STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(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
S 000	Initial Comments Complaint Investigations -1892363/IL101788 -1892585/IL102028	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.1810c)5)D) 300.1810e) 300.1810f) 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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:	S9999		

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S9999	Continued From page 2 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 300.1810 Resident Record Requirements c) Record entries shall meet the following requirements: 5) Electronic Medical Records Policy. The facility shall have a written policy on electronic medical records. The policy shall address persons authorized to make entries, confidentiality, monitoring of record entries, and preservation of information. D) Preservation. The facility shall develop a plan to ensure access to medical records over the entire record retention period for that particular piece of information. e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy. f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.	S9999		

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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 regulations were not met as evidence by:

Based on observation, interview and record review, the facility failed to provide the following services to prevent physical harm: to follow care plan interventions, to follow their "Aspiration Precautions" and "Care Plan" policies and procedures, failed to have a comprehensive care plan addressing aspiration precautions, failed to have the necessary emergency equipment on a crash cart, and failed to ensure that the medical records accurately documented the current diet order for one of three residents (R1) reviewed for diet orders and for incidents/accidents.
These failures resulted in R1 choking on a grilled cheese becoming unresponsive 911 called cardiopulmonary resuscitation being administered, R1 arriving at the hospital in cardiac arrest/asystole.

Findings include:

Review of facility's final incident report (04.06.2018) notes: "... (R1) was noted in hall way by staff under distress. Staff approached resident who was unable to speak and grabbing (R1's) throat. Staff immediately responded by performing Heimlich on resident. Code Blue and 911 initiated. Heimlich noted to be successful as resident stated "I can't breathe" while attempting to ambulate. Staff redirected resident to remain calm and in place while staff continued to provide resident with care. Resident then became nonresponsive. Staff began CPR and continued

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until EMT/Fire Department arrived. Resident was transported to local hospital ED. Facility contacted local coroner office cause of death accidental, choking on food bolus."

Review of R1's ambulance run sheet narrative (04.01.2018) documents: "Called to the nursing home for the patient choking. Upon arrival patient was supine floor w/ (with) staff doing Cardiopulmonary resuscitation compressions only. Per staff patient was choking and they tried to perform abdominal thrusts but patient went unresponsive. Staff states they slowly lowered patient to floor. Cardiac monitor applied and asystole showing. Cardiopulmonary resuscitation and ventilation continued. Patient's airway was clogged with food particles. Food was large enough that it could be removed with forceps. Once airway was cleared patient was intubated with a 7.5 tube and placement verified with proper lung sounds...I/o (intraosseous) initiated in patient's left leg. Three rounds (epinephrine) pushed via i/o. Patient remained asystole throughout run. High quality Cardiopulmonary resuscitation maintained constant throughout call. (Local hospital) contacted and patient transported to (local hospital).

Review of R1's Emergency Room Record (Emergency Department Triage Form, 04.01.2018) documents: "Chief Complaint: Patient arrived in cardiac arrest/asystole (asystole), from (nursing home), (R1) choked on food prior to arrival, EMS found patient apneic and in asystole patient arrived in ER intubated with 3 Epi given prior to arrival and Cardiopulmonary resuscitation in progress."

Review of R1's MDS (Minimum Data Set, 03.01.2018) documents:

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-BIMS (Brief Interview for Mental Status) of 9 (moderately impaired)
-Eating 2/2 (limited assistance/one person physical assist)
-Active Diagnoses: Viral Hepatitis, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, Schizophrenia, Other Symbolic Dysfunctions, Dysphagia (Oropharyngeal Phase) and Pain (Unspecified)

V6 (Licensed Practical Nurse, 05.03.2018 at 10:48 AM and 05.10.2018 at 3:08 PM) said V6 gave R1 a grilled cheese sandwich. She said R1 walked away with the sandwich, "I had my back to (R1), then, 10-15 minutes later, I heard "(R1's) choking, (R1's) choking." V6 said R1 had "(R1's) hand to (R1's) throat, (R1's) mouth was wide open, as if (R1) was choking." V6 said there was no Yankauer suction catheter(rigid, curved catheter with smooth edges) on the crash cart. V6 said V6 felt not having a Yankauer on the crash cart made a difference, "you can't control those flexible catheters."

V13 (Speech Language Pathologist, 05.04.2018 at 11:48 AM) said V13 last saw R1 over a year ago for diet modification. R1 already had a diagnosis of dysphagia and was on a modified diet (mechanical soft/nectar thick liquids) when V13 saw him. V13 said R1 required this modified diet because R1 had difficulty chewing and was on swallow precautions because of R1's impulsivity, "(R1) ate really fast." V13 said" "I recommended (R1) be supervised in the dining room for meals. (R1) shouldn't have been in the hallway eating." V13 said compensatory strategies for R1 included monitor for slow rate and alternating liquids/solids."

V8 (CNA-Certified Nursing Assistant, 05.03.2018

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at 2:19 PM) said R1 began to eat the grilled cheese sandwich offered to R1 by V6 and then left the dining room. V8 said R1 should have been in the dining room so that staff could monitor R1. R1 should have been supervised because R1 was on a mechanical soft diet with thickened liquids. "They always tell us when someone is on a mechanical soft diet to watch them."

V9 (CNA, 05.03.2018 at 3:06 PM) said V6 gave R1 a grilled cheese sandwich. V9 said V9 was still in the dining room when V9 heard someone say "(R1's) choking." V9 said V9 left the dining room, found R1 in the hallway. V9 said V9 performed the Heimlich and saw grilled cheese sandwich come up. V9 said R1 was on a mechanical soft diet because R1 had difficulty swallowing and shouldn't have been in the hallway eating. V9 said the suction machine didn't have enough suction and V6 was using a small catheter to suction R1.

V12 (LPN, 05.10.2018 at 11:10 AM) said R1 was on a mechanical soft diet with thickened liquids and was not allowed to eat in R1's room. V12 said R1 required supervision including cueing to slow down (when eating) and to take small bites.

V14 (CNA. 05.04.2018 at 3:22 PM) said R1 didn't like R1's diet and would take food from peer's trays as well as trays on tray cart; only regular consistency. V14 said R1 wasn't allowed to eat in R1's room because resident was on choking precautions.

R2 (Director of Nursing, 05.04.2018 at 1:42 PM) said residents who are on mechanically altered diets must eat in the dining room.

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S9999	Continued From page 7 Review of R1's medical record (Physician Order Report 01.01.2018-05.02.2018) documents "Diet: NC'S (no concentrated sweets), nectar thick liquids, 2pm snack. Special Instructions: Diet: NCS mechanical soft, nectar thick liquids, 2pm snack. Once A Day; 09:00 AM." Review of R1's current "Clinical Physician Orders (no time frame listed) does not document a current diet order for R1. A review of the electronic medical record (EMR) documents the diet order from R1's previous EMR system was not carried over to the current EMR being utilized by the facility. V1 (Administrator, 05.11.2018 at 3:12 PM) said V1 gave surveyor everything V1 had in current EMR (Electronic Medical Record), V1 said that the diet order should have been transferred to between Electronic medical record systems. R2's diet ticket notes NCS Mechanical Soft (No concentrated sweets, mechanical soft), Nectar Thick Liquid-Aspiration Precautions. R2's care plan (Problem start date 06.18.2015, last reviewed/revised 01.22.2018) states: "Resident is on a therapeutic mechanically altered diet with nectar thick liquids...." Interventions include "Encourage resident to eat slowly." Review of R1's "Speech Therapy SLP (Speech Language Pathologist) Evaluation & Plan of Treatment" (12.24.2015) documents under Recommendations: "Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake; alteration of liquids/solids, rate	S9999		

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modification, bolus size modifications and general swallow techniques/precautions.
This was the only Speech Therapy documentation provided by the facility to this writer; swallow strategies were not listed on meal ticket or added to R1's care plan.

Review of the facility's "Aspiration Precautions Policy" states: "1. B. "Feed according to recommendations."

Review of the facility's "Care Plan" policy states: "A. Policy: All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status."

Review of R2's "Certificate of Death Worksheet" documents R1's immediate cause of death as "Choking on food bolus."

Review of the facility's "Nursing Crash Cart Audit Tool" and Crash Cart Equipment list (located on top of crash carts) state that there should be two Yankauers in Drawer B of crash cart.

Crash carts were inspected on 05.14.2018 from 3:35 PM to 4:22 PM. The following issues were found with two of three of the facility's crash carts:
2nd Floor Crash Cart
Drawer A
-expired IV Administration Set (10.2017)

1st Floor Crash Cart
Drawer A
-expired 24 G x 3/4 inch needles x4 (x2 2014, x2017)
-expired IV Start Kit x2 (08.2017)
-expired 1 ml syringe 29 G x 1/2 inch syringe x5 (10.2017)

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S9999	Continued From page 9 -IV Administration Kit (10.2017) -expired Hypodermic Needle-Pro (07.2017) -expired Angiocath Autoguard 24 G x 0.75 inch x3 (x1 02.2015 with non-intact wrapper, x2 10.2017) -expired 22 G needle (10.2014) Drawer B -expired Yankauer x1 (only one on cart, 04.2018) -expired connector tubing (suction tubing-06.2017) Review of R1's medical record (Progress Notes 09.28.2017 and 10.20.2017 written by V16 Psychiatric rehabilitation Services Coordinator) document: "monthly wellbeing check. Writer met with resident to discuss wellbeing, resident is alert and oriented at this time, resident denies any pain, issues or concerns at this time, resident as (has) aggressive behavior and also pick up other peer food. Resident was encouraged to seek staff assistance as needed, resident was encouraged to participate in the activities of the facility and to be in compliance with medication regimen, resident verbalized understanding to writer, and staff will follow accordingly." The progress note written by V16 for 10.20.2017 is exactly the same as the progress note V16 wrote on 09.28.2017. Progress note for 11.28.2017 written by V16 is the same as the previous two notes with the exception that V16 documents "resident always stated (stating) he needs his tooth pull (pulled). Progress Note (09.09.2017 written by V16) documents "Resident presented with constant behavior has (as) evidenced by picking up other peers food tray in the second floor dining room. Resident was unable to be redirected. Staff will follow up accordingly." Progress Note (10.13.2017 written by V16) documents "Writer was informed that resident can only drink nectar thick liquids, resident was educated but resident not receptive as evidenced	S9999		

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S9999	Continued From page 10 by resident not been (being) able to compliance (comply) with redirection of staff, resident shout at staff and go behind staff. Staff will continue to monitor and follow up accordingly." (B)	S9999		