STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145403	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALDEN POPLAR CREEK REHAB & HCC	**1545 BARRINGTON ROAD HOFFMAN ESTATES, IL 60169**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents care plans were updated with resident centered interventions for 4 of 8 residents (R1, R13, R14, R16) reviewed for care plans. The findings include: 1. R1's Modified [MEDICATION NAME] Swallow Study dated 3/3/20 shows mild-moderate dysphagia .requires supervision/cueing for safe and effective oral intake . .strict adherence to swallow precautions by patient/staff for safe oral intake .diet recommendations: small bites, monitor rate, aspiration precautions, small sips, multiple swallow (2), alternate solid/liquid, supervised feeding. R1's care plan was last updated on 2/13/20 with R1 has a swallowing problem related to dysphagia- R1 will not choke or aspirate. R1's Care Plan does not include swallow precautions recommended by R1's swallow study or the speech therapist on 3/3/20. On 8/18/20 at 10:48 AM, V29 Resident Care Coordinator said does the resident Care Plans and that resident Care Plans should be resident specific and contain specific speech recommendations for swallowing. 2. On 8/18/2020 at 10:30 AM, V1 Administrator said that R14 is seeing speech therapy due to her risk for aspiration. R14's Order Summary Report dated 8/18/2020 shows a diet order for no concentrated sweets, diet mechanical soft texture, aspiration precautions: single sips, small sips, slow rate, and no straw. R14's Care Plan was initiated 6/30/2015 and does not include the above resident specific orders for aspiration precautions: single sips, small sips, and slow rate. 3. R13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/18/2020 at 12:45 PM, R13 was eating lunch in her room. R13 was coughing during her meal. R13 had a mechanical soft diet with nectar thickened liquids on her tray. R13 is care planned for speech therapy but there's no documentation to indicate that R13 is currently being followed by speech therapy. R13's Care Plan was last updated on 4/8/2018. 4. R16's Physician order [REDACTED]. R16's Care Plan updated 11/28/17 shows R16 requires a mechanical soft diet and does not contain anything regarding R16's aspiration precautions.
F 0689 **Level of harm** - Immediate jeopardy **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, interview and record review the facility failed to ensure adequate supervision was provided for a resident at risk for aspiration for one of three residents (R1) reviewed for dysphagia. After R1 was left with his meal tray unsupervised, R1 was found making gurgling noises and subsequently died on [DATE] due to asphyxia. This failure resulted in an immediate jeopardy. The immediate jeopardy started on [DATE] when the facility staff first became aware of R1's speech therapy recommendations for supervision during meals. The immediate jeopardy was identified on [DATE]. V1 Administrator was informed of the Immediate Jeopardy on [DATE] at 9:45 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was: removed on [DATE] at 4:55 PM, but the noncompliance remains at Level two because additional time is needed to evaluate the implementation and effectiveness of training. The findings include: R1's State of Illinois Certificate of Death Worksheet certified [DATE] shows R1 expired [DATE] . cause of death: asphyxia, due to (or consequence of): choked on food bolus. R1's Face sheet shows R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's Minimum (MDS) data set [DATE] shows R1 is cognitively impaired. R1's Video swallow study (done on [DATE] in the hospital) shows penetration of thin liquids and nectar liquids via a cup .penetration and aspiration as described. R1's Hospital Nurse Report Sheet date [DATE] shows R1 is on a mechanical soft diet with honey thickened liquids and needed assistance with feeding. R1's Speech Therapy Evaluation and Plan of Treatment dated [DATE] shows Patient had choking episode in hospital and downgraded to mechanical soft. Patient then completed Video Fluoroscopy Swallow Study and downgraded to honey thickened liquid due to aspiration/penetration Behaviors Impacting Safety: Reduced attention to task, Decreased safety awareness, Poor self-monitoring skills and Inability to make needs known . Patient with delayed swallow response difficulty initiating swallow and decreased safety awareness. R1's Speech Therapy Progress Report dated [DATE] shows Patient (R1) is at risk for aspiration/choking with puree/honey thickened liquids/nectar thickened liquids when not strictly following safe swallow strategies. R1's Modified [MEDICATION NAME] Swallow Study dated [DATE] shows mild-moderate dysphagia .requires supervision/cueing for safe and effective oral intake . .strict adherence to swallow precautions by patient/staff for safe oral intake .diet recommendations: small bites, monitor rate, aspiration precautions, small sips, multiple swallow (2), alternate solid/liquid, supervised feeding. R1's Speech Treatment Encounter Note dated [DATE] shows a repeat Video Fluoroscopy Swallow Study was done with recommendations for mechanical soft/nectar thickened liquids diet Educated patient/wife at lengths regarding results of study, specific strategies of repeat swallows due to pharyngeal residuals, small bites/sips, and recommendations. Discussed results with R1's Registered Nurse V17. R1's Speech Treatment Encounter Note dated [DATE] shows max cues needed for repeat swallow. Instructed patient (R1)/wife in oral motor/pharyngeal/laryngeal exercises. Patient required max cues to follow due to cognitive deficits. R1's Speech Therapy Progress Report dated [DATE] shows R1 and Caregiver training: development & training in use of compensatory strategies: small bites, small drinks, upright at 90 degrees for all oral intake, double swallow to clear pharyngeal residuals, 1:1 assistance. Educated patient's RN (V17) Supervision for Oral Intake=Close supervision (1:1 assistance with all oral intake for swallow strategies.) On [DATE] at 4:40 PM, V23 Speech Therapist said she was treating R1 due to his [DIAGNOSES REDACTED]. V23 stated R1's biggest problem was that he took large amounts of food at one time and was unable to swallow all of the food in his mouth with the first swallow. R1 needed to be instructed to then take a sip of liquid or swallow a second time to clear the food, which is very common with [MEDICAL CONDITION]. V23 said if the food or drink built up in his mouth R1 could possibly choke. V23 said R1 was able to feed himself, but needed one on one supervision to make sure the bites and sips were small enough, and he took a drink or a second swallow to clear the food in his mouth. V23 said R1 is cognitively impaired and his memory was not good so he needed repetitive cueing. V23 stated if no one is watching him directly, his food tray should not be left at the table with R1. V23 said she trained V25 Certified Nursing Assistant (CNA) and V26 Activity Aide/trained feeding assistant to watch R1 closely and to monitor the size of the bites of food and drink, and to take a drink or second swallow to clear his mouth. V23 said she also communicated R1's swallow strategies with R1's regular nurse V17. V23 said R1 was still receiving speech therapy up until his death. On [DATE] at 1:49 PM, V25 CNA said on [DATE] during the noon meal she had fed R1 several times while making rounds in the dining room and helping the residents. V25 said R1 had eaten about 80% of the facility food tray and was finished eating. V25 said there was some food from the family on the table in front of R1 as well as the remainder of the facility tray. V25 stated I was making a peanut butter

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 -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) and jelly sandwich for another resident and could only see the back of R1 when she heard a weird noise. I looked at R1 and he was making a gurgling noise but no gestures so I called the nurse. V25 said sometimes R1 feeds himself. On [DATE] at 1:42 PM, V26 Activity Aide said when she came back from break, V25 had already fed R1 and R1 was finished eating and was calm and sitting at the dining room table with the food (facility tray and his family's food that they brought in for him) still in front of R1. V26 stated she was at another table feeding another resident when she heard R1 cough and make a troubled breathing sound so she called the nurse. On [DATE] at 11:34 AM, V17 RN (R1's primary nurse) stated on [DATE] at the noon meal, R1 was feeding himself, R1 can do it, and the girls were in the dining room to assist. Our food was on the table in front of him and a little tray of food from his wife was on the table as well. I was charting at the Nurses station, I could see R1 but his back was to me. The aides alerted me that R1 didn't look good. R1 was making a gurgling noise like he had something in his mouth that he couldn't swallow. I called out his name and shook him but he wouldn't answer. I did the [MEDICATION NAME] at the table he was still not answering so I called a code and lowered him to the floor. R1's Progress Note by V17 on [DATE] shows at 12:50 PM V17 was called into dining room to check R1. Upon arriving R1 was sitting up in his wheelchair. R1 was unable to answer upon calling his name and noted coughing. [MEDICATION NAME] maneuver initiated, code blue and 911 called. Transferred R1 to the hallway floor. V27 Nurse Practitioner (NP) here and did another [MEDICATION NAME] maneuver, liquid came out. CPR initiated by nurses. V24 R1's Doctor (MD) was present and assisting staff during code blue. R1 Progress Note by V24 MD on [DATE] shows Code blue called overhead .R1 was in the dining room and brought to the hallway in the wheelchair. R1 was not responding and did not have a pulse. Suspect R1 may have choked while eating lunch. [MEDICATION NAME] maneuver attempted by V27 NP multiple times. Small amount of liquid food came out of mouth. R1 remained unresponsive and pulseless CPR initiated immediately by staff. 911 was called R1 had episode of vomiting during code. R1 was intubated by Emergency Medical Service (EMS). Despite all efforts by all staff and EMS, heart rhythm was not regain. R1 was pronounced by EMS. On [DATE] at 10:45 AM, V24 MD said R1 had swallowing issues which is not uncommon with dementia and was working with speech therapy. V24 stated at minimum R1 needed supervision to eat and speech recommendations should be followed. On [DATE] at 11:40 AM, V21 Physical Therapy Supervisor said the speech therapist will educate the staff on the specific recommendations for the residents and then staff should endorse to the next shift. V21 said speech recommendations are typically not an order in the computer and specific swallow strategies are not put in the resident's Care Plan. On [DATE] at 11:41 AM, V19 RN said R1 ate in the small dining room and was on a mechanical diet. V19 said R1 was physically able to feed himself. On [DATE] at 11:52 AM, V20 Memory Care Director said R1 sat in the assisted dining room for meals and due to his cognition and needed cueing at times, but could feed himself. On [DATE] at 12:07 PM, V1 Administrator said R1 sat in the small dining room for meals and required staff supervision. R1's initial Care Plan dated [DATE] shows R1 requires nutritional support with swallowing related to [MEDICAL CONDITION] .R1 is able to feed himself. R1's Care Plan was updated on [DATE] with interventions to alternated liquid and solid, position resident as appropriate for meals, and to assist with meals as needed. R1's care plan was last updated on [DATE] (swallow strategies recommended on [DATE] per speech therapist) with R1 has a swallowing problem related to dysphagia- R1 will not choke or aspirate. R1's Care Plan does not include swallow precautions recommended by R1's swallow study or the speech therapist. The facility's Feeding a Resident Policy dated ,[DATE] shows When finished with his/her meal .remove all equipment and supplies from the eating area. The facility's Meal Service Policy dated ,[DATE] shows assure that each resident receives the amount of assistance necessary remove tray to appropriate area when resident had finished eating. The facility was unable to provide a safety/supervision policy. The Immediate Jeopardy that began on [DATE] was removed and the deficient practice was corrected on [DATE] when the facility took the following actions to remove the immediacy and correct the noncompliance. On [DATE] the Administrator, DON, and the Interdisciplinary Team conducted: -Staff were in-serviced on identifying residents at risk for aspiration and their specific feeding requirements. -Staff were in-serviced on supervising residents needing assistance until the end of their meal. -Staff in-serviced on the need to remove food away from residents who need supervision immediately at the conclusion of the meal or when the supervision cannot be maintained. The facility Quality Assurance Team (including the Medical Director, Administrator, Assistant Administrator, Admission Director, Dietary Supervisor, MODS, DON, and facility consultant) on [DATE] conducted a review of all residents who are at risk for aspiration and choking. -A manager or nurse is assigned to monitor dining rooms, as well as resident rooms, at each meal to ensure that supervision is being conducted as needed for those resident in need. -QA audits were initiated in March and are now being conducted daily for one month to test staff knowledge of supervision needs in the dining room and which residents are in need. These will then transition to monthly X 3 months. -QA audits are being conducted to ensure that resident's trays are removed promptly at the conclusion of feeding or when staff is unable to supervise a resident requiring assistance. These will occur daily x one month and then will transition to monthly x 3 months. -Administration will conduct daily rounds to ensure supervision is provided to residents identified with a supervision need or those identified with aspiration precautions. -The list of residents identified at risk for aspiration will be kept in a binder at each nurses' station, accessible to all staff. Staff in-servicing on this list has been initiated and is ongoing. -Staff re-education on the signs and symptoms of choking, and what to do if someone appears to be choking, was initiated. All in-servicing initiated [DATE] is ongoing and will be completed with all staff on our completion date of [DATE]. The Administrator or designee will be responsible for ensuring all compliance of the items mentioned above. On [DATE], the Administrator, Medical Director, DON, and the Interdisciplinary Team conducted a review of the following policy: -Meal Service including appropriate supervision until the end of the meal and removing meal tray after a resident is done eating. -Aspirations Precautions -Choking -Changes in diet consistency