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	IL6016786	A. BUILDING: _____ B. WING _____	C 05/23/2023

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S 000	Initial Comments Complaint Investigation: 2373900/IL159695	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2 300.1210d)6 300.2040b)1 300.2040b)2 300.2040c) 300.2040d) 300.2040g) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

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 300.2040 Diet Orders

b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.

1) The resident's diet order shall be included in the medical record.

2) The diet shall be served as ordered.

c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is

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changed. Each change shall be ordered by the physician or dietitian. The diet order shall include, at a minimum, the following information: name of resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to the food service department, name of physician or dietitian ordering the diet, and the signature of the person transmitting the order to the food service department.

d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record.

g) All oral liquid diets shall be reviewed by a physician or dietitian every 48 hours. Medical soft diets, sometimes known as transitional diets, shall be reviewed by a physician or dietitian every three weeks. All other therapeutic and mechanically altered diets, including commercially prepared formulas that are in liquid form and blenderized liquid diets, shall be reviewed by a physician or dietitian as needed, or at least every three months.

These Requirements were not met as evidenced by:

Based on interview and record review the facility failed to provide a resident with a pureed diet as ordered by the physician. This failure resulted in R1 being found unresponsive while eating, requiring the Heimlich maneuver and CPR (Cardio-Pulmonary Resuscitation). R1 required admission to the local hospital intensive care unit and expired at the hospital on April 25, 2023.

This applies to 1 of 3 residents (R1) reviewed for improper nursing care in the sample of 3.

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The findings include:

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on November 15, 2021. The EMR continues to show R1 was sent to the local hospital on April 19, 2023 and did not return to the facility. R1 had multiple diagnoses including, polyarthritis, chronic kidney disease, morbid obesity, diabetes, left heel pressure ulcer, sacral pressure ulcer, altered mental status, hydronephrosis, anxiety disorder, recurrent depressive disorders, lack of coordination, and history of falling.

R1's MDS (Minimum Data Set) dated March 29, 2023 shows R1 had severe cognitive impairment, was totally dependent on facility staff for transfers between surfaces, locomotion on the unit, toilet use and bathing, and required extensive assistance with bed mobility, dressing, personal hygiene, and eating. R1 was always incontinent of bowel and bladder.

Facility documentation shows R1 was hospitalized from March 19 to March 23, 2023 due to dehydration, urinary tract infection and altered mental status. R1 returned to the facility on March 23, 2023. Hospital discharge instructions show orders for a pureed diet upon hospital discharge.

On March 21, 2023 at 2:47 PM, V9 (Hospital SLP-Speech Language Pathologist) documented: "Recommendations/Discharge: Swallow Precautions Recommendation: Allow extra time to swallow, clear pocketing left, clear pocketing right, fed only by trained staff/family. Small bites of food. Diet Consistency Recommendation: Dysphagia Pureed Supervision Swallow

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Recommendation: 1:1. Barriers to Safe Discharge SLP: Safety awareness, medical diagnosis, cognitive impairments, severity of deficits, aspiration risk - possible, 1:1 feeder, dysphagia requiring food/liquid modification, requires safe swallow protocol/techniques. Other short-term goals #1: Patient will tolerate dysphagia puree diet with thin liquids with no clinical s/s (signs/symptoms) of aspiration, #2 reassess for upgrade potential with improved bolus control."

The EMR shows R1 returned to the facility on March 23, 2023. Physician orders dated March 23, 2023 show R1's diet order as pureed consistency general diet.

The EMR shows on April 7, 2023, V6 (LPN) discontinued R1's pureed consistency diet. V6 documented the reason for the order change: "Wrong diet." V6 changed R1's diet order from a pureed diet consistency to a regular consistency diet. V6 documented the diet order change was obtained from V13 (Physician).

The facility does not have documentation to show a speech evaluation was done to ensure a regular consistency diet was safe for R1. The facility does not have documentation to show V6 (LPN) discussed the diet order change with a physician, nurse practitioner, or V11 (POA-Power of Attorney for R1) prior to the diet order change.

The facility's Day at a Glance for General Diets, Week 3 Wednesday, printed May 2, 2023 shows the dinner menu served on April 19, 2023 to residents on a general, regular consistency diet included, chicken breast tenders, barbecue sauce, rice pilaf, seasoned corn, mandarin oranges, bread, margarine, milk, coffee/hot tea,

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and condiments.

On April 19, 2023 at 8:04 PM, V6 (LPN) documented: "Around 6 PM during dinner time, the resident assistant came to the nurse's station and stated that the resident was unresponsive while eating dinner. Writer rushed to the dining room and noted that the resident was sitting in the dining room table with her plate @ (at) about 80 percent eaten and she was not responding when her writer called her name. Writer noted that the food was coming out of her mouth and her glass of juice was empty. Writer checked her pulse, and it was present. Writer called for help and the Heimlich maneuver was started right away and also finger was used to remove food out of the resident mouth. Writer noted that the food was coming out her mouth. 911 was called and resident was moved to a safer and clear area. During that time an EMT [Emergency Medical Technician] personnel was at the facility, he came, and we all brought resident on floor and started CPR and a [bag valve mask] was also used. Paramedic personnel arrived as quick as possible and took over. Resident had a pulse of 86. Writer called [V10] (NP-Nurse Practitioner) and left a message, [V11] (POA) was notified as well as [V2] (DON) and [V1] (Administrator). Resident was taken to the nearest [hospital]."

Local fire department documentation dated April 19, 2023 shows upon arrival and assessment of the resident, R1's airway was "completely obstructed" and R1's pulses were absent.

R1's hospital documentation shows R1 was admitted to the emergency room on April 19, 2023 with CPR in progress. On April 20, 2023 at 8:10 AM, V7 (Hospital Physician) documented, "Out of hospital cardiac arrest - likely due to

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choking/aspiration of dinner food." V7's documentation continues to show, "We will get neurologic and pulmonary input on [R1]. I feel she suffered significant anoxic insult to her brain. Her prognosis is grim. If no neurologic improvement in the next several days we will need to speak with family regarding aggressiveness of this care and possible withdrawal of life support."

Hospital documentation continues to show R1 expired at the hospital on April 25, 2023. R1's death certificate with cause of death is pending with the coroner due to continued investigation into the cause of R1's death.

On May 15, 2023 at 2:54 PM, V14 (CNA-Certified Nursing Assistant) said, "I was not there when they discovered her choking. I heard the nurse call the other nurse. I noticed [R1] had chicken chunks on the front of her shirt and her head was down, and the nurse said bring her out of the dining room, and they were trying to see if she had anything in her mouth. They called a code blue. There happened to be a fireman in the building that day, and I ran to get him. When he came to the floor he said we had to get her out of the [high back wheelchair] and down to the floor. I don't know what happened after that because I went to hold the elevator for the paramedics."

On May 15, 2023 at 3:16 PM, V15 (CNA) said, "I was passing dinner trays in my hallway, and I saw them wheeling [R1] out of the dining room in her chair. She was unresponsive. She was slumped over, and they were yelling her name. When the fireman arrived from the other floor, he said let's move her to the floor and let's do compressions. We did chest compressions because she was unresponsive. I did CPR with the fireman until

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the paramedics arrived."

On May 15, 2023 at 3:56 PM, V16 (LPN) said, "What I found was [R1] had her eyes open, and I could see an exchange of air. I thought we should look at her outside of the dining room, so we moved her wheelchair to the hallway. At that point I did not hear an exchange of air, but I noticed she started doing the universal choking sign, and I looked to do a sweep of her mouth. I used a spoon to sweep the inside of her mouth, and there were chunks of chicken coming from inside her mouth onto the spoon. Because of the size of the chair she was sitting in, I could not reach around the resident to do the Heimlich maneuver, so I approached her from the front and pushed on her abdomen, and when I did that, food started to come up and out of her mouth. I heard some air exchange and once I did that, her eyes closed. Her pulse went from thready to none. We called 911. We identified there was an occlusion and kept checking for a pulse. We started CPR. She was eating chicken tenders for dinner and evidently drank some red juice because what came out was red juice and chewed food."

On May 16, 2023 at 1:06 PM, V6 said, "[R1] was on a regular consistency diet before she went to the hospital. When she came back she was on a pureed diet. She was not eating her food. She kept repeating, "I don't eat pureed food." She was not eating, and she was refusing her food. She was not eating, nor touching her food. She was asking why she had to eat a pureed diet. I changed the order to a regular consistency diet. I do not know who I got the order from to change her diet. I just cannot recall. I know I put the reason for the diet change was because she was on the wrong diet. She was on a regular diet

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S9999	Continued From page 8 before she went to the hospital. When she choked, that was the first time in my nursing career that I have had a code blue situation." On May 16, 2023 at 1:57 PM V13 (Physician) said, "The staff usually puts my name on every order they enter. The normal practice would be to do a swallowing evaluation. I would never give an order to go from a pureed diet to a regular consistency diet. [R1] should have had a swallow evaluation before her diet was changed. No, I did not give that order, unless there was a swallow evaluation done at that time. She was in the process of eating and food got into her trachea. It is my expectation they provide the diet as ordered." On May 16, 2023 at 12:20 PM, V10 (NP) said, "I would not have given an order to upgrade from a pureed diet to a regular consistency diet. If the nurses ask about changing her diet, and not eating the pureed food, I will always say have a speech evaluation. I would never say put her on a general diet if I don't know her swallowing capabilities. If that nurse put in an order, there should be a progress note to follow. Normally, they would put in a note saying who they talked to, and they said it was okay to place this order for this diet. She needed to be assisted with meals, based on her encephalopathy and past history. She needed to be closely monitored." On May 16, 2023 at 12:42 PM, V12 (NP) said, "I do not remember giving an order to go from a pureed diet to a general diet. [R1] would not be able to be upgraded until she was evaluated by speech therapy. Obviously, she was on a pureed diet for a reason, and she would need to be reevaluated. She would have to be evaluated by speech therapy first."	S9999		

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On May 16, 2023 at 11:52 AM, V17 (ST-Speech Therapist) said, "I did not see [R1] after her speech evaluation in February, which was before her most recent hospitalization. I usually get flagged to screen the resident if they come back to the facility on a pureed diet. I did not get any information about [R1] being on a pureed diet. Nursing is not supposed to change the diet order. You should never jump two diet consistencies like that. You would go from pureed diet to a mechanical soft diet and if the resident tolerates it, then you can try the regular consistency diet. The resident would need to be evaluated with each diet change. No one ever reached out to me about her diet change."

The facility's Diet Order policy reviewed on "11/22" shows: "General: To ensure that residents receive their specific diets. Guidelines: 1. Upon admission, the nurse will receive a diet order. 4. If a resident is not able to tolerate the diet, the nurse will alert the physician or nurse practitioner for a change in diet and possible Speech Therapy Evaluation. 5. If there is a change in the resident's diet per the physician or nurse practitioner order, the nurse may explain the change to the resident and/or resident's representative. 6. If the resident refuses to follow the diet that is written, the resident and resident's representative should be educated on the reason for the diet and consequences of not following the diet. This should be documented in the nursing notes. ...9. If the resident refuses to eat, the physician is notified to discuss options with the resident and/or their responsible party."

The facility's Diet Manual, approved by the facility on October 13, 2021 shows the following policy developed "4/2017." "Policy: Diet Orders -

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S9999	Continued From page 10 Policy: The facility will offer house standard diet orders. The diets available will be reflected in the diet manual. Procedure: Upon resident admission or diet change, the nurse will verify the diet order with the physician." (AA)	S9999		