STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1035)3)4)5) 300.1035b)2) 300.1210a) 300.1210b) 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 300.1035 Life-Sustaining Treatments 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. b) For the purposes of this Section: 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated. 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 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	S9999		

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review and interview, the Facility failed to provide appropriate actions to clear a resident's airway when found choking on food; and failed to provide Cardio Pulmonary Resuscitation (CPR) when becoming unresponsive after choking on food for 1 of 21 residents (R2) reviewed for choking in the sample of 21. This failure resulted in R2 expiring in the Facility due to an Airway Obstruction. This has the potential to affect 20 residents (R1, R3 thru R21) in the sample who were identified as having swallowing problems with a potential for choking who currently reside in the Facility.

Findings include:

1. The Facility Occurrence Investigation and R2's Nurses Notes, dated 7/28/15 5:40 PM, per E11,

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Licensed Practical Nurse (LPN), document, "I was called to the dining room, with resident coughing. (E7, Certified Nurses Aide) CNA told me that (R2) was choking on a hamburger and I attempted to get resident to spit it out, resident would not and kept chewing what was left in her mouth at this time. (R2) began to wheeze and I attempted a finger sweep with no results and Heimlich performed with no results. (R2) taken back to room, with oxygen applied and another finger sweep attempted with no results. I returned to the desk and called 911 and (R2's) POA (Power of Attorney). I went back to resident's room and (E9, Registered Nurse, RN/ Nurse Manager) was in with (R2). (E9) stated that (R2) had no pulse, but still had some shallow breathing. Ambulance arrived, and placed monitor on resident and stated that (R2) was 'gone.' When the POA was notified, the POA said that she would meet (R2) and the ambulance at the hospital. Earlier in the shift, (R2) was not feeling well and I had notified (Z1) her physician about this. (Z1) ordered laboratory work to be done. Lab work was obtained and sent to hospital, with the order to continue to monitor (R2) at this time. (Z1's) office had called back and wanted (R2) to be started on an antibiotic for a Urinary Tract Infection. The antibiotic was started at 5:35 PM without any difficulty swallowing. At 6:15 PM, the hospital called and said that (R2) had a critical hemoglobin of 7.7."

The Occurrence Report documents a statement dated 7/28/15 at 7:46 PM, made by E7: "I was feeding (R2) the regular food that I was given for her. I was feeding her tiny bites. (R2) started to choke and gasp for air. I told (E8, CNA) to run and get (E11). (E11) came in and asked me what was wrong and I told (E11) that (R2) was choking and couldn't breathe. We tried digging the food

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our of her mouth but, couldn't get it. Her lips started turning blue/purple."

E2, Director of Nursing (DON), stated in an interview on 8/11/15 at 10:00 AM, that Facility nurses receive training on the Heimlich Maneuver and CPR from the American Heart Association. E2 said that the CNA's can obtain training on CPR on the computer, but they are not mandated by the Facility to complete the training. E2 said that CNA's do not receive any hands-on training for the Heimlich Maneuver or CPR. On 8/12/15 at 1:44 PM, E2 said that during the Facility investigation into R2's death, she did not realize that staff had only performed one abdominal thrust in an attempt to clear R2's airway however, she was aware that staff did not start CPR. E2 stated that currently there are 20 residents in the facility, R1 and R3 through R21, who are identified as having swallowing problems and are potentially at risk for choking.

On 8/11/15, at 2:25 PM, E7 stated that he was in the dining room helping feed residents supper on 7/28/15. E11 told E7 that R2 needed to be fed promptly. E7 said that E11 stated "You need to help (R2) eat - she's a feeder." E7 said that R2 had seemed a bit tired that day and normally ate independently. E7 said that he and R2 had been talking and laughing at the supper table. R2 had french fries and a hamburger cut into fourths on her plate. E7 said he gave R2 a small piece of hamburger and told her to chew. E7 then gave R2 another piece of hamburger from the edge of the burger and R2 "began acting weird - she started coughing and gasping." E7 said that he patted R2 on the back a couple of times and told E8, CNA, to go and get the nurse, E11. E7 said that E11 gently patted R2 on the back and said "Can you spit it up?" E7 said that R2 did not

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respond and would not open her mouth. R2 was gasping, coughing and began turning blue. E11 attempted one abdominal thrust while R2 was sitting in her wheelchair. E7 said "I think something was stuck in (R2's) airway." E7 said that E11 then wheeled R2 to R2's room with R2 sitting in her wheelchair and E10, CNA, holding R2's feet up. E7 went to get the blood pressure cuff and stethoscope. E7 said four staff members hoisted R2 into her bed and E7 then left R2's room. E7 said that all of the resident's who need to be fed by staff sit in one area of the dining room - that is how the CNA's know that someone is a "feeder." E7 said that R2 was not sitting in that area and the only reason that E7 was feeding R2 on 7/28/15 was because E11 told E7 to feed R2.

E10, CNA, stated in an interview on 8/11/15 at 2:05 PM that he was standing in the hallway when he saw E11 rush R2 to her room. E10 said "I saw that something was wrong so I grabbed (R2's) legs, and helped (E11) get (R2) to her room. Four of us put (R2) to bed - (E8, E11, E21) and myself. We could not get (R2's) pulse and her blood pressure was very irregular and thready. (R2) was gasping for air - they were short, shallow breaths. I didn't know that (R2) had choked, but (E11) told me while were in the hallway. (E11) left (R2's) room to call the ambulance. (E8, E21) and I were trying to get (R2) to respond. (E9) came into (R2's) room and checked (R2's) pulse. (E9) thought (R2) might have a weak pulse, but wasn't sure. We put an oxygen mask on (R2) as she took her final gasp of air. I didn't see anything in her mouth. Nobody did the Heimlich maneuver nor did anyone start CPR (Cardiopulmonary Resuscitation). The ambulance took about 15 minutes to get there. The EMT's (Emergency Medical Technicians)

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said there was nothing they could for (R2) as she was gone." E10 said that he has not been given any training by the Facility on what to do if someone is choking. E10 said "I don't think that they should have taken (R2) to her room and laid her down. I think they should have started life saving measures in the dining room."

On 8/11/15 at 1:53 PM, E11 said that during the supper meal on 7/28/15, E8 walked up to the Nurses Station and said E11 was needed in the Dining Room . "I got up and walked to the Dining Room. I did not know there was a rush. I went into the Dining Room, (E7) called me over and said that (R2) was choking. (R2) was breathing. I told (R2) to spit out the food. (R2) kept chewing so I tried to get the food out of her mouth. I tried putting my fingers in her mouth, but (R2) was clamping down with her teeth. (R2) started wheezing. I reached around and did the Heimlich maneuver while she sat in the wheelchair. I only did one abdominal thrust. (R2) kept chewing. I told (E7) that we needed to get (R2) back to her room. We got (R2) to her room and she was unresponsive. (R2) was still breathing, but wheezing and with shallow breaths. I tried to do a finger sweep, but didn't feel anything. (E9) came in and took over so I left to call 911. I told (E9) that I had done the Heimlich one time. (R2) was a DNR (Do Not Resuscitate) so we didn't do anything else. (R2) quit breathing right before the ambulance came. (E9) said that (R2) had taken a little gasp and stopped breathing. The EMT's came in and I told them that (R2) had choked. The EMT's said that (R2) was already 'gone' and they left. It was 6:13 PM. I called (Z1, R2's Physician) and he said it sounded like (R2) aspirated. (E9) told me that (R2) was 'gone' when we put her into bed. I have been trained by the Facility after this happened but no one has

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ever told me to do the Heimlich Maneuver more than 1 time. I didn't know that you should do CPR on someone who is choking if they have a DNR."

On 8/12/15, at 2:20 PM, E11 said that R2 had not eaten on 7/28/15. E11 said "My intent was for (E7) to sit with (R2), but he started feeding her."

E9, RN, Nurse Manager, said on 8/11/15 at 1:36 PM, that he had been outside the Facility on break during the evening meal on 7/28/15. E9 said that he came into the building as he heard an urgent page on the overhead. E9 said that staff had taken R2 to her room and placed her into bed. E9 said "I went into (R2's) room and saw that she was unresponsive. (R2's) eyes were fixed and she had agonal breathing. There were 4 or 5 people standing around in (R2's) room. One of the CNA's was trying to take (R2's) blood pressure. (E11) left (R2's) room to call someone, maybe the ambulance, (R2's) physician or (R2's) POA. I tried to get (R2's) pulse so I went and got the Pulse Oxymeter Machine. We had oxygen going on (R2). Her color was dusky, but she had a faint pulse. It was difficult to assess her heart sounds as she was obese. The EMT's got there about 10 minutes later. The EMT's said 'Why did you call us? This lady is gone!' (R2) was a DNR so we did not attempt resuscitation. She had been very depressed - she had said that she wanted to die." E9 said that he did not record any of what occurred with R2 in writing. E9 could not remember who was present in the room with R2. E9 said that he would not attempt CPR on a resident who has a DNR even if they become unresponsive due to choking.

E8, CNA, was interviewed on 8/11/15 at 2:51 PM.

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E8 said that staff would always encourage R2 to eat and that she would eat ice cream "all day long." E8 said that staff normally did not feed R2. E8 said "I was passing trays in the dining room when I heard (E11) tell (E7) to feed (R2). Then, I saw (E11) go over to (R2) and stick her fingers in (R2's) mouth. (R2) was biting down. (E11) did the Heimlich maneuver to (R2) one time. By that time, (R2) was slouched over and had no expression on her face. I told (E11) that (R2's) lips were turning blue. (R2) was gasping for air. I went to get oxygen from (E23, LPN) and she said to ask (E22, LPN) as she was going on break. (E22) was on the telephone so I had to wait for her to finish her call. (E22) handed me the keys for the oxygen room and I got the portable oxygen. By that time, staff were bringing (R2) down the hall. (R2's) lips were purplish/blue and she was pale. Somebody said that we needed to get the sit-to-stand lift to get (R2) into bed. Instead, we manhandled her into bed. We put oxygen on her and (R2) was gasping. We found out she was a DNR so we didn't do anything else. We tried 4 - 5 times to get (R2's) pulse or blood pressure and couldn't get one. (E9) couldn't get one either. The EMT's came and said that (R2's) face was fixed already. We told the EMT's that she choked." E8 said that she had not been trained by the Facility on what to do when someone is choking. E8 said that she could not remember what to do when someone is choking. E8 said that she guessed that you see if there is something in the persons mouth if they are choking.

E24, Speech Therapist, stated on 8/12/15 at 9:38 AM, that she had started working with R2 in early July 2015. E24 said that she first started seeing R2 for cognition as she seemed confused and was talking about her dead husband. During R2's

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evaluation, E24 noticed that R2 was sitting poorly in her wheelchair with her head tilted back. E24 gave R2 water and she coughed a little. E24 said that she had previously worked with R2 for swallowing. E24 said that she then asked some of the CNA's how R2 ate and they said that R2 occasionally choked on her food. E24 said that R2 would take large bites and needed to be cued to take smaller bites. E24 said that R2's food needed to be cut up and placed towards R2's right side due to her previous Cardio Vascular Accident (CVA). E24 said "I told (R2) that we needed to downgrade her diet and give her ground meat, and (R2) said she didn't like it. I told her either we needed to downgrade her diet or work with (R2) to eat regular food. I did tell some of the CNA's (I don't remember who) to REALLY cut up her food but, it was not documented. I usually write up a plan when I finish working with a resident. I saw her three times a week so, I probably saw (R2) about 6 times for swallowing problems. It can take one to two months to complete the process and make recommendations. (R2) fed herself - I don't know why she was being fed that meal."

Z1, R2's Physician, was interviewed by telephone on 8/12/15 at 11:15 AM. Z1 said that R2 had previously had a major stroke and anyone who has had a stroke is at risk for choking. Z1 said that Facility staff should have done the Heimlich Maneuver repeatedly on R2 to clear the obstruction in R2's airway and implemented life saving measures. Z1 said "I would have expected a real, repeated effort to clear (R2's) airway. My understanding is that staff did not follow through because (R2) was a DNR, and they should not have stopped. Choking to death is not a good way to die."

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S9999	Continued From page 10 On 8/12/15 at 1:55 PM, E22 stated that "I was not aware until the inservice training I received today, that you do the Heimlich Maneuver on someone who is choking and is a DNR followed by CPR." R2's Ambulance Service Patient Care Report documents "7/28/15, Call Received at 6:01 PM. Arrived on scene at 6:04 PM. We were called out by 911 for a woman choking and moving very little air. Upon arrival, we found (R2) laying in bed with a CNA and nurses around the bed. They said that they just got her back into bed after choking in the dining room. There was a CNA hooking the oxygen mask over (R2's) face, about 3-4 inches above her face and 2 liters of oxygen running. (R2) was not breathing and did not have a pulse in her arm or at the carotid. (R2's) eyes were already fixed and had mucous starting to form. The nurse said that (R2) was a DNR. The monitor was put into place and it confirmed in all three leads that her rhythm was asystole. The charge nurse called the coroner." R2's Facility Facesheet documents that she was originally admitted to the Facility on 7/8/14 with diagnoses, in part, of Dense Left Hemiplegia due to CVA, Dysphagia, Hemiplegia and Cognitive Deficit. R2's most recent Minimum Data Set (MDS), dated 6/23/15, documents that has a Brief Interview for Mental Status (BIMS) score of 13, which means that she was cognitively intact; and required supervision with setup help for eating. R2's clinical records document a Physician's Order, dated 4/29/15, for "regular diet, regular texture and regular consistency of liquids." R2 also has a Physician's Order, dated 7/4/15, which documents "Skilled Speech Therapy 3 times a week for 8 weeks for treatment of Dysphagia and Cognition. Treat to decrease the risk for aspiration."	S9999		

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R2's Speech Therapy Plan of Care, dated 7/3/15, documents "Reason for Referral: Dysphagia. This 68 year old female with a history of acute CVA last year has been experiencing increased difficulty with her cognitive abilities. Nursing reporting that patient has been confused and asking about her late husband as if he were still alive. Patient has also been demonstrating choking episodes during meals. These have reportedly involved patient coughing, loosing her voice and her face turning red. ST (Skilled Speech Therapy) services are necessary for patient to decrease her risk for aspiration and improve her cognitive skills. Without ST, patient is at risk for worsening confusion and risk for aspiration and choking. Rehabilitation Outcome Measure: Swallowing - moderate to severe."

R2's current Facility Plan of Care, dated 7/9/15, does not document R2's swallowing problems. E2, Director of Nursing (DON) confirmed in an interview on 8/11/15 at 10:00 AM that the Facility did not develop a plan of care for R2's swallowing problems. E2 said that she inserviced staff on 7/31/15 concerning residents experiencing aspiration, swallowing problems and pocketing food. E2 said that the inservice did not include what to do if a resident is choking.

R2's "State Certificate of Death Worksheet", with a certification date of 7/29/15, documents that R2's primary cause of death was "Airway Obstruction." The approximate interval between onset and death is documented as "10 minutes." R2's secondary cause of death is documented as "Swallowing Dysfunction" with an interval between onset and death of "2 years."

The Facility's Emergency Procedure for Choking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004428	A. BUILDING: _____ B. WING _____	C 08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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S9999	Continued From page 12	S9999		

policy documents: "The purpose of this procedure is to prevent choking by expelling the foreign body airway obstruction.
Conscious Resident - Standing or sitting:
1. Ask the resident if he/she is choking. REMEMBER, a choking victim cannot speak or breath and needs your help immediately.
2. Ask the resident to cough or speak it at all possible to determine if his or her airway is obstructed.
3. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign object.
4. Call for help, but stay with the resident.
5. Quickly assure the resident that you are going to stay and assist him or her.
6. If the resident cannot cough, only then should abdominal thrusts be performed as follows:
a. Stand behind the resident.
b. Wrap your arms around the resident's waist.
c. Make a fist with one hand.
d. Place the thumb side of your fist against the resident's upper mid-abdomen, below the ribcage and above the navel.
e. Grasp your clenched fist with your other hand.
f. Press your fist into the resident's upper abdomen with a quick upward thrust.
g. Do not squeeze the ribcage. Contain the force of the thrust to your hands.
h. Repeat the thrusts until the foreign body is expelled or the resident loses consciousness.

Unconscious Resident - Lying Down (or when unable to reach around the resident).
1. Ease the resident gently as possible to the floor.
2. Call for help if assistance is not readily present but do not leave the resident unattended.
3. Position the resident on his or her back with the arms to his/her side.

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S9999	Continued From page 13	S9999		

4. Perform abdominal thrusts as follows:
a. Facing the resident, kneel down and straddle the resident's upper thighs with your body.
b. Place the heel of one hand on the resident's upper mid-abdomen, below the rib cage and above the navel and with fingers pointed toward the resident's chest.
c. Place the other hand directly over the positioned hand.
d. Bring your shoulders forward over your hands.
e. Use your body weight to press your hands into the resident's upper abdomen with a quick upward thrust.
5. Perform the finger sweep maneuver to check for a foreign body as follows:
a. Keep the resident's face up.
b. Perform the tongue-jaw lift to open the resident's mouth. (Note: moving the lower jaw moves the tongue off the throat and opens the airway.)
c. Perform the finger sweep using your index finger as a hook.
1. Insert your index finger into the resident's mouth along side of the cheek and across the base of the tongue.
2. Try to remove any foreign objects.
3. Avoid pushing foreign objects deeper into the throat.
4. Turn the resident's head to one side if needed to sweep an object from the mouth.
6. Alternate steps 4 and 5 until the object is expelled. Arrange for the resident to be evaluated by a physician immediately after the foreign body airway obstruction has been removed.
7. If unable to clear the foreign body from obstructing the airway, arrange emergency transport of the resident to the nearest acute care medical facility.

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8. Proceed with CPR immediately if the resident has no pulse or respirations.

The person performing this procedure should record the following information in the resident's medical record:
1. The date and time the procedure was performed.
2. The name and title of the individuals who performed the procedure.
3. The exact time the choking began.
4. The exact time of any unconsciousness.
5. All assessment data obtained during the procedure.
6. The time the procedure was started and stopped.
7. The resident's response to the procedure.
8. The signature and title of the person recording the data."

The American Red Cross First Aid Recommendations for Choking document:
1. Have someone call 911.
2. Obtain consent from the victim.
3. Lean the person forward and give 5 back blows with the heel of your hand.
4. Give 5 quick, upward abdominal thrusts.
5. Continue alternating back blows and abdominal thrusts until: the obstructing object is forced out and the person can breathe or cough forcefully on his own, or until the person becomes unconscious.

The American Red Cross documents the following recommendations to follow for the unconscious choking adult:
Try 2 rescue breaths. Each rescue breath should last about 1 second. If breaths do not go in, tilt the head farther back. Try 2 rescue breaths again. If the chest does not rise - give 30 chest

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compressions in about 18 seconds. Look for an object in the airway. Remove if one is seen. Try 2 rescue breaths. Repeat until EMS responders arrive or the obstruction is removed and the patient begins to breathe on his/her own.

E2 stated in an interview on 8/11/15 at 10:00 AM, that Facility nurses receive training on the Heimlich Maneuver and CPR from the American Heart Association. E2 said that the CNA's can obtain training on CPR on the computer but, they are not mandated by the Facility to complete the training. E2 said that CNA's do not receive any hands-on training for the Heimlich Maneuver or CPR. On 8/12/15 at 1:44 PM, E2 said that during the Facility investigation into R2's death, she did not realize that staff had only performed one abdominal thrust in an attempt to clear R2's airway however, she was aware that staff did not start CPR. E2 stated that currently there are 20 residents in the facility R1, and R3 through R21, who are identified as having swallowing problems and are potentially at risk for choking.

(A)

IMPOSED PLAN OF CORRECTION

Name of Facility: Hillsboro Rehab & HCC
Date and Type of Survey: IRI of 7/28/2015/IL79202 of 8/19/2015

300.610a)
300.1035)3)4)5)
300.1035b)2)
300.1210a)
300.1210b)
300.3240a)

Attachment B
Imposed Plan of Correction

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 300.1035 Life-Sustaining Treatments

3) procedures for providing life-sustaining treatments available to residents at the facility;

4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;

5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.

b) For the purposes of this Section:

2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions,

and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated.

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 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.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

THIS WILL BE ACCOMPLISHED BY:

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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 by conducting the following:

1. Conducting in-service with staff on Heimlich procedures, identification of swallowing problems and mock code simulations.
2. Identifying and reporting residents who are at risk for choking or swallowing difficulties.
3. Placing Heimlich and CPR signage placed in dining areas and other prominent areas throughout the facility
4. Review and revise policies emergency response policies
5. Inspect and test suction equipment to ensure equipment is in proper working order
6. Documentation of in-service training and preventative maintenance records will be maintained by the facility.
7. The Administrator and Director of Nurses will monitor Items I through VII to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: TEN (10) days from receipt of the Imposed Plan of Correction.

LJK/9/15/2015