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	IL6003024	A. BUILDING: _____ B. WING _____	C 03/26/2025

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S 000	Initial Comments Investigation of Facility Reported Incident of March 20, 2025 /IL188751	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.2040b)2) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

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includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 accidents.

Section 300.2040 Diet Orders

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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.

2) The diet shall be served as ordered.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure R1 was supervised while eating and food items were present within R1's reach. This failure resulted in R1 choking on R1's food and expiring. This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.

Findings include:

The Face Sheet dated 3/22/25 for R1 showed diagnoses including Alzheimer's disease, fracture of neck, type 2 diabetes mellitus, vascular dementia moderate, with psychotic disturbance, deep vein thrombosis, delusional disorder, anxiety, tremors, muscle weakness, and cerebellar stroke syndrome.

The Progress notes for R1 showed on 3/16/25 at 12:27 PM, during lunch resident was having a difficult time swallowing her food (stringy meat) as evidenced by coughing/choking during the meal. Residents' food was cut up into very small pieces and message was left for hospice to return a call to the facility to further discuss the resident's diet. At 2:15 pm, verbal orders received from hospice

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to downgrade resident's diet to mechanical soft texture. POA (Power of Attorney) contacted and in agreement with diet change orders. Diet slip completed and submitted to dietary.

The Physician Orders for R1 showed on 3/16/25 an order was entered for a general, mechanical soft diet.

The Progress Notes for R1 showed on 3/20/25 at 10:37 PM, at 6:00 PM R1 was in the dining room eating supper. A CNA (Certified Nursing Assistant) was sitting beside her. R1 was so fast eating her supper that made her choke. She was already turning blue. She was unresponsive. Did Heimlich maneuver. We brought her to her room and did some suctioning. We were able to get some pieces of food. Resident was grimacing when I was pinching her fingers. At 6:11 PM called the POA and informed him that resident was unresponsive and informed him about what happened. At 6:23 PM, resident was no longer breathing. Vital signs have ceased and eyes fixed. Pronounced death of resident at 6:23 PM. Hospice was notified and said she would call all the parties concerned.

The facility's Incident Report Telephoned to Regional Office form (no date) showed, Date of Incident: 3/20/25; Time of Incident: 6:00 PM. Name of patient/Resident: (R1). Describe what happened, causes(s), injury: Upon investigating it was determined that the resident (R1) was sitting at her regular seat where she was served a general/regular meal for supper on 3/20/25. On 3/16/25 the resident's diet order was changed to mechanical soft. At 6:00 PM the resident began to choke. Staff immediately responded with back blows and Heimlich maneuver. The resident was assisted to her room and the Heimlich was

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continued. The resident went unconscious and was assisted to bed. Suction was attempted. At 6:11 PM, the POAHC (Power of Attorney for Healthcare) was called and requested hospice be notified instead of sending the resident out. Hospice was notified at 6:18 PM ...oxygen saturation 89% on room air, 3 liters of oxygen applied. At 6:23 PM the resident was pronounced deceased. All parties notified. On 3/21/25 a full investigation took place.

On 3/22/25 at 10:35 AM, V8 (Food Service Supervisor) stated, one of our (dietary) staff was passing plates for supper on Thursday night. We were serving pulled pork sandwiches. She got confused; R1 was supposed to have ground meat and got pulled pork instead. V13 Dietary Aide gave the wrong diet to R1. V13 gave pulled pork instead of the ground meat which is mechanical soft.

On 3/22/25 at 1:28 PM, V14 Server stated, I remember someone came in (to kitchen) and said a resident was choking and turning blue. When I came back from break the nurse said R1 ate too fast, choked, and died.

On 3/22/5 at 1:39 PM, V15 Dietary Aide stated she was told that R1 was choking, and someone was helping her. Later the nurse came in with a card and said R1 was dead. V13 didn't know R1 was on a mechanical soft diet and gave her a regular diet. She got bigger pieces than she should have, and it caused her to choke on the food.

On 3/22/25 at 3:34 PM, V3 CNA stated she gave R1 a bite of food and heard another CNA tell one of her other residents to sit down so she went over to check on that resident. V3 stated when

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she was checking the other resident, R1 started choking. The nurse came over and tapped R1 on the back. Two other CNAs came over and rushed R1 to her room. V3 stated sometimes R1 would have to be fed and sometimes not; she was able to do finger foods herself. V3 stated R1 ate fast so if they fed her, she would slow down when eating.

On 3/22/25 at 3:46 PM, V5 CNA stated she was with the nurses when they tried to help R1. They tried to do the Heimlich and tried to suction R1. V5 stated R1 has choked before; she would eat too fast and cough it up. V5 stated most of the time R1 would eat too fast so someone needed to be with her monitoring that.

On 3/22/25 at 4:15 PM, V1 (Administrator) and V2 DON (Director of Nursing) stated the facility has cameras and they saw what happened. They stated V3 CNA had been assisting/supervising R1 for her meal. V3 got up from the table and R1 grabbed food from her plate and put it in her mouth. They stated R1 was very impulsive, and the dietary aides are the ones responsible for removing plates. V2 stated the CNA could have taken R1's plate away. R1 started choking and the nurse was right there and responded right away. V2 stated she asked what R1 choked on, and they told her they were pulling bread out of her mouth.

On 3/23/25 at 12:18 PM, V7 RN stated she was R1's nurse the day that she choked. V7 stated she was at the nurse's station when she heard a commotion in the dining room; someone was choking. V7 stated she went to R1, and she could not talk; her face was turning blue. V7 stated she bent R1 forward and did back blows. V7 stated she did a finger sweep but the blockage was not

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relieved. V7 stated she did the Heimlich; R1 couldn't talk. V7 stated the 2 CNA's put R1 in bed while she got the suction and oxygen. V7 stated they were still trying and doing abdominal thrusts and suctioning. V7 stated small pieces/chunks of meat came out. V7 stated R1 died at 6:23 pm.

On 3/23/25 at 9:45 AM, V8 (Food Service Director) stated she did not have a recipe for the pulled pork. V8 stated the meat for mechanical soft is supposed to be ground to make it safe so there are no chunks of meat. V8 stated her thought with the pulled pork is what if they don't pull it/shred it enough and there are still big pieces. That wouldn't be safe. V8 stated her rule is that meat needs to be ground to the ground beef consistency for mechanical soft. V8 stated the policy for mechanical softs says chop, shred, or grind but she does ground meat and that is what she has always done.

On 3/23/255 at 11:00 AM, V19 (R1's POA - Power of Attorney) stated, he was contacted when this was happening. R1 has been a Do Not Resuscitate (DNR) for a long time and did not want any heroics done. R1 would not have wanted the CCC (continuous cardiac compressions) done, and I would have told the facility to stop. V19 stated he did not want compressions done and neither did R1.

On 3/24/25 at 11:00 AM, V18 (Medical Director) stated on 3/16/25 R1 choked on meat, he was notified, and R1's diet was downgraded to a mechanical soft diet. V18 stated R1 was on hospice and comfort care. V18 stated in R1's case her diet was downgraded to reduce the risk of aspiration and choking. V18 stated R1 choking on the food is most likely why she died. V18 stated it is expected that staff follow diet orders.

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R1's Care Plan dated 12/31/24 showed, Nutritional status: my health problems could affect me nutritionally .... Dietary will provide me a general/mechanical soft, thin liquids with super cereal daily. I eat independently with supervision. R1's care plan did not show that she is impulsive, grabs at food or will eat too fast if not monitored.

On 3/25/25 at 12:37 PM, V2 DON stated, R1's last care plan was done on 12/31/25; she was in her ARD (Assessment Reference Date) period. V2 stated R1's diet was changed on 3/16/25 to a mechanical soft diet. When there is a diet change the registered Dietician will review and update the nutrition care plan. V2 stated R1 had a problem of eating fast; impulsive is the word she would use for her eating. V2 stated R1 needed supervision for meals for that purpose. V2 stated supervision means a staff member would be near her for her meals; not to help her eat but to provide verbal cues to not be impulsive. V2 stated R1's care plan did not show that she is impulsive; it said she fed herself and needed supervision. V2 stated it would have been a good idea to have that on the care plan, so staff were aware of exactly what they were supervising her for. V2 stated what could have been done better in that situation would have been to take R1's plate away, and the care plan could have said the reason R1 needed supervision for meals.

On 3/25/25 at 1:02 PM, V22 LPN (Licensed Practical Nurse/ MDS/Care Plan Coordinator) stated, nursing does nurse related care plans and dietary does the resident's nutrition care plans. V22 stated she coordinates the care plans and conducts the care plan conferences. V22 stated R1 was known for hoarding, eating too fast, and being impulsive with eating. V22 stated this

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S9999	Continued From page 8 should have been on R1's care plan so staff could have been alerted to why R1 needed supervision at meals. R1's MDS (Minimum Data Set) dated 12/17/24, showed partial/moderate assistance needed for eating. The facility's Aspiration Precautions and Choking Prevention Policy (10/3/24) showed, Purpose: To establish guidelines for creating a safe consumption experience and prevent aspiration and/or choking by providing basic nursing interventions to decrease the risk of aspiration. Behavioral risk factors for choking include eating too quickly, putting too much food in their mouth. Ensure food prepared is in accordance with resident dietary orders. (A)	S9999		