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
	IL6004881	A. BUILDING: ______ B. WING ______	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK REHABILITATION & HCC	1700 WHITE STREET MOUNT VERNON, IL 62864

(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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)3) 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 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	

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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:

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.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to anticipate a residents pain and administer as needed pain medication prior to wound care for one resident of one resident (R12) reviewed for pain in the sample of 35. This failure resulted in R12, while being repositioned and treated during wound care, crying out in pain and distress.

Findings Include:

R12's Face Sheet documented an Admission Date of 1/27/22. R12's Cumulative Diagnosis Log documented diagnoses including Diabetes Type 2, Lung Cancer, CVA (Cerebral Vascular Accident) by history, and Dementia.

R12's 8/28/23 Minimum Data Set (MDS) documented a Brief Inventory for Mental Status Score of zero, indicating R12 experiences severe deficits in cognition. The same MDS documented

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in the five days previous to the assessment, R12 experienced non verbal indicators of pain (crying, whining, gasping, moaning or groaning) and facial expressions indicative of pain (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw).

R12's Care Plan, dated 10/12/23, documented a problem area,"Comfort alteration related to lung cancer, potential for air hunger, and impaired mobility," with a corresponding intervention, "Observe for non-verbal indicators of pain. Ask resident if she is in pain, however she may not always be able/willing to give verbal response. Complete pain assessment prn (as needed). Administer pain medication as ordered."

On 11/17/23 at 9:11am, V9 and V10, both Licensed Practical Nurses, were observed providing wound care for R12, who was awake but non verbal. R12 was noted to have large stage 4 pressure ulcers to her sacrum and left hip, and an unstageable pressure ulcer to the left ankle. When R12 was repositioned during the procedure and as the wounds were being cleansed, R12 would cry out and whine loudly. When asked if R12 had had any pain medication prior to the procedure, V9 stated she had not given R12 anything for pain prior to the treatment. V9 stated R12's dressings are normally changed in the afternoon and pain medication is given prior to the treatment. V9 stated she would give R12 pain medication after the treatment was over. At the conclusion of the procedure, R12 was positioned to her back and was no longer crying out. V9 was then observed administering the morphine to R12.

R12's November 2023 Physicians Order Sheet documented an order for Morphine Sulfate 100

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milligrams per milliliter (ml) take 0.5 ml every hour prn (as needed) for moderate to severe pain. R12's November 2023 PRN Medication Administration Record and November 2023 Pain Flow Sheet contained no documentation R12 received morphine on 11/17/23, nor that her pain had been assessed.

On 11/21/23 at 9:40am, V2, Director of Nursing, confirmed R12 should have received pain medication prior to the wound care treatment.

The facility's Pain Prevention and Treatment Policy, dated 12/7/17, documented, "It is the facility's policy to assess for, reduce the incidence of and the severity of pain in an effort to minimize further health problems, maximize ADL(Activities of Daily Living) functioning and enhance the quality of life. Assessment of pain will be completed with changes in the residents condition, self reporting of pain or evidence of behavioral cues indicative of pain and documented in the nurses notes or on the Pain Management Flow Sheet. The Pain Management Flow Sheet will be initiated for those residents with but not limited to routine pain medication, daily pain, and diagnosis that may anticipate pain (for example arthritis, wounds, fractures, etcetera.)"

(B)

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300.610 a)
300.1210 b)
300.1210 c)
300.2040 e)
300.2040 f)

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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 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.

Section 300.2040 Diet Orders
e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

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f) The kinds and variations of prescribed therapeutic diets must be available in the kitchen. If separate menus are not planned for each specific diet, information for each specific type, in a form easily understood by staff, shall be available in a convenient location in the kitchen.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide a mechanically altered diet as ordered for 1 of 4 (R17) residents reviewed for mechanically altered diets in a sample of 35. This resulted in R17 choking on 9/6/23, requiring the Heimlich maneuver, chest compressions, and evaluation in the emergency room, and a subsequent choking episode on 10/28/23, in which the Heimlich maneuver was again required.

Findings include:

1. R17's New Admission Information documented an admission date of 11/2/20. R17's Cumulative Diagnosis Log documented diagnoses: anxiety, lewy body dementia, dementia with agitation, and physical deconditioning.

R17's Minimum Data Set (MDS), dated 7/11/23, documented a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. R17's MDS section G documented limited one person assistance with setup or clean-up assistance with eating.

R17's care plan documented an 11/10/20 potential risk for altered nutritional status with a 1/17/21 intervention that R17 must be monitored during meals related to choking hazard. R17's Social Services Interim Treatment Plan, dated

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11/2/20, documented, " ... List perceived weakness based on admission assessment:... a choking risk- doesn't appear to take the time to chew properly- must be monitored ..." R17's 11/29/22 Nutritional Assessment documented R17 was edentulous (no top or bottom teeth).

R17's Speech Therapy Daily Treatment Note, dated 4/20/21, documented, " ... was seen for skilled dysphasia therapy this date during lunch meal with (R17) continuing with trial of mechanical soft solids. (R17) demonstrates adequate mastication and bolus formation given (minimal) verbal cues for use of bite size and rate of modification. Continue with current diet trail of mechanical soft solids.."

R17's August 2023 Physician's Orders documented a 11/1/22 diet order of " ...Mechanical Soft Solids ... Must be monitored at meals (related to) choking ..."

R17's September 2023 Physician's Orders documented a 9/11/23 diet order change to pureed solids and a 9/27/23 diet order change to " ... (Mechanical) Soft Solids, (Finely Chopped and Heavy Moistened with) No Breads ..."

R17's Skilled Progress Note, dated 9/6/23 at 11:50 am, by V5 (Licensed Practical Nurse/ LPN) documented " ... sitting in dining room CNA (Certified Nursing Assistant) ... noticed (R17) was choking on pizza. (V4, LPN) and other CNAs started the Heimlich (maneuver). (V5, LPN) switched with (V4) and attempted the Heimlich (maneuver) as well. Resident legs started to buckle and lose consciousness. We then lowered (R17) to the ground while 911 was being contacted ... started CPR compressions as (V5) went to grab the (ambu-bag). There was pieces

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of pizza crust retrieved. (R17) regained consciousness as the fire department and police department arrived at 11:55 am ... ambulance arrived at 11:57 am and took (R17) to the hospital ..."

On 11/16/23 at 12:27 pm, V4 (LPN) said she was caring for R17 on 9/6/23 during the noon time meal. V4 said she was called by a CNA due to R17 choking. V4 said R17 had been served a whole piece of pizza by Dietary staff. V4 said she and other facility staff had attempted the Heimlich maneuver on R17, and were not able to clear R17's airway. V4 said R17 then lost consciousness and was lowered to the floor and facility staff started chest compressions on R17. V4 said she was able to complete a finger sweep to remove the pizza crust from R17's throat. V4 said by the time Emergency Medical Services (EMS) arrived, R17 had regained consciousness and was transferred to the Emergency Department (ED) for further evaluation. V4 said R17 returned to the facility the same day from the ED.

On 11/16/23 at 12:42 pm, V5 (LPN) said she was present on 9/6/23 when R17 choked on a piece of pizza. V5 said R17 was served a whole piece of pizza from Dietary staff. V5 said R17 was sitting in the dining room when R17 choked. V5 said the Heimlich maneuver failed to clear R17's airway and chest compressions had been started, and two pieces of bite sized pizza crust were removed from R17's throat. V5 said R17 had several instances of choking in the past.

On 11/16/23 at 12:58 pm, V3 (Dietary Manager) said a piece of pizza was considered mechanically soft. V3 said pizza has always been considered mechanically soft, and no one had

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ever told her otherwise. On 11/16/23 at 2:50 pm, V3 said there was no difference between the pizza served to residents with regular diet orders and mechanically soft diet orders; all the pizza served was made with a biscuit crust. V3 was asked how thick the pizza crust was supposed to be, V3 responded about half an inch to an inch thick depending on who is cooking. V3 said the pizza served on 9/6/23 to residents with mechanically soft diet orders did not have sausage and was only cheese pizza.

On 11/16/23 at 1:47 pm, V7 (Speech Pathologist) said mechanically soft diets should be defined as foods that are soft and fork tender with ground meats. V7 said the texture of the food should have a moist cohesive texture. V7 said she would not expect resident's with orders for mechanically soft diets to receive pizza with crust. V7 said even when using a biscuit mix for the pizza crust, V7 did not feel it would be appropriate for residents with mechanically soft diet orders.

On 11/16/23 at 1:56 pm, V8 (Regional Dietitian) said, "The facility did not have a recipe for mechanically soft pizza. Dietary staff should ensure the crust of the pizza is soft, the meats are ground, and there is added moisture." V8 was asked how staff were trained to know it is soft enough to be appropriate for mechanically soft diets, V8 responded staff were trained upon hire to know what on the diet spreadsheet is soft enough to serve to residents with mechanically soft diet orders.

On 11/16/23 at 2:10 pm, V6 (Social Services Director) said she had made a note on 11/2/20, when R17 was first admitted to the facility, that R17 was at risk for choking to alert staff to cut up R17's food and to monitor for choking. V6 said

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she expected staff were assisting R17 to cut R17's food into bite sized pieces due to having some difficulty swallowing. V6 said R17 eats very fast, and must be monitored by staff at all times when eating.

R17's hospital After Visit Summary, dated 9/6/23, documented, " ... Diagnoses ... Choking episode ... Choking due to food in larynx ..."

The facility's Diet Spreadsheet Week 3 documented on 9/6/23 the evening meal was substituted for the noon time meal, and mechanical soft diets should receive cheese pizza with soft crust.

The undated facility recipe for Sausage Pizza which included using a biscuit dough crust did not indicate what type of diet it was for, and did not contain any special instructions for mechanically soft diets.

R17's Speech Therapy Plan of Care, dated 9/11/23, documented, " ... Treatment Diagnosis ... Dysphagia, Oropharyngeal ... was referred to skilled speech therapy by nursing staff following a choking episode on 9/6/23 in which (R17) had to be administered the Heimlich maneuver and was found to have pieces of unchewed food blocking her airway ... Diet Level ... Prior Level ... Mechanical Soft ... Current Level ... Puree ..." R17's Speech Therapy Daily Treatment Note documented a 9/14/23 note " ... (R17) was seen during the evening meal with (R17) receiving a tray of puree solids and thin liquids. (R17) is visibly opposed to current puree diet, making statements such as "I'm not eating that" and "that looks gross." A 9/19/23 note, " ... (R17) was seen during the noon meal with (R17) receiving a trial of mechanical soft solids (without bread) and thin

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liquids. (R17) requires supervision through entire meal as impulsive behaviors appear periodically ... demonstrates effective bolus formation and swallow initiation, (minimal) to no oral stasis and effective airway protection ..." A 9/27/23 note, " ... Staff inservice / education provided regarding diet change and maintenance program to maximize (R17's) safety during (oral) intake while providing (R17) with the safest, least restrictive diet ..."

R17's Nurse's Notes, dated 10/28/23 at 12:45 pm, by V4 (LPN) documented, " ... began choking at lunch (related to) was given potato wedges for lunch. Able to encourage resident to cough, staff began Heimlich (maneuver) and potato wedge became dislodged and was in side of throat and this scribe was able to remove with finger sweep. Spoke with kitchen (manager) about approved foods for resident based on diet order ..."

On 11/17/23 at 10:11 am, V4 (LPN) said she was caring for R17 on 10/28/23 during the noon time meal. V4 said R17 was served whole potato wedges from the Dietary staff. V4 said R17 was sitting in the dining room when R17 began to cough, then choked on a potato wedge. V4 said she was able to clear R17's airway by completing the Heimlich maneuver. V4 said V4 then went to the kitchen to speak with V3 (Dietary Manager). V4 said she told V3 that R17 should never be served anything like whole potato wedges, due to R17s frequent choking events. V4 said after the potato wedge was cleared from R17's airway, V4 removed the rest of the potato wedges from R17 plate and R17 received mashed potatoes as a replacement. V4 said EMS was not called due to V4 being able to clear R17's airway.

On 11/16/23 at 2:50 pm, V3 (Dietary Manager) said the potato wedges served to R17 on

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10/28/23 did have a skin on them. V3 said residents with mechanically soft diets should not have been served potato wedges, but instead mashed potatoes. V3 said she did recall speaking with V4 (LPN) about mechanically soft diets, but did not recall the specifics of the conversation due to the conversation happening over two weeks ago.

On 11/21/23 at 9:30 am, V7 (Speech Therapist) stated the facility should not have provided the potato wedge to a mechanical soft diet on 10/28/23, unless it was cut up in small pieces and no skin. V7 went on to state she would expect the facility to follow the diet spreadsheet for a mechanical soft diet. If the spreadsheet indicated mashed potatoes, she would expect them to follow the recipe for mashed potatoes.

The facility's Diet Spreadsheets Week 2 documented on 10/28/23 the noon time meal mechanical soft diets should have received mashed potatoes to replace the potato wedges.

On 11/16/23 at 3:36 pm, V1 (Administrator) said she did not investigate R17's 9/6/23 choking incident because V1 was present, therefore, she had no documentation to provide in addition to what was in the nursing notes for that incident. V1 said she had not completed an investigation on the 10/28/23 incident when R17 choked on a potato wedge due to V1 not having knowledge of the incident until 11/17/23. On 11/21/23 at approximately 2:30 pm just prior to exit, V1 produced a 9/7/23 Quality Improvement Review document that was handwritten by V1 documenting R17's 9/6/23 choking event. The document described R17's 9/6/23 choking event to be different from V4 (LPN) and V5's (LPN) interviews, and documented, "... Staff reported

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resident in DR (dining room) choking. Nurse on duty attending to another resident. (V1) immediately responded. Upon assessment noted resident staring but not talking or coughing. Unable to perform Heimlich (related to) resident size (and) inability to stand long enough. (R17) taken to the floor (and) chest thrusts preformed until food particles able to be observed. Able to extract some of the loose pasty food from airway ... CNA present for meal stated pizza product served. Was soft, cut up (and) bread like, food extracted was wet (and) in small little bits ..."

The facility's Therapeutic & Mechanically Altered Diets policy, revised 10/2020, documented, " ... A mechanically altered diet is a diet specifically prepared to alter the consistency of food in order to facilitate oral intake ... 1. A physician's order is written for all diets including therapeutic and mechanically altered diets ... 3. The Food Service Manager and/ or dietitian write an extension of the regular diets using the same food when possible. 4. The dietitian approves signs and dates all menus ... 8. The facility prepares and serves all therapeutic and mechanically altered diets as planned ..."

The facility's undated Mechanical Soft Diet policy documented vegetables to avoid " ...most raw or undercooked vegetables and those with tough skins ... Fried Vegetables ..." and grains to avoid as " ...Breads, rolls, muffins with dry hard crusts ..."

(A)