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
	IL6008783	A. BUILDING: ______ B. WING ______	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE SPRING VALLEY	1300 NORTH GREENWOOD STREET SPRING VALLEY, IL 61362

(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 Investigation 2229085/IL153313	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)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 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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: 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to directly supervise a resident (R1) who required supervision and assistance while eating. This failure resulted in R1, who has a history of dysphagia, is on a mechanically altered diet, is impulsive with eating and needs verbal cuing to eat slowly and take small bites, being served a lunch meal tray within R1's reach without staff members directly present. R1 subsequently choked on food items from R1's lunch tray. R1 required the Heimlich Maneuver, Cardiopulmonary Resuscitation efforts and transfer to the local area hospital where R1	S9999		

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S9999	Continued From page 2 expired. Findings include: The facility's "Dining Experience: Staff Roles" policy, 2020, states, "Staff members will strive to enhance the resident's quality of life while serving meals that meet nutritional needs, offers choice, is served with dignity and considers the person-centered care plan. Staff will offer personal attention to each resident and monitor the resident's satisfaction and food intake. Procedure: 4. Staff members serving in the dining room will offer personal attention to each resident, giving consideration to the resident's plan of care, their preferences, intolerances and allergies." The facility's "Feeding and Assisting Residents to Eat" policy, undated, documents nursing personnel assisting should be positioned/seated at eye level with the resident to provide a relaxed and comfortable environment and documents that chewing and swallowing should be encouraged. The facility's "Dental Soft/Mechanical Soft Diet" policy, dated 2017, states, "The Dental Soft/Mechanical Soft Diet is for individuals with limited or difficulty in chewing regular consistency foods. If a mechanical soft diet is ordered, the Dental Soft/Mechanical Soft Diet would be appropriate if there is a chewing/dentition problem. This diet may also be used by a Speech Language Pathologist/SLP in the treatment of dysphagia with individualization per recommendations by the SLP." "For individuals that have any swallowing problems or dysphagia, it is recommended that a SLP be consulted and one of the Dysphagia Level Diets may need to be implemented."	S9999		

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R1's Facesheet documents R1 with diagnoses to include but not limited to: Dysphagia; Epilepsy; Unspecified Dementia; Schizophrenia; Bipolar Disorder; Unspecified Intellectual Disability and Postural Kyphosis. The Facesheet documents R1 with an original admission date of 4/18/2016.

R1's Minimum Data Set Assessment, dated 10/4/22, documents the following: R1 can comprehend most conversation; requires extensive assistance of one person physical assist for eating; and R1 is on a mechanically altered diet.

R1's current Care Plan documents R1 has an Activity of Daily Living/ADL self-care performance deficit and needs assistance to complete ADL care related to Postural Kyphosis, Lack of Coordination and Weakness. Interventions/Tasks are stated as "Eating: Requires hands on assist, extensive assist of one." This same Care Plan documents R1 with short and long term memory impairments and impaired decision making.

R1's Physician Order Sheet, dated 9/20/21 at 1:30 PM status post video swallow study, states, "Recommend mechanical soft solids, thin liquids. No more than one ounce to be presented to the patient (R1) at a time, due to impulsivity. (R1) to be seated upright, 90 degrees during all meals. (R1) to take small bites of food, small sips of liquids and eat slowly. Recommend cough/throat clear periodically during meals as well."

R1's Dietary Initial/Quarterly Evaluation, dated 9/2/22, documents R1 requires "extensive assistance" for eating.

R1's Speech Therapy Plan of Care notes on

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8/26/21 documents R1 required speech therapy services for evaluation and treatment of swallowing dysfunction and documents R1 required prompting for safe intake patterns.

R1's Speech Therapy Discharge Summary, dated 9/27/21, documents R1 at risk for aspiration of liquids and R1 was discharged from therapy services on a mechanical soft diet with nectar thick liquids and supervision during meals. This form states, "Pt (patient/R1) training on safe swallowing strategies. Constant supervision with verbal prompting for consistent use."

R1's Physician Progress Note on 11/8/22 at 10:29 AM documents R1 was evaluated by V3 (R1's Physician). This same note states, "15. History of dysphagia: status post video swallow. (R1) is followed by speech therapy. We will continue to monitor their recommendations and monitor the patient clinically on his current diet."

R1's current Physician Order Sheet/POS documents the following orders: "General diet, mechanical soft texture, nectar consistency"; "Give no more than one ounce of fluid at a time d/t (due to) impulsivity. Take small bites of food and small sips of liquids for oral dysphagia" with a start date of 9/21/21; Have (R1) drink liquids after 2-3 (two to three) bites of food" with a start date of 11/4/21; "Please have resident stay upright for 2-3 hours after meals" with a start date of 11/4/21.

R1's Meal Card documents R1 was on a mechanical soft diet with nectar thick liquids.

The facility's "Diet Spreadsheet" week two, day 13-Friday documents the dental/mechanical soft menu as "Ground Beef Stew, Biscuit, Soft

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S9999	Continued From page 5 Cooked Vegetable, Apple Streusel Cake and Beverage." R1's Nursing Note on 11/11/22 at 12:10 PM, signed and dated by V2 (Director of Nursing/Registered Nurse/RN), states, "This RN (V2) was notified by RN and CNA (Certified Nursing Assistant) that (R1) was choking. (V2) proceeded to do the Heimlich Maneuver on (R1) while in his chair. This RN (V2) could not get behind (R1) to do the proper maneuver. (V2) instructed for 911 to be called. (V2) proceeded to place (R1) on the floor on his left side. This RN (V2) did a mouth sweep and noticed some food that was obstructing (R1's) airway. This RN (V2) instructed for another RN to get the suction off the crash cart. Suction hooked up and was initiated by this RN. EMS (Emergency Medical Services) took over residents care. EMS started compressions and called (local area hospital) ED (Emergency Department) doctor due to resident was a DNR (Do Not Resuscitate) code. Doctor instructed for EMS to bring (R1) in and to continue to code (R1). (R1) left with EMS via ambulance (to local area hospital)." R1's "Code Blue Event" note, signed and dated by V2 on 11/11/22, documents R1 was brought to V2 by another staff member after R1 was found to have choked on R1's lunch. This form documents Code Blue was called on 11/11/22 at 12:10 PM, 911 was called on 11/11/22 at 12:20 PM, and CPR was initiated on 11/11/22 at 12:28 PM. This same form documents suctioning, and the Heimlich Maneuver were performed on R1. Paramedics are documented to have arrived at 12:28 PM on 11/11/22 and R1 was transported to the nearest emergency room. R1's condition at the time of transfer is documented as "unresponsive" and "cool." This same form	S9999		

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S9999	Continued From page 6 states, "Time of Death: 11/11/22 at 12:40 PM." R1's Emergency Medical Service/EMS Report documents on 11/11/22, EMS was dispatched to the facility for R1 who was "choking and not breathing." This same report states, "(R1) was found on the ground and not breathing but (R1) still had a pulse present. The known downtime was five minutes prior to our arrival. (R1) is visible cyanotic. There were CNAs and Nurses around the patient suctioning the patients airway trying to dislodge the food." "Medic15 had continued to suction (R1's) airway and was able to get more food out of (R1's) airway. At this time, Medic24 had checked for a pulse and there was none present." This report documents that CPR and lifesaving measures were continued the entire time en route to the local area hospital. R1 remained in Asystole with no pulse regained. "The Emergency Room doctor ceased all efforts at this time and presented (R1) as deceased." R1's Emergency Department note dated 11/11/22 at 12:34 PM, states, "Chief Complaint: Respiratory Arrest. Stated Complaint: Unresponsive. Initial Comments: (R1) brought in from the nursing home as a full arrest. (R1) was reportedly eating, then choked on food. Paramedics called and by the time they arrived, (R1) had suffered a cardiac and respiratory arrest. On scene, paramedics removed the visible food from (R1's) oropharynx and ultimately intubated (R1), performed CPR and transported (R1) to the Emergency Department." This same note documents R1 with a medical history of Cognitive Impairment, Schizophrenia, Bipolar Disorder and that R1 is wheelchair bound. "Physical Exam: (R1) is asystolic with no blood pressure and no spontaneous respirations. Intubated. Unresponsive to verbal or painful	S9999		

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stimuli. Pupils fixed and dilated."
"Progress/Clinical Impression: (R1) asystole on the monitor. (R1) has a history of DNR (Do Not Resuscitate) order. Since there is no readily identifiable reversible cause of patient's arrest, resuscitation efforts were discontinued and (R1) was pronounced dead at 12:40 PM."

The facility's Initial Report to the local state agency documents that on 11/11/22 at 12:10 PM, R1 choked in the dining room; 911 was called, Heimlich and suctioning were performed. EMS arrived and transported R1 to the local area hospital.

V7s (Certified Nursing Assistant) written statement, dated 11/11/22, states, "(V4/R2's Family Member) yelled, 'He's choking.' I got up and yelled for a nurse and started pushing (R1) towards the Nurse's Station. I was at the table next to (R1) but (my) back was towards (R1). I was feeding (R7 and R8). After (V4) yelled when I looked at (R1) he was turning blue. I saw V5 (Licensed Practical Nurse/LPN and she took (R1). I moved residents out of the way. I helped get (R1) on the ground and held his head while (V2) was trying to suction."

V5's (Licensed Practical Nurse) written statement, dated 11/11/22, states, "I pulled (V11/CNA) out of the dining room because (R4) was threatening to throw herself down. (V12/CNA) was in with (R4) and she asked me to go get one of the girls. (V11) came to help her. Then as I was walking towards the dining room with some pills, (V7) hollered that (R1) was turning blue. I grabbed (R1) and pulled him towards the nurse's station and yelled for (V2). (V2) then started giving (R1) the Heimlich. (V2) tried suctioning him and the paramedics came."

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V13's (CNA) written statement, dated 11/11/22, states, "I was feeding (R6) and (R1) was at another table. I could see the back of (R1). (V4) yelled (R1) was choking. We stood up and (R1) was turning purple. (V7) grabbed (R1) and started moving him towards the nurse's desk. Then (V5) was coming, so she took him. I stayed in the dining room with the other residents."

V6's (LPN) written statement, dated 11/11/22, states, "I was standing at the nurse's station. I heard (V7/CNA) yell at (V5/LPN). I saw him turning blue. I called 911. I pulled up (R1's) chart for code status and printed out his paperwork. I tried to help (V2) with suctioning before the paramedics came."

V11's (CNA) written statement, dated 11/11/22, states, "I was sitting in between (R1) and (R3). (V5) came to get me because (V5) needed help with (R4). I got up to help (V12/CNA) with (R4). (R1) wasn't eating when I walked away. (R1) had just finished a bite of coleslaw. (R1) did have a biscuit on his plate but I hadn't given it to (R1). (V9/CNA), (V13/CNA), and (V7/CNA) were in the dining room. When I was walking back towards the dining room, I saw (V5/LPN) pushing (R1) towards the nurse's station."

V14's (Dietary Manager) written statement, dated 11/11/22, documents R1 is a mechanical soft diet, and that stew, biscuit cabbage and dessert were served for lunch on 11/11/22.

V9's (CNA) written statement, dated 11/11/22, states, "I was in the dining room. I was sitting with (R5). I had my back towards (R1). (V4) yelled, 'I think he's choking.' (V7/CNA) got up and started pushing him towards the nurse's desk and

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S9999	Continued From page 9 (V5/LPN) took (R1). I stayed in the dining room with the other residents." V12's written statement, dated 11/11/22, states, "I was on C Hall in R4's room. (R4) was threatening to throw herself on the floor and trying to climb out of her bed. I asked (V5) to help me because I couldn't leave (R4). (V11) came to help me. (V11 and V12) got (R4) in her chair. I think it was a little after noon. As we were coming out of (R4's) room, we saw everyone in the hallway with (R1)." V4's (R2's Family Member) written statement, dated 11/11/22, states, "I was sitting with (R2) and (R1) picked up a roll. The girl (V11) at the table had left. I saw (R1) was choking. A girl (V7) behind him got up. It seemed like forever. (V7) immediately wheeled him back by the nurse's station. (R1) was turning blue." On 11/11/22 at 7:08 PM, V2 (Director of Nursing) stated, "On 11/11/22, in the main dining room, at lunch time, the CNA (V11) was called away from (R1) due to another resident (R4) threatening to put herself on the floor. (V11) left the table. (V4) was sitting with (R2) at the table. (R1) was at the table in (R1's) wheelchair and (V4) was next to (R1). (V4) told (V7) that (R1) was choking. (V7) took (R1) out of the dining room and wheeled (R1) to the nurse's station. I was at the nurse's station at that time. I tried to do the Heimlich Maneuver. I didn't have enough strength to do it right. We lowered R1 to the floor and I told (V6) to call 911. R1's body is curved (contracted) to the side and he has Kyphosis, so he can't lay flat very well. I was laying on the floor with him doing the Heimlich. I could see something in (R1's) mouth so I did a finger sweep. I got a fingertip worth of mushy biscuit. I got the (suction catheter) and started sucking. (R1's) lips were turning blue.	S9999		

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(R1) was not able to talk but he had a pulse. EMS came and started CPR. EMS pulled two large forceps full of mushy biscuit out of (R1's) mouth. They continued CPR and left with (R1). The coroner called me and said that (R1) passed away at 12:40 PM." V2 stated that R1 sat at the assisted dining table and that R1 needed "small bite cues" V2 stated, "(R1) likes to shove food in his mouth at times. (R1) needs reminded to take sips (of liquids) after bites and to slow down." V2 stated V11 should not have left R1 while R1 was eating. "If (V11) was called away, she should have told someone to come over and sit with (R1) or push (R1's) plate away from him. There is enough room on that table to move the plate away and it is not near another resident or within (R1's) reach." V2 stated two residents sit with one CNA for assisted dining. At this time, V2 verified that no staff members were sitting at R1's table monitoring R1 with R1's tray of food.

On 11/12/22 at 9:48 AM, V4 (R2's Family Member) stated that on 11/11/22, V4 was eating lunch with R2 at the same assisted dining table as R1. V4 stated there was not any staff members present at the table at all. V4 stated, "I saw (R1) pick something up and put it in his mouth. (R1) started gagging. I yelled out 'He's choking.' (R1) was turning blue. I had to yell three times before any of the staff responded and then they immediately wheeled him to the nursing station and closed the doors. This should not have happened, no one was watching him (R1) eat."

On 11/11/22 at 7:41 PM, V15 (LPN) stated that residents who require supervision/assistance with dining should never be left alone while eating. V15 stated, "They don't even start delivering trays until staff is present with the residents."

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S9999	Continued From page 11 On 11/11/22 at 7:53 PM, V8 (CNA) stated that assisted dining table residents should never be left unattended while eating. On 11/11/22 at 7:55 PM, V10 (CNA) stated, (R1) sat at the assisted dining table because (R1) would eat too quickly and shove everything in too fast and shove too much food in. (R1) needs cues to slow down. (R1) should never be left alone with his meal tray." On 11/11/22 at 7:59 PM, V16 (Registered Nurse) stated that R1 sat at the assisted dining table and that R1 was a high risk for choking. V16 stated, "Oh, of course not. (R1) should not be left alone with (R1's) meal tray." On 11/11/22 at 8:05 PM, V17 (CNA) stated that R1 sat at the assisted dining table and that R1 was able to feed himself at times. V17 stated R1 would "eat too fast" and that staff sat with R1 to remind R1 to slow down and take small bites. V17 stated, "No one at that table (assisted dining table) should ever be left alone. They don't even deliver the trays until a staff member is present." On 11/11/22 at 8:21 PM, V11 stated, "I was sitting at the lunch table with (R1). (V5) came and told me that (V12) needed help. I left (R1) to help her because the other resident (R4) was trying to get out of bed. (R1) had his tray in front of him when I left him. When we walked out of (R4's) room, I saw (R1) in the area by the nurse's station. I was probably gone five to ten minutes. We dressed (R4), got the (mechanical lift) sling underneath her and got her up with the (mechanical lift)." V11 stated R1 sat at the assisted dining table because R1 would need physical assistance with certain food items. V11 stated R1 could hold toast but	S9999		

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	IL6008783	A. BUILDING: ______ B. WING ______	C 11/16/2022

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S9999	Continued From page 12 holding a spoon would be hard for R1. V11 stated R1 would need physical assistance with eating and R1 would also need cues to take drinks in between bites and that sometimes R1 would eat too fast. V11 stated, "I checked (R1's) plate after everything happened, his coleslaw and biscuit were gone." At this time, V11 verified the following: V11 did not push R1's tray out of R1's reach before leaving R1's table, did not say anything to R1 before leaving the table; and did not ask anyone else to watch R1 while V11 was gone. V11 stated, "I should not have left (R1) unattended. I left when the nurse (V5) came and got me. (V5) didn't stay with (R1) either, she was doing med pass. There were three staff members at the other feeding table, but they were feeding (residents) too. No one was directly laying eyes on (R1)." On 11/11/22 at 8:41 PM, V1 (Administrator) stated, "(On 11/11/22) I was in my office, I heard V6 (Licensed Practical Nurse) page maintenance (V18/Maintenance Director) to the nurses' desk immediately. I went back there to see what was going on. I saw (V2) trying to give (R1) the Heimlich in his chair. She was trying to get up underneath him. He was real floppy. He was awake but blue. (V2) said, 'Let's get him out of the chair.' (R1) had the (mechanical lift sling) under him so a bunch of staff lowered him to the floor. (V2) said to get suction. Once (R1) was on the ground, (V5) ran and got suction and we rolled (R1) on his side. The suction plug was too far away from where he was lying, so I ran to get an extension cord. When I came back, they already had the suction working and (V2) was suctioning (R1). (V2) said, 'Come on (R1), let's get it out.' It looked like they were suctioning wet cracker out of his mouth. They kept checking a pulse and said that he still had one. EMT	S9999		

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(Emergency Medical Technician) got there and used a device to open his throat and look down. They pulled up what looked like chewed up cracker. Then they said he didn't have a pulse. EMT started compressions. (V6) said he was a DNR. The paramedics then called the ER (Emergency Room) doctor and the doctor said that if something was obstructing his airway, to bring him in so they took him to the ER. EMT was doing CPR the whole time. No one here did CPR. (V2) said he had a pulse and was suctioning him." V1 stated, "We couldn't get a grip around him, He couldn't sit up on his own. V2 was trying. V1 stated that R1 should not have been left alone with R1's food tray at the assisted dining table. V1 stated, "There were three other CNAs in the dining room helping feed but from where they were sitting, they didn't see (R1) was choking until (V4) yelled out and (V7) ran over."

On 11/12/22 at 11:57 AM, V5 (LPN) stated, "(On 11/11/22), I had to pull one of the CNAs from the dining room to help with a behavior down the hall. I go back out to the dining room and was notified by another CNA that (R1) was turning blue. (R1) was still in his wheelchair, we were able to get (R1) over to the side to get behind him enough to do the Heimlich Maneuver. We then used the (mechanical lift) sling that was under (R1) to lower him to the floor."
V5 stated that R1 sat at the assisted dining table because R1 required assistance with eating. V5 stated that R1 should not have been left alone with his food tray.

On 11/12/22 at 12:14 PM, V9 (CNA) stated, (On 11/11/22), I was sitting at the other feeder table. No one was observing (R1) directly. My back was towards (R1). (R1) sits at the assisted dining table because he is a choke risk. (V4) yelled, 'I

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S9999	Continued From page 14 think he is choking' and then they took (R1) through the doors. At this time, V9 verified no staff was present at R1's table when R1 was eating. On 11/12/22 at 12:28 PM, V13 stated, (On 11/11/22), I was feeding (R6). (R1's) back was to me at the other table. No staff was at the table with (R1) and (R1) had his food tray. (R1) sits at the assisted dining table because he has problems swallowing. His liquids are thickened, and he uses (adaptive cups). (V4) started yelling, 'I think he's choking.' There was a CNA (V7) behind him. (V7) took (R1) to (V5) and (V5) took him out of the main dining room. (R1's) face was purple. No staff was at (R1's) table. (V11) was supposed to be at that table. I didn't see when she left. There was an empty chair between (R1) and (R3). That's the chair for us to use to feed them. I know that (R1) eats fast and grabs large amounts of food with his hands and puts it in his mouth." On 11/12/22 at 12:36 PM, V12 stated, (On 11/11/22), I was in (R4's) room. I asked (V5) to get me help. (V11) came to help me. (R1) should not be left alone with food. (R1) is on nectar thickened liquids, he has a hard time swallowing. He was choking on the thin liquids. We have to sit with (R1) to watch him and make sure he's ok. Sometimes he can feed himself and sometimes he needs help." On 11/12/22 at 12:43 PM, V6 (LPN) stated, "(On 11/11/22), I was standing behind (V2) at the nurse's station. (V5 and V7) brought (R1) to the nurse's desk. He was cyanotic. (V2) was attempting the Heimlich Maneuver. I'm nine months pregnant so I was no help with lifting. They lowered him to the floor and was suctioning	S9999		

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food out of his mouth. The (catheter tube) clogged so I ran to get water to help clear the tubing." V6 continued to say that R1 sat at the assisted dining table because (R1) "got impulsive with eating and would not take appropriate size bites." V6 stated, "(R1) should not have been left alone with his food tray. No feeder should be left alone with a food tray. It's not a good idea, it's unsafe."

On 11/14/22 at 10:09 AM, V7 (CNA) stated, "(On 11/11/22), I was in the dining room feeding (R7 and R8). (V4) got my attention that (R1) was choking. I could see that (R1's) face had turned blue. I yelled for another CNA to get the nurse. (V5) then took (R1) from me and they were trying to suction the food out of his mouth, but they couldn't. We (V7 and R1) were sitting with our backs to each other in the main dining room at the time of the incident. (R1) was not in my direct line of vision. No one was at the table with (R1). Another CNA (V11) was originally sitting with R1. She did not say anything to me that she was getting up from the table with (R1). (R1) needs assistance with feeding and has thickened liquids. (R1) has difficulty handling silverware but can feed himself finger foods. (R1) should not have been left unsupervised with his tray. I did not attempt Heimlich Maneuver, I wanted to wait for the supervisors and get him out of the dining room. (V2 and V5) immediately took over. Once he was on the floor, I helped hold his head while they were suctioning him. I couldn't see anything in his mouth directly. I think this could have been prevented if staff was with (R1) while he was eating, or we could have at least got to him quicker. (R1) looked like he had been choking for a while before anyone noticed. Had I known the staff was leaving (R1), I would have sat with him."

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S9999	Continued From page 16 On 11/15/22 at 4:13 PM, V3 (R1's Physician) verified that R1 has chronic dysphagia and requires assistance with eating. R1's Death Certificate, signed and dated 11/14/22 by V19 (Medical Examiner/Coroner) documents R1's date of death as 11/11/22. The cause of death is documented as "Choking" and "Food Aspiration." This same certificate states, "Describe how injury occurred: (R1) was seated at the dining table when he put a whole biscuit into his mouth and then started choking on it. (R1) was transported to the hospital and soon pronounced dead." The manner of death is documented as "Accidental." (A)	S9999		