STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007892	A. BUILDING: _____ B. WING _____	C 03/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION PLACE	1001 NORTH GREENWOOD AVENUE PARK RIDGE, IL 60068

(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 Investigation of Facility Reported Incident of March 2, 2022/IL144383	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210c) 300.1210d)3)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. Based on interview and record review, the facility failed to inspect outside food brought in by family; failed to follow their protocols on providing emergency choking procedures; and failed to provide training to staff on how to properly provide emergency choking care. This failure affected 1 (R1) of 3 residents in the sample which caused R1 to go in to respiratory distress and cardiac arrest resulting in death. Findings include: R1 was a confused 64-year-old resident with diagnosis of aphasia following cerebral infarction, diabetes, and psychosis and with diet orders for consistent carbohydrate mechanical soft diet and thin liquids consistency. R1's care plans dated 8/3/20 reads in part, (R1) has diagnosis of left basal ganglia CVA (Cardiovascular Accident), history of multiple CVA and has expressive aphasia, right facial drooping; at risk for neurological changes; risk for	S9999		

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S9999	Continued From page 2	S9999		

aspiration. Goal: (R1) will remain free from signs and symptoms of complications from CVA, aspiration. Approaches: Monitor to assure adequate fluid intake to prevent dehydration; Monitor and document resident abilities for activities of daily living and assist as needed; Monitor for signs and symptoms of aspiration." Additional care plans read: "(R1) requires supervision to occasional limited assistance with ADL's. Goal: Will receive ADL assistance to maintain safety. (R1) is following a consistent carbohydrate diet, mechanical soft, thin liquid diet to ease chewing/swallowing function, BMI obesity class 1 (At risk of malnutrition and aspiration). Goal: Resident will adhere to therapeutic diet."

On 3/25/22 at 10:30 AM interview with V2 (director of nursing-DON) stated, "Yes, I know (R1), she was a hoarder and when we searched her room she stored a lot of different food items in her room and I believe she hid a lot of food behind a curtain. Her ex-husband came in the day before this incident and gave (R1) grapes to eat and he told the staff that she tolerated it well so there didn't seem to be a problem." Surveyor asked if grapes were allowed or safe for her to eat, V2 stated, "I don't think it was, but the dietician can answer that for you." Surveyor asked if residents are allowed food from outside who monitors any leftover food, V2 stated, "We should be." Surveyor asked about the emergency procedures, V2 stated, "I was not part of the code and did not participate in the code. I just came up and asked to see if they needed anything. I observed them: V4 (PM supervisor) was performing CPR, and V3 (RN), and V5 (CNA) were all performing CPR. Surveyor asked what role each of the 3 staff she mentioned, V2 stated, "I'm not sure, I just know there were a lot of nurses in the room". Surveyor asked if anyone of

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S9999	Continued From page 3 her staff were able to revive R1 or start an IV, V2 stated, "No one started the IV..I just saw two separate paramedic teams coming in. I called the B-team was in there first because they didn't seem to be able to do anything and then I saw another paramedic team come in. I call them the A-team because they seemed to do CPR fast and placed an electronic machine over her, but it still didn't work to revive her. They hooked her up to a monitor and I believe during CPR, a full grape popped out of her throat. I saw this. I also heard back from the coroner's office, and they said that (R1) died of asphyxia ruled as accidental according to corners office". On 3/25/22 at 1:15 PM V4 (PM Supervisor) stated upon interview, "The nurse V3 (RN) came to the nurses station that the resident (R1) was choking. When I got to the room, the resident was sitting down next to her bed, and they were letting me know she was choking. She was still conscious, and you can tell she was in distress. I tried to sweep the mouth, but she was clenching her teeth. She's a confused resident and she had a stroke, and she was unable to say any words. I did the Heimlich maneuver with thrust on the abdomen. I was behind her and she (R1) was sitting down. At that point the CNA (V5) moved her back to the bed and at that time she became unresponsive. We were checking her pulse if she was breathing and there was no pulse for 10 seconds and so we started CPR. I did the chest compressions, but the crash cart was not there at the time. They attempted to start an IV, but I did know who started the IV, I don't recall there were a lot of staff in the room. Then the paramedics came they took over and I stepped out. " Records show nursing progress notes entered by V3 (RN) dated 3/2/2022 at 10:16 PM reads, "4:15	S9999		

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PM. Reached to the room to check the blood sugar. Resident was coming out from the bathroom with few grapes in her hands whole and broken. She looks like coughing slightly and nauseated. Front of the shirt was wet with something. Took her back to the bathroom near the sink. Took the grapes from hand and throw to the garbage. Resident sit in the toilet without pulled the pants. Looks tired and lean backward. Looks like choking. Suddenly get her up and did Heimlich by abdominal thrusts also. Nothing came and the staff tried to sweep the mouth. Resident having very difficult to breath and called emergency. Put resident back to bed start to do CPR and called the 911."

Interview with V3 (RN) on 3/25/22 at 1:40 PM stated, "I was (R1)'s nurse. I call her (R1) but she doesn't pay much attention because she doesn't understand me but she's alert and oriented x 1-2 but only speaks Spanish. During the weekday in the evening around after 4:15 PM, I usually take blood sugars and she came out from the bathroom, and she was holding some grapes in her hand and she showed me the grapes." Surveyor asked why R1 showed her grapes that were in her hand, V3 stated, " I don't know why she showed me grapes. I called her out of the bathroom so I could do her blood sugar check. I took her grapes and threw them in the garbage. She then smiled and she was making a facial movement and asked her if she wanted to throw up and I took her back to the bathroom and she was standing in front of the sink, so I went back to her, and she sat back on the toilet without taking her pants off and sat down. Then she leaned back on the toilet, and I asked her what happened. I then got her up right away and took her out from the bathroom and I tried to do the Heimlich right in front of the bathroom." Surveyor

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S9999	Continued From page 5 asked V3 if she believed R1 was choking at this point, V3 stated, "Yes, she didn't look good like she couldn't breathe." Surveyor asked what she did next, V3 stated, "So she (R1) was standing up and I came from behind her but she was heavy and obese so I could not get my arms around her to perform the Heimlich and so I came towards her front and I put my left hand on her back and my right hand on her sternal area and pushed but she still was choking so I told her to sit down and I went to get a CNA and V10 (CNA) came and I told her call someone for help. Another CNA (V5) came and said she will do the abdominal thrust and came from behind to do Heimlich and that time the patient was already fading so we put her right away on the bed. Then V4 (PM supervisor) and V11 (nurse) came. V4 was doing CPR but there were a lot of nurses coming in to the room. I called 911 that we had emergency and said patient could not breath and was choking." Surveyor asked if she saw food in the room being brought in by family, V3 stated, "I only saw cereal in the room. I didn't notice anything else in the room. She is not a hoarder that I know of. She normally eats in the room for dinner because I work PMs. She's on mechanical soft diet and she eats by herself. I knew she was a swallow and choking risk." On 3/25/22 at 1:50 PM, Surveyor asked V3 to show R1's previous room and to walk surveyor through the incident that occurred. R1's room was on second hallway to the left of the nursing station in the far left hand side of the hall. V3 pointed to the first bed R1 occupied which was the bed nearest the bathroom. V3 stated, "(R1) was standing here outside the bathroom door and she was kind of smiling or something. It's hard to know what she is saying because It's hard to understand her." Surveyor asked if R1 was	S9999		

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S9999	Continued From page 6 providing her a universal sign of choking, V3 stated, "What is that?" Surveyor explained and asked whether R1 placed her hands on her throat to demonstrate she was choking, V3 stated, "No." Surveyor asked how she knew she was choking, V3 stated, "I saw grapes in her hand and I told her to go in the bathroom to try to throw it up and she couldn't." Surveyor asked why she asked R1 to throw up, V3 stated, "Because she was choking." Surveyor asked if R1 is able to understand and follow commands, V3 stated, "I don't know but I tell her to just go to bathroom." Surveyor asked if she went to the bathroom with the resident, V3 stated, "No I waited for her to give her privacy and then I went in later and found her sitting on the toilet." Surveyor clarified when she knew R1 was choking, V3 stated, "I knew she was choking when she had a weird expression on her face, so I told her to go to the bathroom." Surveyor asked to demonstrate how R1 was in the toilet. V3 pointed to the toilet and said V1 leaned way back in the toilet. " Surveyor asked if R1 was still conscious, V3 stated, "I think so, her head went way back, and she was leaning far back in the toilet." Surveyor clarified when she knew R1 was having difficulty breathing, V3 stated, "When I saw her in the toilet leaning back so I walked her out of the bathroom, and I told her to sit down, and I did a thrust to her sternum." Surveyor asked again where she did thrusts on R1, V3 stated "Her sternum. (and pointed to her own sternum to demonstrate location)." Surveyor asked if she did a finger sweep of R1's mouth to dislodge the grape, V3 stated, No I didn't. She started looking bad and I called the V10 CNA-(certified nursing aide) to come in and help and they tried to do the Heimlich too but couldn't get her to breathe. I saw V5 (CNA) try to reach around her and V5 is a bigger girl, and she couldn't wrap her arm around her either."	S9999		

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S9999	Continued From page 7 Surveyor asked what happened next. I went out and called the V4-nursing supervisor and they put her in bed and started CPR on her. Surveyor asked what she did while V4 was doing CPR, V3 stated, "I was watching for 911 to come." V5 (CNA) could not be reached for interview during this survey. V2 (DON) stated, V5 had her own emergency and was not on duty but provided a telephone number. Efforts to call the number were left unanswered. On 3/25/22 at 2:45 PM, interview with V8 (Dietary manager) stated, "We cannot upgrade her diet. It would have to be speech therapy and she was not upgraded so maintained mechanical soft, thin liquid diet. I observed her during breakfast meal and she appeared to be weaker and needed feeding in her room (on 2/22/22). I think she remained in room to eat all her meals. With eating, we do a malnutrition assessment which consist of their BMI and or recent her MNA was 11. They put in the aspiration because she is at a higher risk for aspiration because she has dysphagia. Dysphagia is swallowing difficulty. Her appetite has been fair and per nursing staff she was eating 50% of her meals and we ordered a fortified oatmeal. There were some instances we saw snacks at bedside being brought in by family, but they were appropriate. Grapes are not appropriate for the diet she was on. If they were to give grapes, they would have to remove the skin. On 3/25/21 at 3:30 PM interview with V9 (Speech Language Pathologist) stated, "We worked on her (R1) dysphagia and her swallowing disorder. I ultimately recommended mechanical soft and thin liquid diet and we did try regular solids, but she refused pureed foods, so I trialed mechanical soft	S9999		

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S9999	Continued From page 8 foods which was least restrictive. I put elevated risk with advanced consistency regular solids and those mechanical soft solids and thin liquids are recommended as the safest least restrictive diet. She had poor responsiveness to cues and aggressive behaviors. Anytime I would cue her, she was aggressive by tapping clinicians hands and moving pushing hands away. (R1) has severe aphasia and she was non-verbal." Surveyor asked about grapes, V9 stated, "Grapes are not a recommended as part of a mechanical soft diet. It's really because of the skin and the texture of it. Even if sliced it's the skin. Just a grape in general cannot be part of a mechanical soft diet." Surveyor asked if staff were aware of R1's diet, V9 stated, "I put care instructions and give education with the patient's son and nursing staff and informed them that the diet level for R1 is supervision and aspiration precautions. I recommended and discussed this all with staff and it included the recommended diet level and precautions, so they are aware of this. The patient requires maximum cues for meals although with poor responsiveness with verbal or visual instructions." Surveyor asked to explain further, "If we were to show her to cut her meals, she could not follow instructions. I let the staff know that she needs supervision, but she was not very responsive to the staff. " Surveyor asked if R1 required assistance in feeding, V9 stated, "I don't know and I don't have any documentation that they tried to feed her. As mentioned, she had severe expressive receptive aphasia which means a disorder of language. She did not have ability to repeat any words back, just a lot of mumbling and could not express verbally or comprehend instructions"	S9999		

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S9999	Continued From page 9 Records of V9' s' notes dated 8/11/20 showed R1's progress during her treatments that read in part, "Treatment diagnosis: Dysphagia, oropharyngeal phase. The patient warrants maximum assistance although remains with poor responsiveness to cues and aggressive behaviors. Elevated risk of choking with advanced consistency (regular solids). Mechanical soft solids, thin liquids recommended as the safest, least restrictive diet." Emergency Medical Systems response record dated 3/2/22 read in part, "Dispatch complaint: cardiac arrest/death. Crew performed CPR with rhythm checks and Epi administration for 30 minutes. Patient rhythm remained asystole (no heart rhythm) for duration of the arrest. Crew given time of death of 1659 (4:59 PM) by doctor." Facility policy dated 12/2016 (revised 4/2021) titled "Emergency Procedure-Choking" reads in part, "Conscious resident-standing or sitting: Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately. Ask the resident to cough or speak if at all possible, to determine if his or her airway is obstructed. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign object. Call for help but stay with the resident. If the resident cannot cough, only then should abdominal thrusts be performed as follows: Stand behind the resident. Wrap your arms around the resident's waist. Make a fist with one hand. Place the thumb side of your fist against the resident's upper mid-abdomen, below the ribcage and above the navel. Grasp you clenched fist with your other hand. Press your fist into the resident's upper abdomen with a quick upward thrust. Repeat the thrusts until the foreign body is	S9999		

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S9999	Continued From page 10 expelled or the resident loses consciousness. Unconscious resident--Lying down (or when unable to reach around the resident): Call for help if assistance is not already present but do not leave the resident unattended. Position the resident on his or her back with the arms at his or her side. Perform abdominal thrusts as follows: Facing the resident, kneel down and straddle the resident's upper thighs with your body. Place the heel of one hand on the resident's upper mid-abdomen, below the ribcage and above the navel and with fingers pointed towards the resident's chest...Perform a finger sweep maneuver if you see the foreign body. Perform abdominal thrusts until the object is expelled or until the person becomes unconscious. If the resident has no pulse or respirations, follow the procedure: Cardiopulmonary resuscitation and protected code blue." (A)	S9999		