STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009948	A. BUILDING: _____ B. WING _____	C 11/14/2024

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CITY VIEW MULTICARE CENTER	5825 WEST CERMAK ROAD CICERO, IL 60804

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S 000	Initial Comments Complaint Investigation 2498586/IL179641	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210d)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 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 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. 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 accident.	S9999		

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These requirements were not met as evidence by:

Based on interview and record review, the facility failed to ensure a cognitively impaired resident on an altered diet did not have access to a regular consistency sandwich. This failure resulted in R5 who was found choking and subsequently died.

The findings include:

R5 is a 60-year-old male admitted to the facility on 8/22/23 with terminal illness under hospice services with diagnoses of frontotemporal neurocognitive disorder, dementia, diabetes, bipolar schizophrenia.

Per facility assessment dated 9/4/24, R5's BIMS (Brief Interview for Mental Status) score was 7 which means R5 has severe cognitive impairment. The same assessment showed R5 was in need of supervision when eating and R5 is up and ambulatory independently.

Physician Order Sheet (POS) dated 10/2024 showed R5's diet order as: no added salt and no concentrated sweets diet, pureed texture, nectar consistency.

R5's progress note dated 10/12/24 timed at 7:45 PM, documents: at approximately 7:40 PM showed staff reported that resident appeared to be choking, Heimlich Maneuver performed, 911 arrived and took over Heimlich maneuver. Resident left via emergency services with a pulse and was breathing.

R5's progress note dated 10/12/24 timed at 8:20 PM, showed a call as received from the local

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hospital ER (Emergency Room) that the resident had expired. Resident was pronounced dead at 7:48 PM, cause of death recorded as "hypoxic cardiopulmonary arrest."

R5's incident report dated 10/12/24 by V8 (License Practical Nurse-LPN) showed "observed resident standing struggling for breath appeared to be choking as he was trying to cough ...attempted Heimlich maneuver and when resident continued to be SOB [shortness of breath], we sat him down on his buttocks and continued Heimlich [maneuver]. I had already instructed staff to call 911. When 911 arrived, they continued Heimlich [maneuver] no food removed and then placed him on cart to hospital."

Emergency Medical Services (EMS Police Dept) report dated 10/12/24 showed, "summoned for 60 year old male unresponsive. Upon arrival patient was found at the nursing home being held up sitting up by nursing staff. Per the staff on scene they state that the patient was eating a sandwich when he began choking. Heimlich maneuver was not being performed by nursing staff. Patient continued choking and [the] crew initiated Heimlich maneuver on the patient. Patient was unresponsive with agonal respirations, crew initiated ventilations on the patient. Patient was transferred to the ambulance where crew continued patient care... Patient became pulseless and initiated ACLS [Advanced Cardiac Life Support] protocols. Patient arrived at the receiving ED [Emergency Department] nursing staff."

R5's ED hospital records dated 10/12/24 showed, "Patient was found choking at nursing home called EMS. Upon EMS arrival at the nursing home, patient was unresponsive but had a pulse.

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said they performed Heimlich maneuver and was transported to ER. On the way patient arrested and intubated patient for airway protection. EMS said after intubation patient arrested...CPR [Cardiopulmonary Resuscitation] was performed. Upon arrival to ER, patient was actively vomiting with ET [endotracheal tube] tube in mouth, information from nursing home showed he was hospice and DNR [Do Not Resuscitate]. CPR was terminated. Confirmed deceased at 7:48PM (10/12/24)."

On 11/8/24 at 3PM, V20 (Medical Legal Investigator (Local County)) said R5's cause of death was: Immediate-asphyxiation-choked on food bolus, Secondary-neuro cognitive disorder manner of death- accident. An autopsy was performed on R5.

On 11/12/ 24 at 8:53 AM, V21 (Medical Examiner (Local County)) said he performed an external autopsy on R5. External autopsy result showed R5 was found with solid foods on his distal trachea. V21 also said that a police report showed that facility staff V8 (License Practical Nurse-LPN) and V12 (Certified Nursing Assistant-CNA) both informed the police responders that R5 grabbed a turkey sandwich and ate the sandwich. (R5 was on pureed diet.)

On 11/8/24 at 10:42 AM, V12 (Certified Nursing Assistant-CNA) said it was after dinner approximately around 7PM. V12 said he was coming out from the dining room after having break. He saw R5 by the elevator wearing just an incontinent brief with no gown on. V12 said he went to R5 to redirect him to his room. "We made few steps then he suddenly stopped, put his head down so I asked him, 'Are you ok?' He did not respond gasped for air, so I called the nurse. The

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Nurse (V22 LPN) came and did the Heimlich maneuver."

On 11/14/24 at 8:28 AM, V22 (LPN) said he was by the nurses' station when he heard V12 (CNA) calling for help. V22 said he ran to R5. R5 was clutching his throat. R5 was trying really hard to cough. V22 said he tried to open R5's mouth and R5's mouth was full of saliva. V22 said he cannot recall if he did a mouth sweep. Heimlich maneuver was done and 911 was called R5 was sent to the emergency room.

On 11/8/24 at 1:30 PM, V8 (LPN) said she was R5's nurse last 10/12/24. At around 6:30ish on 10/12/24, she was in the nurses' station with the other nurse when they were alerted by V12 that R5 appeared to be choking. V8 said she ran by the elevator where R5 and V12 were. R5 was short of breath, gasping for air and not talking. R5 was tall, so R5 was lowered to the floor, the Heimlich maneuver was done, back blows, and abdominal thrust. No food was coming out, did a mouth sweep did not feel any food. 911 was called. Paramedics came and also performed Heimlich maneuver then R5 was brought to the ER. Later, got a call from the ER and asked for his code status. R5 was a DNR. R5 coded on his way to the ER. V8 said she was informed R5 passed away shortly. V8 said R5 is up and able to ambulate independently. R5 has dementia and was on pureed diet. V8 said she does not recall telling the paramedics about R5 having a sandwich. V8 said residents with pureed diets should not have regular sandwich.

On 11/8/24 at 11:15 AM, V13 (CNA) said she was R5's CNA for the day and PM shift last 10/12/24. R5's dinner was pureed food. R5 ate 100%. After dinner V13 walked with R5 to his room

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because he needed to be changed. R5 was provided bedtime care. R5 was left in his room lying in bed with gown and clean incontinent brief. V13 said he later learned R5 was sent to ER due to possible choking. R5 might have gotten up from bed after he was provided bedtime care. R5 was able to walk around independently.

On 11/11/24 at 3:23 PM V23 (CNA) said she was one of the CNAs working on 10/12/24 PM shift. She was in one of the residents room taking care for another resident when she heard what happened to R5. V23 said the incident happened around 7PM. V23 said she had taken care of R5 in the past. R5 is a tall, large guy, able to walk, he can come out in his room, walks around the hallways then goes back to his room. V23 said bedtime snacks come around that time. R5 gets apple sauce. Other resident gets either PBJ (Peanut Butter and Jelly) or turkey sandwich.

On 11/18/24 at 10:15 V16 (Dietary Manager) said she was at the facility that time 10/12/24 during the evening meal. The kitchen was short of staff, so dinner trays were prepared in the kitchen instead of the usual steam table. The menu on 10/12/24 evening meal was grilled cheese sandwich, tossed salad and pudding. V16 said R5 was served pureed diet. After dinner was when bedtime snacks were served that consisted of deli sandwiches- turkey sandwich and peanut butter and jelly sandwich. Residents on puree diets cannot have regular sandwich

On 11/8/24 at 1:10 PM V18 (Assistant Director of Nursing (ADON)) said she was on call (10/12/24) and that evening, she was informed code blue was called on R5. Not sure what happened or how R5 choked. Staff performed Heimlich maneuver and was sent to the hospital via 911.

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R5 expired that same evening. R5 has behaviors of paces and wanders, R5 had declined in cognition that was why he was on hospice.

On 11/8/24 at 2:35 AM V2 (Director of Nursing) said she was informed that on Saturday 10/12/24, R5 was in distress and was sent to the ER via 911. V2 said she was told the incident happened around 7PM when dinner was already done. Dinner was at 5:30ish (PM)
V2 said she was told that V12 (CNA) was the first staff who noticed R5 was having SOB. R5 was trying to talk and cannot talk so he called for the nurses (V8 and V22 both LPN) who performed Heimlich on R5. V2 said R5 was on pureed diet, ambulatory on hospice due to dementia. V2 said V3 (Chief Nursing Officer) did the investigation.

On 11/8/24 at 9:30 AM, V3 (Chief Nursing Officer) said she was the one who did R5's possible choking episode investigation. R5 was able to feed himself on pureed diet. R5 was ambulatory, on hospice services due to dementia and was DNR. V3 said her investigation showed that none of the staff could tell her what happened. V3 said the coroner has an ongoing investigation regarding R5's death.

The updated policy and procedure dated 11/14/24 showed: -Supervision of Residents on Puree diets; residents that are on pureed diet require supervision that they are not able to get non pureed foods as it relates to their swallowing ability as determined by a speech therapist. Delivery of food to the Nursing Units; To ensure that food, such as snacks and meals is always under supervision. The dietary department will ensure that the food delivered is handed to the nursing department or dietary staff are serving the food.

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S9999	Continued From page 7 During this investigation, R5's police report and death certificate were requested, but both were unavailable as of 11/14/24. (AA)	S9999		