diet change to regular mechanical soft with thin liquids. Resident to eat in assisted dining room.

R1's current Care Plan dated April 2, 2019 shows, R1 has a problem with her right wrist and is having problem with her eating she is currently being given PROM (Passive Range of Motion)

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and is being monitored in the large dining room due to spilling of her liquids she has been given a "Sippy" cup and a plate guard. There is no mention of R1's tendency to eat fast, lack of chewing, referral to speech therapy or move to small assisted dining room.

On May 22, 2019 at 3:30 PM, V12 (Dietary Aide) stated he was serving the residents in the assisted dining room the night of the incident on May 21, 2019. V12 stated there were two CNAs, V3 and V4, in the dining room. V12 stated he usually started to serve when there were 3 or more CNAs, so the food would not get cold. That night V4 told him to start, "they (CNAs) were running behind." V12 stated when he started to serve there were 4 or 5 residents in the dining room including R1. He plated the other residents their regular food and then he plated R1's mechanical soft diet. V12 stated he saw R1 eating with her food and there was no staff sitting at her table. V12 stated he thought it was strange because normally there is staff at the table when she eats. V12 stated about two minutes after she received her food, he heard V3 start yelling, "She's choking, she's choking". V4 went over to R1. V3 and V4 started during the Heimlich. V12 stated normally there is a nurse in the dining room during the meal. But that night there was not. V12 stated he ran through the kitchen and to the other dining room to get a nurse. V12 stated V3 and V4 were passing trays and drinks when R1 started choking. The next thing there were a lot of people there. There were paramedics in the building and they came to help.

On May 23, 2019 at 9:01, V14 (CNA) stated R1 sat at the table where residents are fed. R1 was able to feed herself, but she sat at the feeder table because "you have to watch her because

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she would eat really fast." The night of the incident V14 stated she was in the dining room but her back was toward R1. V14 was loading the hall trays on the cart. She turned toward R1 when she heard V3 yelling "she's choking, she's choking!" V14 stated V3 and V4 were busy passing trays and drinks in the dining room. There was no staff sitting at the table with R1.

R1's ambulance run report dated May 21, 2019, shows the ambulance crew had just dropped off another resident at the facility and they saw a resident was choking in the dining area. The ambulance crew stood by while the facility staff attempted to do the Heimlich maneuver on the patient. The patient was turning cyanotic and the staff member were not having any luck getting the foreign body out of the patient's airway. The ambulance crew asked the staff if they wanted their assistance. The staff member agreed, and the ambulance crew took over. The patient was assessed, and no air was going through her airway. Due to the fully obstructed airway, the ambulance crew started the Heimlich maneuver again. On the fifth thrust of the belly the patient was able to expel a piece of food as well as her dentures. The patient was now breathing with shallow rapid breaths. A stridorous wheeze was present. The patient's oxygen saturation was in the 50th percentile. A nonrebreather mask was applied at 15 liters per minute. The ambulance crew offered to take resident to emergency room. The ambulance crew contacted medical control and told to continue nonrebreather mask with valve-bag until they could intubate. AN intravenous line was initiated and Versed was given prior to intubation. The patient rhythm changed from sinus bradycardia to asystole. The patient's carotid artery was palpated, and the patient was now pulseless, and was no longer

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S9999	Continued From page 10 breathing. CPR was initiated with two rounds of epinephrine given. The ambulance arrived at its destination with CPR in progress. The DNR was present to physician at the destination, decision made to stop CPR. The patient was pronounced dead at 6:26 PM. (A)	S9999		