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
	IL6004410	A. BUILDING: ______ B. WING ______	09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RETIREMENT VILLAGE	1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073

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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 10/10/19

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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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidence by:

Based on interview and record review the facility failed to provide the necessary care and services for a resident at risk for choking (R12) following an acute choking episode on September 7, 2019. This failure resulted in R12 having a second choking episode on September 10, 2019 that resulted in R12 requiring CPR (cardiopulmonary resuscitation), emergent transport to the hospital, and hospitalization. R12 expired on September 12, 2019 from choking, and cardio-pulmonary arrest.

This applies to 1 of 31 residents (R12) reviewed for quality of care in the sample of 31.

The findings include:

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R12's Care Plan dated August 19, 2019 showed R12 was cognitively impaired with diagnoses including dementia and dysphagia (difficulty swallowing), oropharyngeal phase. R12's Care Plan also showed to monitor, document, and report any signs and symptoms of dysphagia which included choking, coughing, and pocketing of food.

R12's Admission Summary Note dated August 19, 2019 showed R12 was readmitted to the facility after being hospitalized for hypoxia and aspiration pneumonia. R12 was readmitted on a pureed diet with honey thickened liquids.

R12's Speech Therapy Plan of Care showed R12 received speech therapy services from August 22, 2019 through September 11, 2019, due to (R12's) diagnosis of dysphagia.

A Physician Order for R12, dated September 5, 2019, showed R12's diet was upgraded to regular texture, regular consistency.

R12's Health Status Note dated September 7, 2019 at 5:31 PM showed R12 choked during the evening meal (first choking episode in the facility). R12's face began turning blue and (R12) required back blows by facility staff to facilitate coughing and removal of food from (R12's) mouth. The Note showed R12 "opened (R12's) mouth, food was scooped out of (R12's) mouth, and (R12) coughed and spit out chunks of unchewed bread and fish ..."

R12's Discharge Summary Note dated September 10, 2019 at 5:15 PM, showed R12 choked a second time, during the evening meal. The Note showed R12 began choking on food,

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became unresponsive with no palpable pulse, and required CPR. R12 was transferred to a local hospital emergently via ambulance.

R12's hospital Emergency Department Documentation dated September 10, 2019 showed R12 arrived to the emergency room "in an unresponsive state after a choking episode in a nursing home, with no pulse...CPR performed briefly and paramedics attempted intubation without success secondary to food obstruction ..." R12's hospital Physician Documentation showed R12 was declared brain dead and expired on September 12, 2019.

On September 17, 2019 at 1:48 PM, V4 Speech Therapist (ST) stated he began treating R12 in August 2019, for dysphagia. V4 stated, "(R12) needed supervision with eating and repeated cues to take small bites and slow down when eating. He did not have great safety awareness when eating due to (R12's) cognition. I upgraded (R12's) diet to regular consistency on September 5, 2019, because (R12) had been doing ok with regular consistency foods during therapy." When V4 ST was asked why R12's diet was not downgraded immediately after (R12's) first choking episode on September 7, 2019, V4 stated, "I was aware (R12) choked on September 10. I was not notified (R12) choked on September 7. I would have downgraded (R12's) diet immediately on September 7 if I had known (R12) choked."

On September 17, 2019 at 2:00 PM, V5 Licensed Practical Nurse (LPN) stated she was the nurse caring for R12 on September 7 and 10, 2019, during both of R12's choking incidents. V5 stated that on September 7, 2019, during R12's first choking incident, R12 "began choking in the

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dining room while eating dinner. (R12's) lips got blue and (R12's) mouth was full of food ...The CNA (certified nursing assistant) hit (R12) on the back a few times and (R12) started coughing and spitting out food. We did get the food out and took (R12) to the bathroom to get (R12) cleaned up. No, I never notified (R12's) doctor about this. I didn't tell anyone about (R12) choking but I did write about it in (R12's) chart. I figured they would read the note on Monday. I didn't downgrade (R12's) diet. I didn't really even think about doing that." V5 LPN also stated she did not consider R12's first choking episode on September 7, 2019, a major concern at the time.

On September 17, 2019 at 2:25 PM, V6 Physician stated, "I had absolutely no idea (R12) had a choking episode on September 7. Had I known this, I would have immediately downgraded (R12's) diet on September 7. I was not notified of any of this. I just knew (R12) choked on September 10 and expired in the hospital."

On September 17, 2019 at 1:55 PM, V3 Nursing Supervisor stated V5 LPN never notified her of R12's first choking incident on September 7, 2019. V3 stated, "Nurses can immediately downgrade a resident's diet after a choking episode. We don't need to wait for a physician's order to do so. The expectation is that we (nursing administration) and the physician are immediately notified of all choking episodes."

On September 18, 2019 at 9:05 AM, V9 Registered Nurse (RN) stated, "If a resident had a choking episode, I would immediately downgrade that resident's diet and call the doctor. Every nurse should know what to do when a resident chokes. It's basic nursing."

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	The facility's Diet Orders Policy (undated) showed, "6. Speech/MD/Nursing is able to downgrade (diet) if there is a change in condition or resident request, or staff concern." (A)			