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	IL6007983	A. BUILDING: _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S 000	Initial Comments IRI of 7/26/2017/IL97296 Statement of Licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1035a)2) 300.1210b) 300.1210d)2)6) 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 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 2) the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician	S9999	**Attachment A** **Statement of Licensure Violations**	

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orders limiting resuscitation. Any orders under this policy shall be honored by the facility. (Section 2-104.2 of the Act);
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. 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
2) All treatments and procedures shall be administered as ordered by the physician.
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on record review and interview, the facility failed to provide supervision during a meal to prevent choking, and failed to attempt cardiopulmonary resuscitation on an unconscious

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resident for one of 4 residents (R2) reviewed for a swallowing difficulty and a change in condition in the sample of 4. This failure resulted in R2's death from asphyxiation from a foreign body on 7/26/2017.

Findings include:

R2's EMR (electronic medical record) documents diagnoses, in part, as Oropharyngeal Dysphagia, Intellectual Disabilities, History of Gastrostomy, Aphasia and General Muscle Weakness.

The annual Minimum Data Set (MDS), dated 7/13/2017, documents R2 has a BIMS (Brief Interview of Mental Status) score of 4, which is severely impaired with cognition and decision making, and requires one person limited assistance for eating.

The CAA (Care Area Assessment) for R2's nutritional status, dated 7/13/2017, documents, in part, "History of G-tube (gastrostomy tube). Receives mechanical soft diet. Can feed self with set up help. Sits at feeder table to ensure she eats. Can eat fast. Monitor for choking."

R2's EMR documents a Physician's Orders (PO) from Z2, Physician, for 7/2017 as,"Regular diet, Mechanical soft, regular liquids consistency. Supervision required: remind resident to take small bites/sips, reduce rate of intake and alternate food with liquid wash. Do Not Resuscitate (DNR).

The Dietary Profile for R2, dated 7/13/2017, documents, in part, "Current diet order-mechanical soft. Can feed self with set up help from staff. Is eating in the dining room. At times is observed either in dining room or hall.

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Eats 75 to 100 percent of food. Needs supervision to remind resident to take small bites, reduce rate of intake and alternate foods with liquids."

The facility's Final Incident Investigation Report, dated 7/26/2017 at 5:37 PM, documents, "(R2) was noted to be slumped over at her dinner table. (R2) is a DNR (do not resuscitate). With that in mind, staff went with the assumption that (R2) was choking. There were no visible food particles in her mouth at the start of the Heimlich maneuver. Staff began doing the Heimlich immediately, with no positive result, Staff removed (R2) from the dining area. Staff then placed her in the TV (television) room, for privacy and to continue the Heimlich. EMS (emergency medical services) had been called on the onset, and had arrived at this time. They also tried to perform the Heimlich. The EMS pronounced time of death."

The Certificate of Death for R2 completed by Z6, Medical Examiner/Coroner, on 7/28/2017 documents, in part, "date of sudden death-7/26/2017 at 6:08 PM. Describe how injury occurred-choked on a hot dog while eating dinner."

The Progress Notes, dated 7/26/2017 at 7:03 PM, documents, in part, "This nurse (E5, Licensed Practical Nurse, LPN) heard people yelling for a nurse and ran from the front nurses desk into the dining room and saw resident (R2) slumped over. Staff was doing the Heimlich maneuver. This nurse then tried doing the Heimlich maneuver and some food particles came out of resident's mouth. Resident was rushed to TV room, and staff continued to do the Heimlich maneuver to try to get foreign object out. Resident's father (Z3)

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was in the facility. Staff member called 911. EMS arrived to the facility and assessed (R2) and time of death was 1808 (6:08 PM). This nurse spoke with (Z2), and he stated he would sign the death certificate and that the cause of death was asphyxiation secondary to foreign body in trachea. This nurse spoke with (Z1), Coroner, and was given report on situation. He gave verbal for okay to release body to funeral home."

The Prehospital Care Report Summary for R2 prepared by the EMS staff, Z4, Paramedic, dated 7/26/2017 documents, in part, "Call received: 17:52:27 (5:52 PM), On scene: 17:59:48 (5:59 PM), Patient Contact: 18:00 (6:00 PM). The Report documents R2 was unconscious, had no lung sounds, color was pale, no capillary refill, normal skin temperature and both pupils were not reactive. The Report documents R2 was in asystole (flatline) and the Glasgow Coma Scale was 3" (normal is between 3 and 15, with 3 being the worst). The Report documents R2 was "dead in the field". The Report further documents, "AOS (arrived on scene) to find PT (patient) unresponsive, not breathing, sitting in a chair. RN (Registered Nurse) on scene stated PT was eating dinner when she started choking. RN stated performed Heimlich on the PT and was able to get a piece of food dislodged and out of her mouth. RN stated PT was not breathing at that point and was unresponsive. RN stated she could not feel a pulse and PT is a DNR so CPR (cardio-pulmonary resuscitation) was not started. PT was placed on the cardiac monitor showing asystole in 2 leads. RN had the PT's original copy (orange) of the DNR in hand. DNR was filled out properly and all signatures. DNR was honored by EMS. RN contacted (local) county Coroner. PT was left in the care of RN."

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R2's DNR was signed by her and witnessed on 4/19/2017. The section for Comfort-Focused Treatment documents, in part, "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 Care Plan, dated 7/14/2017, documents, in part, "(R2) is at risk for complications with her weight and nutrition related to her swallowing and chewing deficit. She had a G-tube (gastrostomy tube) but on 7/11/16 G-tube was pulled out and not replaced. She is receiving a mechanical soft diet and requires some assistance with her meals. Interventions-9/6/16: Supervision required. Remind (R2) to take small bites/sips, reduce rate of intake and alternate food with liquid wash. Monitor for signs/symptoms of aspiration: coughing, abnormal lung sounds, elevated temperature. Staff to provide assistance with her meals."

On 10/04/2017 at 9:40 AM, E7, Certified Nurses Aide (CNA), stated, "It was a hot dog. I was in the dining room serving trays. We serve and observe residents at the same time. (R2) is a mechanical soft and always needs assistance. She feeds herself, I didn't serve her tray. She sits in the back. The hot dog-I can't say if it was cut up. My back was turned to get a tray. I heard someone say (R2) was choking. I turned and saw (R2) with her head down. I said (her name)-no response. She was moving and breathing. I assumed she was choking. I was the closest to her. I started the Heimlich on her. Some hot dog was coming up. Another CNA hollered for a nurse. (E5, LPN) came running. I grabbed her feet and we took her to the TV room and shut the door. She wasn't coughing. It happened so fast. I started crying. I loved (R2). I came out once the nurses took over.

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I took care of her every day. I've never known her to choke. You have to observe her and see the amount she eats. No trouble swallowing I was aware of. I never opened her mouth to look into it. I was doing the Heimlich the whole time."

On 10/04/2017 at 10:00 AM, E5 stated, "I heard they needed a nurse STAT (without delay). I ran in there. (R2) was slumped in a chair. No coughing or gasping. She was bluish in color. A CNA-I don't remember who was there. I started the Heimlich, I checked her mouth. It had a little chewed up food on the side of her jaw. I removed the food and continued the Heimlich. There was me and a lot of staff. She was reclined in a high back wheelchair. I had to lean over the back of the wheelchair. At one point she took a breath. We continued until EMS came. The EMS checked for pulse-don't think she had one. They put on EKG (electrocardiogram) leads to see if she had a rhythm. There was no activity. The coroner and (Z2) did not come out (to the facility). The coroner gave authorization to release (R2) to the funeral home. I didn't see her tray. There was a lot of staff in the dining room. You have to tell (R2) to slow down when eating. It happened so suddenly."

On 10/04/2017 at 10:22 AM, E6, CNA, reported she was passing meal trays on 7/26/2017 when she heard someone yelling and went over to help R2. E6 reported E7 was performing the Heimlich maneuver on R2 with no response. E6 reported she helped E7 take R2 to the TV room. E6 reported R2 had "thrown up." E6 reported staff had to sit at the table to watch R2 eat, but she fed herself. E6 reported she did not know if any staff had been sitting with her at the time she began to choke.

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S9999	Continued From page 7 On 10/04/2017 at 1:50 PM, E10, CNA, reported she was passing meal trays and had been standing and facing the service window when another CNA told me (R2) wasted a drink. E10 stated, "I was standing to the side of the table where (R2) was seated. I went over there to see if she needed another drink. I walked in front of her and saw her head slumped. Her hair was falling forward. I looked down and saw some spit coming out of her mouth. I hollered for another CNA and to get a nurse. The dining room was full of CNA's. With (R2), you just watch her. She eats real fast, but can feed herself. Two or three CNA's came over, and they got the nurse (E5). A nurse or a CNA began the Heimlich maneuver. After that, I got out of the way. (R2) needs encouragement to put food in her mouth one bite at a time and not eat so fast." On 10/04/2017 at 11:10 AM, E11, LPN, reported she responded to the call for help in the dining room during dinner on 7/26/2017. E11 reported when she entered the area, R2 was slumped over, and E7 was behind R2. E11 reported R2's eyes were open, and her body was jerking due to the Heimlich maneuver. E11 reported R2 was not coughing or gasping when she initially came in to the dining room. E11 reported R2 briefly became responsive, gasped for air and looked around a little. E11 reported she opened R2's mouth, did not see anything and did a finger sweep of her mouth. E11 reported there was nothing in R2's mouth, but had food on her clothes. E11 reported after R2 was moved to the TV room there was a pulse and her color was normal. E11 stated, "She was still with us." E11 reported R2 again became unresponsive, and the Heimlich was again performed, with no food return. E11 reported then R2 had no pulse or respirations. E11 reported E9, LPN, checked R2's code status which was DNR.	S9999		

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E11 reported she left the area when EMS arrived and took over. E11 reported R2 tried "to shove everything in her mouth very quickly and food would spill onto her clothes. The same thing with drinks."

On 10/04/2017 at 10:55 AM, E13, Cook, reported he had prepared R2's evening meal on 7/26/2017. E13 stated, "It was mechanical hot dog, crumbled up with bread, mashed potatoes and fruit cocktail. I don't know who served it to (R2). I was back in the kitchen preparing other trays. I didn't hear or see anything."

On 10/04/2017 at 10:49 AM, E9, LPN, reported she did not play a big part with R2 that evening, but did call 911 (emergency number) and the EMS came quickly. E9 stated, "I have watched (R2) eat. She would shove food in her mouth, you had to really watch her at the dining room table, She would eat with her hands. She did not like assistance. She would get mad and pout like a child."

On 10/05/2017 at 12:35 PM, E8, CNA, reported she was in the dining room when she heard someone was choking. E8 stated, "I turned around. I was facing the service window. I saw a girl trying to Heimlich her (R2), and nothing came up. (R2) was unconscious with no response. Some of the nurses came in and took her to the TV parlor area. I stayed in the dining room. I saw EMS come and go in there. (R2) always ate on her own and fed herself. She liked to eat real fast, piling food in her mouth. I didn't see anyone sitting with her that day. She was beginning to turn blue at the dining room table."

On 10/04/2017 at 3:30 PM, Z2, Physician, was asked if R2 should have had staff sit with her

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during meals. Z2 stated, "I can't tell you off hand. She (R2) puts stuff in her mouth and forgets to chew. That's why I wrote the order like that, so she should slow down. She is more than mildly, but is moderately developmentally disabled with significant cognitive impairment. I wrote to monitor during a meal, and it's a good idea to sit there to remind her. Given the situation, they should sit with her. It happens that quickly, a tragic thing. It's hard to say if staff was negligent. My impression is they should keep an eye on her. The same thing could have happened if they were watching her, but they would have been aware sooner to help her."

On 10/05/2017 at 10:25 AM, Z4, Paramedic, reported R2 was sitting in a wheelchair, unconscious, unresponsive with no vital signs or respirations when EMS arrived on the scene 7/26/2017. Z4 stated, "We hooked her to a monitor-in asystole, I believe. Told she had been eating, started choking and they did the Heimlich. I don't recall if they told me they did chest compressions. If she had no DNR, start CPR. Because she had a DNR, nothing we could do. Negative for removing food. There was a piece of hot dog on the floor, a small piece. Like it was cut up. (R2) had no signs of life. I don't recall if they did vital signs, The Heimlich was done. Usually you start with the Heimlich. If not effective and when they become unconscious, you do chest compressions. If no pulse and had a DNR, no chest compressions."

On 10/05/2017 at 10:35 AM, Z5, EMT (emergency medical technician), reported he also responded to the 911 call with Z4 on 7/26/2017. Z5 stated, "We went to the private room and she (R2) was sitting in a wheelchair, unresponsive, not breathing. I could tell she choked on

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something, food-emesis all over her. I think there was brown emesis on the floor, if I'm not mistaken. She (R2) was obviously dead. She was a normal color-had just passed. She had started to turn cool to the touch. We placed EKG electrodes on her and confirmed she was flat lined-asystole. (Z4) called (local hospital) to report and received the time of death. We stuck around and the staff called the coroner. We helped get her in bed so her father could see her, staff had shown us a signed DNR."

On 10/05/2017 at 2:00 PM, E1, Administrator, and E2, Director of Nursing (DON), reported they could not confirm that any staff were sitting and supervising R2 during the evening meal on 7/26/2017.

The facility's Meal Service policy and procedure, dated 9/2017, documents, in part, "Residents who require feeding or dining supervision must eat in the dining room. Residents are positioned in an upright position to prevent choking or aspiration. Residents are encouraged to eat by all facility staff, as part of the dining room supervision."

The facility's Choking: Heimlich Maneuver policy and procedure, dated as reviewed 9/2017, documents, in part, "The Heimlich maneuver is performed on victims whose airway is obstructed by a foreign object. All staff trained to do the Heimlich maneuver. PROCEDURE: To identify a complete obstruction if the victim is able to speak or cough. Do not do the Heimlich maneuver on anyone who is coughing or talking. Perform thrusts until the foreign body is expelled or victim becomes unconscious. Once the victim is unconscious: Call for help. Try 2 rescue breaths, give 30 chest compressions, look for the object in the airway, if present remove. If no object

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present, attempt 2 rescue breaths and repeat process. Repeat sequence until resident is breathing or paramedics arrive."

The web site, entitled "patient.info/doctor/choking-and foreign-body-airway-airway-obstruction-fbao"and entitled "Choking and Foreign Body Airway Obstruction (FBAO)" documents, in part, "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 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

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	IL6007983	A. BUILDING _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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	Continued From page 12 CPR (even if a pulse is present in the unconscious victim)." The Adult First Aid/CPR/AED (Automated External Defibrillator) ready reference guide from the American Red Cross (undated), 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 breath. 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 personnel take over. You are too exhausted to continue. The scene becomes unsafe." (A)	S9999		