STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145781	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENERATIONS AT APPLEWOOD	**21020 KOSTNER AVENUE MATTESON, IL 60443**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews the facility failed to monitor a resident with a history of swallowing problems closely during meal time to immediately intervene when and if the resident showed difficulty swallowing and or aspiration. This applied to one (R1) of three residents reviewed for supervision. As a result R1 was found by a housekeeper unresponsive and later noted with food in mouth by paramedics and pronounced dead. Findings include: According to R1's face sheet, R1 has [DIAGNOSES REDACTED]. R1's Minimum Data Set ((MDS) dated [DATE] shows R1's Brief Interview for Mental Status (BIMS) score was 12, with disorganized thought behavior present and fluctuates. R1 had impairment to one upper extremity. Facility initial report to state agency dated [DATE] indicated R1 had [DIAGNOSES REDACTED]. V1 (Administrator) notified that resident noted unresponsive in her room. Code called. Staff responded and initiated CPR. 911 responded to the facility and took over CPR. Resident expired in the facility and EMT's left. Responding officer, when leaving facility mentioned to V1 that the EMT had removed a piece of beef. Initial review of resident's plan of care indicate that she was on a regular diet. Investigation initiated and full report to follow. The local police department report dated [DATE] shows in-part offense code, death investigation. Reported at 1:57pm. Responding officer was dispatched to Generations at Applewood to assist Fire Department with a non-responsive resident, not breathing. Responding officer and paramedics arrived on scene and observed V8 (Certified Nursing Assistant/CNA) performing chest compressions on R1, who was laying on her bed in R1's room. Paramedics took over CPR efforts on R1 who was still not breathing nor responding. Local paramedics observed pieces of food (meat) in R1's throat, which they removed in effort to clear R1's airway. Paramedics advised R1 had no pulse. Responding officer spoke to R1's CNA (V6) who advised that she last saw R1 responsive at approximately 1:30pm when she brought her food tray containing soft roast beef, cut potatoes and cobbler. V6 stated R1 can feed herself so she left the food tray with R1 and left the room. At 2:39pm responding officer spoke to the medical examiner to discuss the facts of the incident. At 2:56pm Medical Examiner contacted responding officer and opened a Medical examiner case for R1. Medical examiner said a case was opened due to the fact pieces of food were found in R1's throat. In respond to the officer's report, on [DATE] at 2:10p.m V1 stated that the responding police officer only mentioned that R1 had food particles around her mouth. R1's MDS assesment dated [DATE] indicated R1 required extensive assistance with one person physical assist with eating. R1's plan of care with last review date [DATE] shows R1 requires assist with ADL (Activity of Daily Living) related [MEDICAL CONDITION](stroke), history of falls and anxiety. The approach for ADL assist includes: bed mobility - extensive x 2 staff assist; eating - supervision and set up for meals; transfers - mechanical lift x 2 staff; toileting - extensive x 1 staff; 2 for bed mobility, incontinent; dressing/grooming - extensive x 1 staff; bathing - extensive x 1 staff, 2 with showers; and positioning - unable to ambulate. Needs assist with initiating and completing meals. R1 has swallowing problems related to history of dysphagia; goal shows that R1 will not choke. The approach is assess for dehydration, regular diet thin liquids, no tomatoes, baked potatoes, spinach, citrus products or orange juice, monitor for signs and symptoms of aspiration pneumonia, monitor for signs and symptoms of malnutrition, observe resident closely for signs of difficulty swallowing and/or aspiration. Use aspiration precautions. R1's plan of care does not mention what aspiration precautions that will be utilized for R1. R1's plan of care does not mention how the facility will monitor R1 during meals times and does not show how the facility will observe for difficulty with swallowing and aspiration. According to the above information, R1's plan of care and MDS assessment does not reflect the same information for assistance with eating. R1's progress notes dated [DATE] at 2:44pm documented by V4 (Nurse) show housekeeper entered residents room and witnessed resident unresponsive; when writer was made aware by the nursing assistant writer assessed resident for vitals, non-present, crash cart was obtained, HOB (head of bed) was lowered, board was placed under resident, mattress was deflated, airway was checked, CPR was initiated and 911 was called. Supervisor and MD made aware. Writer also contacted R1's daughter and updated; daughter stated she would call back to let facility know what her next plans are. Will endorse to next shift nurse. On [DATE] at 12:44pm during interview, V6 (CNA) said when she was summoned to R1's room because R1 was not breathing, V6 saw food on the upper part of R1's gown. V6 said it look like beef that R1 was eating. On [DATE] at 3:45p.m V12 (Assistant Director of Nursing/ADON) said V9 (Nurse) mentioned to her that the paramedics pulled 2 food particles out of R1's mouth. On [DATE] at 10:58a.mp.m V9 denied saying to V12 that the paramedics pulled food particles from R1's mouth. V9 said she did see food on R1's gown when she responded to R1 being unresponsive. On [DATE] at 10:58a.m V4 (Nurse) said she was the nurse responsible for R1's care on [DATE] and R1 does not need assistant with meals, just set up only. V4 said when she responded to R1's room she observed food on R1's clothing around her neck. On [DATE] at 12:44pm V6 (CNA) said she was the aide responsible for R1's care on [DATE] for the 7:00a.m - 3:00p.m shift. V6 said around 1:30pm on [DATE] she took R1's lunch tray to her. R1 was awake and alert. V6 said she set R1 up for lunch by raising the head of the bed and placing pillows behind R1's back. V6 said she set the lunch tray on the table, she cut up the roast beef and opened the beverages for R1 to eat. V6 said she cut R1's roast beef up into pieces. V6 said she set the tray up and left the room because R1 does not require assistance with meals, just set up only. V6 said she knows what assistance R1 requires because she always works with R1 and she knows her residents. V6 said she did not look at R1's kardex that day. V6 said the kardex shows what type of assistance the residents need for ADLs (Activities of Daily Living). V6 said she did not check R1's electronic record either to see what kind of assistance R1 required. On [DATE] at 12:44p.m V6 said R1 was contracted at the left elbow and did not have full range of motion to the left upper extremity, but she used her right hand to eat. V6 stated R1 would have to use her right hand to activate the call system as needed. On [DATE] at 11:32a.m V9 (Speech Pathologist) described aspiration precaution as oral care, cleaning the mouth, make sure resident's head of bed is elevated between ,[DATE] degrees when eating, which allows for optimal digestion, prepping the food tray, cutting the food up in bite size pieces and offering a drink in between bites, sometimes offering after every bite, and cueing the residents. V9 said after the resident takes the last bite or swallow make sure that the resident is sitting up for at least 30 minutes after the meal; this allows for digestion because as you get older food travels slower. V9 said she would suggest to use aspiration precautions at all times. V9 said someone must be present to give cueing and encouragement. R1's Physician order [REDACTED]. R1's kardex that was presented by V4 (Nurse) on [DATE] with a run date of [DATE] shows ADL functional Rehabilitation, eating: supervision and set up for meals. Needs assist with initiating and completing meals. On [DATE] at 1:54p.m V3 (Restorative Nurse) said R1's baseline for meal assist is supervision with set up only; R1 does not need assistance with meals. V3 said supervision means the aide can check on the resident whenever they get a chance, but the nurse should determine how often the CNA checks on the resident during meal times. On [DATE] at 12:58p.m V2 (MDS Coordinator) said she completed R1's MDS section G for ADLs for [DATE] and R1's status of requiring extensive assist with one person physical assist with eating was based on the data gathered by the program (electronic records). The program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) pulls over the information based on the staff documentation over the past 7 days. V2 said R1 must have required a higher level of assistance at least 2 to 3 times in that 7 day look back period. V2 said she did not make an observation of R1's eating ability. V2 said she does not usually complete section G of the MDS. V2 said she did not mention to anyone that R1's eating assist changed because it was not a significant change in condition. A review of R1's point of care charting 7 days prior to R1's MDS assessment date of [DATE] shows R1 had episodes of requiring total assistance and one person physical assistance with meals. On [DATE] at 2:14p.m V11 (Physician) said the facility informed him that R1 was eating and later she passed out. V11 said he was not made aware that the paramedics pulled food from R1's throat. V11 said if the care plan shows R1 needs supervision with eating then the facility should provide supervision. Facility policy titled Comprehensive Care Plans dated ,[DATE] shows to develop a comprehensive, person centered plan of care, consistent with the residents rights, that includes measurable objectives and time frames to meet the resident's medical, nursing and mental psychological needs. The comprehensive care plan will include services that are to be furnished to attain or maintain the resident's practicable physical, mental psychological well-being while preventing decline when possible. Areas of potential risk to the resident with interventions to eliminate or reduce risk. The identity of the professional services that are possible for each element of care. Measurable objectives and time frames. To achieve desired outcomes and fulfill the person centered ace approach the facility will provide the services and or items included in the plan of care. Care plans are revised as changes in the resident condition dictates but no less than on a quarterly basis.