STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000756	A. BUILDING: _____ B. WING _____	07/26/2022

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HERITAGE HEALTH-JACKSONVILLE	873 GROVE STREET JACKSONVILLE, IL 62650

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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)6) 300.2040b) 300.2040e) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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 b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. e) A therapeutic diet means a diet ordered by the physician 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). Section 300.3240 Abuse and Neglect	S9999		

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S9999	Continued From page 2 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 Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supervision while eating for residents with potential choking hazards for 5 of 5 residents (R41, R46, R57, R216, R217) reviewed for supervision to prevent choking. This failure has resulted in R57, R216, and R217 choking that resulted in death related to the incidents of choking. Findings include: 1. R57's Health Status Note, dated 7/13/22 at 1:21 PM, documents, "housekeeper yelled out 'hey i think she needs some help in here'. Writer ran to resident room noted resident sitting in bed, head of bed up meal tray in front of her. When staff asked what she needed writer noted res (resident) unable to talk food running out of her mouth and down her clothing writer asked again if she was choking unable to respond verbally just looked at nurse. Mouth sweep done small amount of food obtained, writer gave several back thrusts continued with nonverbal. Writer yelled at housekeeper to get help, another nursing staff member, and emergency equipment. CNA (Certified Nurse Aide) arrived assisted resident with abdominal thrusts from in bed resident became unresponsive lips turning and fingertips turning blue, pulse obtained at this time. resident assisted to floor per 2 CNAs DON (Director of Nurses) arrived writer went to call 911	S9999		

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S9999	Continued From page 3 and get confirmed code status. DON AND CNA's remained with resident." R57's Health Status Note, dated 7/13/22 at 1:25 PM, documents, "This writer entered the room and observed resident minimally responsive with her eyes open and gasping for air. Two staff are present in the room attending to resident. Pulse present to radial pulse upon palpation. Elevated head and suctioned resident. Performed Heimlich Maneuver performed. HR (heart rate) 32, SPO2 (oxygen saturation) at 85%. Applied Oxygen via non rebreather mask at 10L (liters). Remain with resident until paramedics arrived." R57's Health Status Note, dated 7/13/22 at 1:25 PM, documents, "911 called at this time." R57's Health Status Note, dated 7/13/22 at 1:27 PM, documents, "Ambulance/paramedics here in facility." R57's Health Status Note, dated 7/13/22 at 1:30 PM, documents, "Writer called (V48, R57's Power of Attorney- POA) informed of current status and res choking paramedic with resident now." R57's Health Status Note, dated 7/13/22 at 1:37 PM, documents, "Paramedics working with resident unable to obtain vitals called passing at this time." R57's Health Status Note, dated 7/13/22 at 1:50 PM, documents, "Writer called to have (V49, Coroner) paged regarding passing of resident at this time." R57's Health Status Note, dated 7/13/22 at 2:04 PM, documents, "(V49) returned call informed res had passed called by paramedics/informed of	S9999		

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S9999	Continued From page 4 circumstances following up to death. (V49) informed that staff may return resident to bed hold body until had a chance to talk with family." R57's Face Sheet, print date of 7/14/22, documents R57 was admitted on 1/28/21 and has medical diagnoses of Myasthenia Gravis, Hemiplegia and Hemiparesis following Cerebral Infarction, Dysphagia (difficulty swallowing) following Cerebral Infarction affecting right dominant side, Dysarthria (difficulty with speech) and Anarthria (inability to articulate speech in the absence of any deficit both of auditory comprehension and of written language. R57's Minimum Data Set (MDS), dated 5/4/22, documents that R57 was cognitively intact, requires extensive assist of two staff members for bed mobility and is totally dependent on 2 staff members for transfers. This MDS further documents that R57 requires supervision and one person physical assist with eating and R57 has range of motion limitation of one side on both the upper and lower extremities. R57's Order Summary Report, Active Orders as of: 7/13/22, documents, "REGULAR diet, Easy to Chew (Mech) (EC7) texture, Moderately Thick (Honey) consistency and DNR (Do Not Resuscitate)." R57's Care Plan, dated 5/18/22, documents, "(R57) is at risk for wt (weight) fluctuations. dx (diagnoses) dysphagia, diabetes type 2, history of stroke, with hemiparesis and Hemiplegia rt (right) dominant side. 4/27/22, dietician requested due to gradual weight loss, a diet change from low concentrated sweets to regular. Interventions: Provide divided plate/wt (with) built up utensils. Provide, serve diet as ordered by MD (Medical	S9999		

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S9999	Continued From page 5 Doctor). Sit upright for all meals and provide supervision." R57's Care Plan, dated 5/18/22, documents, "ADL (Activities of Daily Living) r/t (related to) CVA (Cerebral Vascular Accident) with right sided weakness, cognition deficits/poor safety awareness and poor balance, DX of Myasthenia Gravis. Res has RT sided hemiplegia/flaccidity from stroke, dysphagia, RT wrist/hand decreased ROM (range of motion)/contracted. Interventions: Eating, feeds self with set up, sit upright for all meals and supervision, may need assist at times." The Facility's Dietary Spread Sheet, dated week 3 Wednesday, documents, "Easy to Chew / Mech (EC7) 4 oz (ounces) Chop meatloaf w (with) / 2 oz. gravy, #8 scp (scoop) mashed potatoes, 2 oz L (ladle) gravy, 4 oz S (scoop) Brussels Sprouts, 1 each bread/ Marg (margarine), 4 oz watermelon, no seeds, 8 fl (fluid) oz milk." R57's Care Plan, dated 12/23/21, documents, "Advanced Directives. I have formulated advanced directives. No code." R57's Health Status Note, dated 7/13/22 at 2:25 PM, documents, "(V49) returned called informed writer that (V48) has no concerns with what happened with death had no issue due to resident had frequent issues with swallowing since stroke. POA is very happy with the care she has received during her stay here and is ok with going ahead to release the body to the funeral home. "(V49) informed writer she has no issues at this time happy with POA response order May release body to Funeral Home when ready." On 7/13/22 at 1:25 PM, V31, Licensed Practical	S9999		

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Nurse (LPN), stated, "(R57) was choking. The housekeeper said that (R57) needed help. I ran down there. I got there and she couldn't talk and she was just staring. I was trying to do the Heimlich on her, but she was like dead weight. She had a pulse. I tried to do a finger sweep, but I couldn't get anything. I yelled to get the crash cart and call 911. She had a pulse, but they lost it about a minute ago. The paramedics are working on her now there are so many people in there now."

On 7/13/22 at 2:00 PM, V36, Housekeeping, stated, "I just finished cleaning that room (pointing to R57's neighbor's room) and was coming up this way. I always look in the rooms as I walk by. I noticed she (R57) was in bed and having trouble. I thought she was choking so I went up and told the nurse that I thought R57 was choking, and she (V31) ran down the hall to her." When asked if anyone was in the room helping (R57) eat, (V36) stated, "No, she (R57) was alone."

On 7/13/22 at 4:45 PM, V35, LPN, stated, "During my medication pass, (V39, CNA) came and told me (R57) would not wake up to eat. I told her to cover up her tray and try again later. I told both her and (V28, CNA) that we would try later to get her up and feed her. Everyone knew that she was supposed to be supervised during meals because she was thickened liquids. I was at break. I just got my food and they told me (V31) needed me because of (R57). When I got to the room, (R57) was on the board on the floor and (V2, Director of Nurses-DON) was suctioning her at the time. She (R57) told me about a month and a half ago that she was 97 years old, and she didn't want to get out of bed anymore and she wanted to eat in bed. They told me yesterday she went out to the dining

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S9999	Continued From page 7 room for lunch. I don't know how they got her out there." On 7/13/22 at 4:52 PM, V28, CNA, stated, "(V50, CNA) called me in there and I put the bedside rail down and I was able to position her (R57) where I could stand on the floor and get behind her and I did the Heimlich. She did throw up a little bit and some food was visible in her mouth, so I cleaned that out of her mouth. During this process, (V31) told (V50) to get the back board and then we got her on the ground. This is my first time working with her, but I do know that she ate in the dining room at a regular table. I really don't know how she got her tray today." On 7/13/22 at 4:55 PM, V31, LPN, stated, "I was at the nurse's station and (V6, Dietary Manager) came up and said (V36) needs you. I ran down the hall yelling. She (V36) yelled I am in (R57's) room. I went in she (R57) was sitting up in bed. It looked like she threw up some green stuff on her, her tray was in front of her, and it looked like she pushed it away a little. She had whole brussel sprouts on her tray. I don't know about the rest. I just saw the brussel sprouts because of the green. I asked her if she was choking. She couldn't answer. She was just staring at me. I leaned her forward and hit her on her back a few times. It didn't help. I couldn't get behind her or move her by myself. (V28) came in and we were able to move her enough for (V28) to get behind her and do the Heimlich. (R57) lips and the tips of her fingers started turning blue, so I knew I needed someone to get me the back board and suction machine. By the time we got her on the floor, (V2, DON) came in and told me 'I am here, you go call 911 and check her code status'." On 7/13/22 at 5:15 PM, (V39, CNA) stated, "I sat	S9999		

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S9999	Continued From page 8 her (R57) up and tried to wake her up and I gave her her tray. She had a whole meatloaf piece and mashed potatoes. I don't know if the brussel sprouts were whole or not. She had three thickened drinks. I went and told the nurse (V35) that she was sleepy, and she said we will try again later. She would eat in her room all by herself all the time. I guess she woke up and started to eat." On 7/14/22 at 12:47 PM, V44, Dietary Field Supervisor for the Heritage Corporation, stated, "EC7 is an easy to chew diet it is the International Dysphagia Diet Standardization Initiative." When if brussel sprouts are on an easy to chew mechanical diet, V44 stated, "Yes they are." On 7/14/22 at 1:45 PM, V2 stated, "So I was in the hallway, they said, someone said someone is choking so I started running to where all the people were. I said get the suction machine to (V51, Admission Coordinator). She grabbed the crash cart it has suction on it. I got to the room (R57) is already on the floor on a back board. 2 CNA's are in the room, (V28) is at her head and (V34) is at her chest. (V34) had her hands on her chest, I didn't see her doing CPR (cardiopulmonary resuscitation), but she told me she did. There was not a nurse in the room. I do know that (V31) had been in the room maybe she was calling 911." When asked if she told (V31) to leave the room that you were there and go and call 911, V2 stated, "I don't remember that." V2 stated, "Her eyes were open she had a pulse. You could tell she was gasping for air. I raised her head and put it in my chest and suctioned her. I was able to get some food out. It was brown. I assume it was meatloaf. Once I was done suctioning, (V28) did the Heimlich. At this time, her heart rate was 32, her O2 (oxygen saturation)	S9999		

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S9999	Continued From page 9 was 85%. I applied 10 liters of oxygen on a nonrebreather mask. The medics came and took over at this time she still had a pulse. At 1:37 PM, she no longer had a heart rate. The medics cannot call time of death. Myself and another nurse (V16, Registered Nurse- RN) called the time of death. (R57) was a DNR (Do Not Resuscitate). (R57) needed supervision while she ate because she had dysphagia which is difficulty swallowing. She should not have been in the room eating alone." When asked how this happened, V2 stated, "I have not finished my investigation yet." When asked, if she saw R57's food tray, V2 stated, "I told them to save it for me but by the time it was all over someone had gotten rid of it." On 7/14/22 at 1:45 PM, V6, Dietary Manager, stated, "I did not deliver (R57's) tray. I was walking down the hall and (V36) said she need help. I yelled at (V31). (V31) ran past me. I stood in the doorway and got (V31) gloves. (R57) was sitting at a 90 degree angle maybe even more in bed. I remember seeing meatloaf and mashed potatoes and gravy on her tray. I cannot tell you how the meatloaf was. I want to say it was cut up but not sure. With her diet, she should of had a piece of meatloaf that is broken up with a fork then gravy is put over it to give it liquid and that is done in the kitchen. Whoever set (R57) up should have cut her brussel sprouts in half." On 7/19/22 at 10:46 AM, V51, Admission Coordinator, stated, "The dietary manager called me on my phone and said she couldn't reach (V2) DON, and we have someone choking down here. Can you get the crash cart? I went that way and passed (V2) in in the hall. I went to the dining room to get it (the crash cart) and a dietary aide	S9999		

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said they already got it. I went down to the room, and it wasn't there. I went back and (V35) was bringing it out. I took the cart to the room. She (R57) was already on the floor, (V2) started to suction her. It was me, (V2, V31, V35 and 2 CNA's and V16) was right behind us. (V2) to able to suction a couple of wads of meatloaf that was in her jowls and some mucous. (V2) thought she felt a pulse, so I put a pulse oximetry meter on her, and we were able to get a pulse. (V2) placed (R57) on oxygen on a nonrebreather mask, then the paramedics came and took over."

On 7/19/22 at 10:57 AM, V34, CNA, stated, "I was bringing my resident out of the dining room, and I saw (V50) CNA running down the hall with the back board. I got my resident out of the way and followed (V50). When I got to (R57's) room, (V50) was pulling (R57) out of the bed, she put her on the floor on top of the back board. (V28) was holding her head. I heard someone, I think (V31), but I haven't worked here that long to know all the voices, said to start CPR. I started CPR, I probably got 15 compressions in. Then (V2) entered and said do you have a pulse, I said I don't know I just started CPR, (V2) checked and got a pulse and told me to stop. We got the suction machine all hooked up and (V2) was behind (R57) suctioning her and doing the Heimlich. I also did suction because I was in front, and I could see in her mouth. I was able to get some food chunks out but not all some of the pieces were too big for the suction machine. Some of the pieces were the size of pebbles and even nickels. It looked like she hadn't chewed her food at all. Then the paramedics came and took over."

On 7/19/22 at 11:20 AM, V16, RN, stated that she was made aware of (R57's) choking. V16 stated,

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S9999	Continued From page 11 "I started going that way when I got to the nurse's station someone yelled call 911. I stopped and did. I was on the phone with them for a few moments. I hung up when done and I went to see if I could help. (V2) was at her head suctioning her and working with her. I was trying to get the room clear of the CNA's that did not need to be in there. I told the maintenance man to go met the paramedics at the door and make sure the hallway was clear. The paramedics showed up and were talking to (V2). They put their electrodes on her, and they did get a heart rate. It was in the 30's. Then her heart rate stopped. One of the ambulance guys came out of the room and called the coroner. I asked what time they were going to call the death for charting and one of the paramedics said that they don't do that. (V2) and I called the time of death. I did not see (R57's) tray." When asked if R57 should have been in her room eating unsupervised, V16 stated, "No (R57) should not have been eating by herself." On 7/19/22 at 2:53 PM, V55, Firefighter/Paramedic, stated, "We were the first on the scene. The ambulance pulled up behind us. We were told that CPR had been initiated but it had not been. She (R57) was on the floor with her head in someone's chest. She had oxygen on. Her mouth was wide open, she was not breathing, and I could not see any airway obstruction in her throat. The facility had been suctioning her and there was what looked like meatloaf and mucous in the suction container. We did not suction her because the facility already had, and I did not see an obstruction. We felt for a pulse and thought we got one radially, so we checked it on the carotid, and we did not get one. She had no rise and fall of the chest and did not respond to painful stimuli. Her pupils were fixed and dilated. We put the monitor on her, and	S9999		

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S9999	Continued From page 12 we were getting an initial pulse of 35 which dropped to 10. The monitor was indicating PEA (pulseless electrical activity). The hospital was called for medical directive since she was a DNR, and they said to stop treatment." The local Fire Department Incident Report, dated 7/13/22, documents, "Primary Impression: Cardiac Arrest. Initial Patient Acuity: Dead without Resuscitation Efforts. Final Patient Acuity: Dead without Resuscitation Efforts. Vital Signs: 1:25 PM Unresponsive, Pulse 35 R (regular), RR (Respiration Rate) 0. 1:29 PM Unresponsive, Pulse 25. ECG (electrocardiogram): 1:25 PM PEA (pulseless electrical activity). 1:29 PM PEA. Assessment: Mental Status: Unresponsive. Skin: Cyanotic Pale. Eyes: Left 6 mm (millimeters). Non-Reactive. Narrative: Rescue (1:51 PM) dispatched to above address for a pt. choking that has gone unresponsive and stopped breathing. Upon arrival staff member stated they believed CPR was being performed on pt. Upon arrival to pt. room. CPR was not being performed and pt. was unresponsive and apneic. NH (nursing home) staff had suctioned food from pt's mouth and cleared pt's airway and then placed pt on O2 via non rebreather. When asked how long pt. has been choking prior to arrival NH staff stated that they did not know and that pt. was found in her room. (1:51 PM) checked pt's radial pulse and believed a weak and thready pulse may have been felt. Pt's carotid pulse then checked and was absent. NH staff then present (1:51 PM) with DNR paperwork. (1:51 PM) then placed pt. on cardiac monitor showing 35 bpm (beats per minute), and pt's pulse rechecked at both radial and carotid locations and confirmed by two members from 1351 (1:51PM) to be absent. Pt in PEA. Local ALS (Advanced Life Support) ambulance then arrived on scene. (Local	S9999		

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S9999	Continued From page 13 ambulance) then contacted medical control and informed them of the situation. Medical control then advised (ambulance) to not perform resuscitation efforts. (1:51 PM) cleared from the scene. Specialty Patient - CPR: Cardiac Arrest: Yes, prior to EMS (Emergency Medical Services) arrival. Cardiac Arrest Etiology: Respiratory/ Asphyxia." On 7/20/22 at 10:45 PM, V54, Fire Chief, stated that PEA is the heart is dying but it does show some electrical activity still. R57's Death Certificate, dated 7/19/22, documents that R57's Date of Death was 7/13/22 and the cause of death was choking due to food. On 7/20/22 at 9:45 AM, V49, Coroner, stated, "(R57's) cause of death was choking. I did speak with (R57's) family about (R57's) death. I explained to the family that to prove a choking death I would have to do an autopsy and they did not want a autopsy done on her. The family said that she had problems with swallowing and they were very happy with the care (R57) received while at the facility. The primary cause of death is choking and the secondary cause will be all of her comorbidities. I did speak with the fire department and the hospital. The hospital did tell the fire department to stop treatment because she was a DNR." 2. R217's Health Status Note, dated 3/25/22 at 7:57 PM, documents, "Called to resident room she was choking her color was blue and no air exchange. Was able to lift her up in w/c (wheelchair) lean forward and she cleared enough mucus to get air. Attempted to suction	S9999		

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with little success due to congestion very deep. Contacted POA (Power of Attorney V56) she does not want resident transferred to hospital under no circumstances. Neb (nebulizer) treatment started. Talked with her son who was visiting he had fed her 1 glass of blue berry juice/2 sm. candy bars/1 sm. mint candy bar then water where she started coughing and after she stopped for few min (minutes) he gave her boost supplement that is when cough got worse he called staff. Currently no further problems in dining room for supper drank her orange juice without issue."

R217's Health Status Note, dated 5/13/22 at 6:10 PM, documents, "Called to dining room after drinking med pass resident started coughing up phlegm. Color pale/blue. Taken to room to bed, resp. (respirations) faint, back compression/rub chest with no change. 02 (oxygen) started at 2L. (liters) no change. 6:15 PM called family. family on her way to facility. Resp. about 2 per min (minute) pulse faint. Coroner notified. Body mottled."

R217's Health Status Note, dated 5/13/22 at 6:11 PM, documents, "Family aware of current condition verbalize wished not to send resident to hospital. Keep resident in facility to keep comfortable."

R217's Health Status Note, dated 5/13/22 at 7:36 PM, documents, "Resident expired in facility at 6:25 PM in her room per dayshift nurse."

R217's Illinois Department of Public Health Final Report, dated 5/18/22, documents, "On 5/13/22 at 6:10 PM, resident observed coughing out frothy phlegm in the dining room. Resident was minimally alert upon nurse initial assessment and observed pale in color. No visual obstructions

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S9999	Continued From page 15 observed to oral cavity. There was no food in front of the resident. Per staff, resident has consumed her supplement drink (med pass) that was in front of her. Resident was the only one at the table and had not yet been served food. Per dietary staff who was present in the dining room stated that she visually observed resident sleeping when she entered the dining room. Around 6:00 PM she observed resident was awake and smiled at her. Few minutes later she heard a faint coughed and resident started to change in skin color asked for staff help. POA was notified and verbalized wishes not to send resident to ER (Emergency Room) and just keep her comfortable in the facility. Resident was transferred back to her room to continue to assess and provide intervention. Nurse provided back thrust and chest rub. Resident is DNR - comfort focus treatment per her advanced directives. Nurse applied oxygen from 2 liters to 4 liters with no improvement. Administered nebulizer treatment to help with respiratory distress. Head of bed elevated to 45 degrees. Assigned nurse and staff stayed with resident to provide interventions for comfort while waiting for family members until she passed a 6:25 PM. MD (Medical Doctor) notified. Family was aware of all interventions provided and honored POA's wishes. Resident has diagnosis of Dysphagia, Diabetes type 2, COPD (Chronic Obstructive Pulmonary Disease), Hypertension, and Coronary artery disease. Resident is on pureed diet with thin liquid related to dysphagia." It continues, "Re-education provided to all staff on handling possible aspiration." The Facility In-Service Attendance Sign in Sheet, dated 5/16/22, documents, "Topic: Med Pass. Content of Program: Nurses to be present until Med Pass is consumed by resident do not leave	S9999		

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S9999	Continued From page 16 resident unattended." The Facility In-Service Attendance Sign in Sheet, dated 5/16/22, documents, "Topic: Suctioning. Content of Program: All dining rooms have suctioning machines. Reeducation of Oral suctioning with Policy and Procedure attached." On 7/18/22 at 2:45 PM, when asked if staff ever did the Heimlich, suctioned or called 911 for R217, V2 stated, "That is why I did the education to teach the staff how to handle a choking situation. Then a few days later I actually did a mock drill on choking with a real person and I wanted to see how the staff reacted and educate them if they did need more education." The Facility In-Service Attendance Sign in Sheet, dated 5/17/22, documents, "Content of Program: All staff re-education on oral suctioning to clear airway if resident having aspiration or choking episodes. Performed Heimlich maneuver or resuscitate if necessary and call 911 immediately." The policy Oral Suctioning, dated 9/16/22, documents, "Objective: To maintain a patent airway. To maintain good oral hygiene." On 7/18/22 at 2:38 PM, V35 LPN, stated, "When I went in the dining room to give her (R217) her med pass, she was asleep, so I left it on the table in front of her. Then a little while later the dining room called for me, I went in, and she R217 was coughing. I got her back to her room; I did do a finger sweep of her mouth, but nothing was there. I went to call the family and left her with (V46, LPN) the other nurse. The family said they did not want her sent out. They said let nature take its	S9999		

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S9999	Continued From page 17 course. The other nurse said he did the Heimlich, but I did not see that." When asked if R217 was ever suctioned, V35 stated, "We had the equipment in the room." On 7/19/22 at 8:50 AM, V2 stated, "If I was in this situation, I would have suctioned, Heimlich and called 911 just like I did for (R57)." On 7/19/22 at 11:40 AM, V35 stated, "(V46, LPN) did do the Heimlich. We did not call 911 because the family did not want her sent out. If 911 would have showed up they would have taken her and that is not what the family would have wanted. She had choked a few months before. (At that time) The son was present, and he was feeding her things she shouldn't have had. He called me and said she was choking. He wanted me to send her out but his sister the POA said no, don't send her anywhere." On 7/19/22 at 1:27 PM, V46 stated, "I was not present the second time she choked but I was the first time. (V35) came and got me and said R217 is not breathing. I went and got the crash cart, did the Heimlich, and started suctioning. During one of the Heimlich's, she coughed up a popcorn kernel. She then took a breath and started breathing again. R217's son was present, and he wanted R217 sent out but V35 talked to the POA and the POA did not want her sent out. I thought that was crazy, so I even called the Assistant Director of Nurses and (V16) to confirm this." On 7/19/22 at 4:30 PM, V2 stated, "I did not know about (R217's) choking incident on 3/25/22. I was on vacation that week and I was not notified. I think (V35) is confused because from my investigation of 5/13/22 (V46) had nothing to do with it."	S9999		

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S9999	Continued From page 18 R217's Face Sheet, print date of 7/18/22, documents R21 was admitted on 8/1/2018 and has diagnoses of Dementia and Dysphagia. R217's MDS, dated 4/5/22, documents that R217 is severely cognitively impaired and requires extensive assistance of 1 staff member for eating. R217's Care Plan, dated 4/19/22, does not address the need for eating assistance. R217's Physician Orders, dated May 2022, documents, "REGULAR diet, Pureed (PU4) texture, Thin consistency and DNR-comfort focused treatment." On 7/20/22 at 9:45 AM, V49, Coroner, stated, "(R217's) death was reported to me as a comfort care resident that had multiple comorbidities and that she died a peaceful death. I had no idea that she had a choking incident and did not receive any treatment or assistance for it because she was a DNR. If I had known that I would have made this a coroner case and ruled it an accidental death by choking. Even if I call something a coroner case, I don't have to do an autopsy because it is not going to change the outcome. I can go back a year and change a death certificate." 3. R216's Face Sheet, print date of 7/18/22, documents that R216 was admitted on 5/20/22 with diagnoses of Stroke, Pneumonitis due to Inhalation of food and vomit and Dementia. R216's Hospital Record, dated 5/13/22, documents, that R216 was admitted to regional hospital on 5/13/22 and that his wife stated he	S9999		

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S9999	Continued From page 19 had been having trouble with choking for the last week. R216's Hospital Summary Visit, dated 5/20/22, documents, "Diet Carb Controlled. Fluid consistency: Nectar thick Fluids." R216's Physician Order, dated 5/20/22, documents, "LCS (low concentrated sweets) diet Reg RG7 texture mildly thick nectar consistency for nutrition. R216's Health Status Note, dated 5/20/22 at 11:55 PM, documents, "Res (resident) had his thickened liquids spilled all over him, his covers and the bed. Noted res tongue and mucous membranes in his mouth where dry and res nodded head yes when asked if he was thirsty. Gave res 250 ml's of nectar thick water. He needs to be fed and given drinks as he will not follow commands." R216's Health Status Note, dated 5/21/22 at 1:20 PM, documents, "Writer summoned to room per wife stated resident choking and coughed up thick meat airway cleared Wheezing noted to right lungs updated (V47, Physician) Received order to down grade diet to mechanical soft till Monday so speech therapy may eval (evaluation) and chest Xray T (temp) started q (every) 4 hours at this time Xray ordered." R216's Health Status Note, dated 5/21/22 at 4:00 PM, documents, "Writer went to room to check on resident and found wife lying bedside resident saying he is ok he is sleeping writer observed deep breathing walked over to bed calling his name gently no response Massaging chest no response. Pulse and respiration present 97.3 173/108 103 36 spo2 (oxygen saturation) and	S9999		

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S9999	Continued From page 20 92% RA (room air). writer left staff with resident to monitor for changes." R216's Health Status Note, dated 5/21/22 at 4:12 PM, documents, "Ambulance called per H1 nurse while writer remained with resident performing safety measures." R216's Health Status Note, dated 5/21/22 at 4:46 PM, documents, "Returning to room blood sugar 289 coverage given spo2 dropped to 82% RA Rebreather in place periods of apnea (no respirations) noted After elevating HOB (head of bed) with stimulation resident vomited a moderate of brown substance no odor noted unable to clear mouth suction resident blood tinge color in tubing and mouth. Ambulance arrived to facility for transport resident arousing more upon departure Spoke with (V47, Physician) update on resident okay to transport Wife followed in private vehicle." R216's Health Status Note, dated 5/21/22 at 11:07 PM, "Writer called to check status on resident. Writer was informed that resident was admitted with a dx of Intracranial hemorrhage with subquertal herniation and aspiration pneumonia. POA is at bedside." The facility nurse interview written by V45, LPN, dated 5/21/22, documents, "Writer at nurses station when resident wife approached alone with nurse manager. Wife stated, "I think my husband choked on his food." Writer immediately traveled to resident room with wife behind me. Entered room found resident almost laying flat on his back. Immediately elevated head of bed 45 degrees. No evidence of any choking found on bed, floor or around resident mouth. At that point wheezing noted complete assessment and notified (V47 Physician)."	S9999		

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S9999	Continued From page 21 The local hospital report, dated 5/21/22, documents, "Around noon today, patient choked and aspirated while eating. Patient became non responsive afterwards. He was in respiratory failure on arrival to ED (Emergency Department). Patient was placed on non-rebreather oxygen and saturating in the low 90's." It continues. Glascow coma scale (clinical scale used to reliably measure a person's level of consciousness) of a 4 on admission. ED physician discussed transfer to higher level of care with family for neurosurgery evaluation. However, wife who is surrogate decision maker refused transfer to higher level of care. she stated that husband doesn't want any extraordinary measures if in a coma." It continues, "He was hypoxic from aspiration pneumonia." It continues, "Patient expired at 2:15 AM on 5/22/22." R216's Report to Illinois Department of Public Health, dated 5/27/22, documents, Final Report; On 5/21/22 around 1:20 PM, the resident's wife report to the nurse that resident has started coughing during lunch. Nurse immediately went to the room to assess resident. Upon nurse entering the room, resident is alert, observed laying flat in the bed. Nurse immediately elevated head of bed and inspected oral cavity for obstruction. No signs and symptoms of respiratory distress during nurse initial assessment. Per nurse assessment there is not evidence of foreign material obstructing airway. Resident diet order is regular consistency for solid and nectar liquid upon admission to the facility. Diet is served per ordered. Resident is afebrile. Lungs sounds assessed with wheezing to right lobes on auscultation. MD (Medical Doctor) made aware of the incident. Order for	S9999		

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inhouse chest Xray and downgraded diet order to mechanical soft and referred to ST (speech therapy) to eval and treat. Order for inhouse chest Xray placed by the nurse. On the same day at 4:00 PM, nurse went to reassess resident and observed resident to be apneic SPO2 at 82%, observed resident with brown emesis. Wife present in the room at this time. There is not evidence of food or drinks that resident had consumed at this time. Nurse suctioned resident and then applied oxygen via nonrebreather mask and immediately called ambulance for transfer." It continues, "Resident also have a diagnosis of Transient Cerebral Ischemic Attack and Cerebral Infarction which is being managed with Coumadin. Resident also has a history of Pneumonitis Due to inhalation of food and vomit on his medical record. Resident was sent to ER (Emergency Room) to eval and treat. CT (computed tomography) of the head was done at the hospital and showed a large intraparenchymal hematoma with the left frontal and left parietal lobe which crosses the midline, extending into the medial aspect of right frontal and parietal lobe. Chest Xray is consistent with aspiration pneumonia. Resident was admitted to hospital with admitting diagnosis of Hemorrhagic stroke, Cerebral Herniation with midline shift left to right, recent ischemic stroke, aspiration pneumonia. Resident passed away at 2:15 AM on 5/22/22 per hospital records."

On 7/18/22 at 2:45 PM, V2 stated that it did appear the R216's wife was feeding him while he was lying down, and that staff should have supervised to ensure she was feeding properly.

On 7/20/22 at 10:10 AM, V49, Coroner, stated, "I think (R216) had a stroke first and that his wife was feeding someone who was having a stroke. I

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S9999	Continued From page 23 will have the hospital pull all of his records and take a good look at it." 4. R41's Face Sheet, print date of 7/19/22, documents that R41 was admitted on 11/2/21 with diagnoses of Parkinson's Disease, Dementia and Stroke. R41's Order Summary Report, dated 7/19/22, documents, "Regular diet easy to Chew (Mech) (EC7) texture." R41's MDS, dated 4/21/22, documents R41 is cognitively intact and requires supervision and set up while eating. R41's Care Plan, dated 5/5/22, documents, "ADL (Activities of Daily Living) Self Care Performance Deficit related to confusion, Impaired balance, musculoskeletal impairment. Interventions: Eating; feeds self independently after set- up." On 7/12/22 at 8:21 AM, V38, CNA, set R41's breakfast tray up in R41's room for R41. V38 asked if there was anything else R41 needed and then V38 exited the room. V38 then continued passing other breakfast trays on the hall. 5. R46's Admission Record, print date of 7/14/22, documents that R46 was admitted on 2/24/2020 and has diagnoses of Type 2 Diabetes Mellitus and Major Depressive Disorder. R46's Physician Order, dated 3/30/22, documents, "LCS (Geriatric Diabetic) diet, Easy to Chew (Mech) (EC7) texture, Thin consistency." R46's MDS, dated 4/25/22, documents that R46 is severely cognitively impaired and R46 requires	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000756	A. BUILDING: _____ B. WING _____	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-JACKSONVILLE	873 GROVE STREET JACKSONVILLE, IL 62650

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S9999	Continued From page 24 supervision and one staff member physical assist with dining. R46's Care Plan, undated, documents, "NUTRITIONAL STATUS: (R46) is at risk for wt fluctuation r/t intake and dx~ Type 2 Diabetic, Heart Disease, Depression. Intervention, dated 7/21/22, Requires supervision with eating, along with verbal and visual cues. Do not leave unattended at table with food/drink." On 7/25/22 at 7:49 AM, R46 was sitting at the feeding assist table with her head down on the table edge. R46 has a plate of scrabbled eggs and toast in front of her with her liquids. At this time, there is no staff in sight. Approximately 45 seconds later, V18 CNA came around the corner with two drinks in her hand. On 7/25/22 at 9:50 AM, V40, LPN, stated, "I did give (R46) her tray this morning. (V18) and I were delivering trays." When questioned if anyone was at the table with (R46) she stated, "No I think she (V18) was grabbing a drink and sitting down. (R46) was not asleep. She was curled up in a ball, which is how she likes to sit. I have been in serviced on feeding assistance and that we need to be with people that need supervision which is what (R46) is." On 7/25/22 at 9:55 AM, V18, CNA, stated that R46 had not been sitting at the table for long without supervision. V18 stated that while she is at the serving line she can still see the feeding assist table. The serving line is approximately 30 feet from the supervision feeding assist table and if V18 could see R46 from there she would have seen the back of her head. On 7/25/22 at 10:10 AM, V63, Regional Nurse,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 25 and V64, Regional Director, both stated that staff should be present at the table watching residents when they receive their food not just present in the dining room. The facility policy and procedure Meal Service-Nursing Responsibility, dated 3/4/22, documents, "A licensed / certified member of the nursing staff must check meals trays for accuracy, and present in the dining room during the entire meal service. (A)	S9999		