STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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 - Immediate jeopardy to resident health or safety 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** 41639 Based on interview and record review, the facility failed to provide 1:1 supervision for a resident (R2) during mealtimes after R2 experienced a choking episode. This failure resulted in R2 experiencing a second choking episode with cyanosis, low oxygen levels, and hospitalization . R2 expired in the local hospital on [DATE] from complications of aspiration pneumonia and choking on food. This applies to 1 of 3 residents reviewed for safety and supervision in the sample of 8. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when R2 experienced a choking episode and R2's nurse practitioner ordered for R2 to have 1:1 supervision until he was evaluated by speech therapy. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 1:30PM. While the immediacy was removed on [DATE], noncompliance remains at a Level Two due to additional time needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R2's electronic face sheet printed on [DATE] showed R2 has diagnoses including but not limited to Parkinson's disease, dementia without behaviors, dysphagia, congestive heart failure, and muscle weakness. R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment. R2's nursing care plan dated [DATE] showed, (R2) requires nutritional support .feed slowly. Give resident time to chew and swallow, meal monitoring and recording as indicated. R2's speech therapy discharge summary dated [DATE] showed, Supervision for oral intake= distant supervision (resident able to feed self, supervision in dining room). R2's nursing progress notes dated [DATE] showed, Resident was choking at dinnertime, and he was able to remove all the food. (V7-Nurse Practitioner) here and saw resident at the time after he was done with episode of choking. (V7) referred resident to re-evaluate for swallow study. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's nurse practitioner visit note dated [DATE] showed, Dysphagia-discussed with nursing to repeat speech evaluation, continue 1:1 feeding. Slow feeding. On [DATE] at 3:08PM, V6 (Speech Therapist) stated, When a resident has a supervision level of distant supervision that means the resident needs to eat in the dining room with staff present. (R2) was still a risk for choking as he has a diagnosis of dysphagia and just recently had his diet upgraded from a mechanical soft diet to a regular diet. On [DATE] at 11:53AM, V15 (Certified Nursing Assistant) stated, I was working the day (R2) had his first choking incident. A resident yelled he's choking! so I ran into the dining room and began patting (R2's) back and at first, he wasn't breathing. I kind of froze and didn't know what else to do other than pat his back so I yelled for the nurse. One of the nurse's looked into the dining room and stated, 'That's not my resident, I'll go get his nurse.' I couldn't believe she just left me there alone in the dining room with a resident that was choking. There was nobody else in the dining room and I was the only one that responded. I was shocked nobody was in there supervising any of the residents. By the time (R2's) nurse came to the dining room, he had already coughed up what he was choking on and then the nurse took over. On [DATE] at 2:09PM, V7 (Nurse Practitioner) stated, I saw (R2) after his initial choking incident. I recommended for a speech evaluation and ordered 1:1 feeding at a slow rate. 1:1 feeding means staff are sitting with the resident and providing constant, close supervision and cues for safe swallowing. (R2) has a history of swallowing difficulties and had dysphagia so he is at a higher risk for choking. If staff were not supervising (R2), it put him at increased risk for choking which led to his pulmonary complications. On [DATE] at 9:51AM, V14 (Licensed Practical Nurse-LPN) stated, On [DATE] one of the aides notified me that (R2) was coughing while he was eating and looked like he was choking. I had (V7) assess him and she wanted me to have staff sit with (R2) while he ate but I didn't realize nobody knew that. I told (V8 - LPN) about (R2) coughing, but I did not report any of (V7's) orders to him so he would have no way of knowing what (R2) needed. There is always 1 person in the dining room, but we can't spare a staff member to provide 1:1 assistance for feeding, we don't have the staff for that during mealtimes because it's a busy time of day. Looking back, I should have called the kitchen right away and notified them to downgrade (R2's) diet to mechanical soft and I should have entered the orders and notified the CNAs (Certified Nursing Assistants) to provide 1:1 supervision. The orders should have also been entered into the medical record so all staff were aware, but I was just busy and thought it would be okay to do it the next day. R2's nursing progress notes dated [DATE] showed, Resident noted in dining room eating breakfast, nurse on duty noted to be observing residents in the dining room. Resident noted to be coughing while eating, nurse went to assess resident and decided to start the Heimlich maneuver. Resident noted to expectorate chewed up food from his mouth. Oxygen was administered to resident via non-rebreather mask at 10 liters, oxygen saturation noted at 68% with rapid breaths. 911 was called .resident transported to hospital for further evaluation . (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:00AM, V8 (LPN) stated, I worked the overnight shift on [DATE] and was still on the unit on [DATE] during (R2's) choking incident. I was sitting at the nurse's station charting and (V5-LPN) was passing medications outside of the dining room when she began yelling Help! Help! I looked in and (R2) was blue and looked lifeless. I ran over and started the Heimlich while (V5) went and got oxygen. (R2) looked like he was recovering so I went to call 911 and then (V5) called out for help again so I put the phone down and ran back over and helped her get (R2) to his room. We took him to his room and then I went to the nurse's station to call 911. His oxygen was in the 60's and he looked bad. There were no staff members near him when we ran into the dining room so there couldn't have been anyone providing 1:1 assistance. I didn't know there had been a choking incident the night before or that he needed a downgraded diet or 1:1 supervision. This is the first I'm hearing about this as it was never provided to me in nursing report. That is a significant event that should have been reported to me so that I could monitor him closely and make sure the correct interventions were implemented. From what I remember, (R2) had regular food on his plate and had been choking on sausage that was not ground up. On [DATE] at 11:07AM, V5 (LPN) stated, If a physician or nurse practitioner orders a resident to have 1:1 supervision, then that means staff are to be sitting next to the resident during mealtimes supervising them. If staff are not sitting with the resident and providing them cues or assistance, they could choke. I was working the day that (R2) had his choking incident. I was outside of the dining room passing medications and when I looked in, (R2) was blue. I called for help and (V8) ran in to help me and performed the Heimlich. We got (R2) to his room as fast as we could to finish caring for him while 911 was on their way. From what I remember, there were no staff members feeding (R2) otherwise they would have yelled for help when he started choking. On [DATE] at 1:30PM, V6 (Speech Therapist) stated, 1:1 supervision is provided to residents that are at high risk for swallowing difficulties that could result in choking. I would consider a resident that has had a recent choking incident at high risk for another episode. (R2) should have been provided 1:1 supervision as ordered until we could evaluate him and clear him. I remember walking in on [DATE] and (R2) was being wheeled out to the ambulance so we never even had a chance to evaluate him. On [DATE] at 2:54PM, V11 (CNA) stated, (R2) was on my assignment for [DATE] but I did not take him to the dining room. Night shift gets him up and takes him to the dining room, but nobody told me that he needed 1:1 supervision at meals. That wasn't normal for him, and I wasn't aware there had been an incident the day before with his swallowing. R2's death certificate dated [DATE] showed, Cause of death: complications from aspiration pneumonia, choking on food. On [DATE] at 2:42PM, V24 (Corporate Registered Nurse) stated, We didn't know (V7) gave orders to the nurse until you told us. It never came out in our investigation. It is absolutely unacceptable that the nurse didn't enter the orders or tell the oncoming nurse of the changes with (R2). If a resident is supposed to have a mechanically altered diet or receive 1:1 supervision at meals, then that is what we must provide for them. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy titled, Physician's Orders dated ,d+[DATE] showed, 1. Verbal telephone orders may be accepted form each resident's attending physician/Nurse Practitioner/Physician's Assistant by licensed nurses or pharmacists. Verbal orders must always be based on actual conversations with the prescribing practitioner or on approved written protocols .Verbal orders are documented in the resident's medical record with the date, time, and signature of the person receiving the order. As of [DATE], the facility was unable to provide a policy regarding supervision of residents at mealtimes. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the immediate jeopardy: (Facility) respectfully submits this Removal Plan which also represents the facility's allegation of compliance for F689 and on this date [DATE]. The facility requests the immediacy be removed as of [DATE]. Submitted on [DATE]. Residents who have suffered, or are likely to suffer, a serious adverse outcome because of the non-compliance: F689. o The facility failed to provide 1:1 supervision for R2 during mealtimes. o The facility failed to ensure that order for 1:1 supervision was input and carried out. o This failure had the potential to impact all residents who require 1:1 supervision during mealtimes. Action the facility will take: F689. On [DATE] education listed below was started by (V2-Director of Nursing), with all nursing staff that were working and those that were scheduled to work upcoming shifts on [DATE]. Education will continue to be conducted prior to the start of the next shift for each nursing staff and on an ongoing basis until all nurses scheduled to work have been educated and demonstrate understanding of the education through written quizzes and/or return demonstration of competency. Education will focus on all nursing staff with the potential to be impacted by the non-compliance and not limited to staff involved in the actual incident. On [DATE], a review of all residents who are at risk for aspiration, choking and/or noted with swallowing difficulty was conducted. All nursing staff were educated by (V2), or designee on the facility's Diet Consistency/Texture Change Protocol policy. Completed [DATE]- ongoing for incoming staff. All nursing staff were educated by (V2), or designee on 1:1 supervision for meals. Completed , d+[DATE]-ongoing for incoming staff. All nursing staff were educated by (V2), or designee on ensuring interventions were established to prevent further choking episodes based on root cause analysis/assessment. Initiated ,d+[DATE]- completed , d+[DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All residents who are high risk for aspiration/choking will be monitored at all meals by managers, nurses, CNAs. Initiated [DATE]-ongoing. Systems, Policies and Procedure: F689 On [DATE], (V2) and (V1-Administrator) reviewed policies and procedures on choking, diets, change in condition, and physician orders with the medical director. This review included but is not limited to staffing, addressing risk factors, assessing changes in conditions related to swallowing ability. The following policies were reviewed with no changes made. -Diet Consistency/Texture Change Protocol policy -Choking -Meal monitoring policy Monitoring, Audits, QAPI, and Facility Assessment. (V1) and (V2) conducted a review of compliance using Quality Assurance Audit tool for monitoring resident change in ability to swallow and/or requiring 1:1 supervision. An audit of residents at high risk for aspiration/choking was started on [DATE]. The audit will be done for 5 residents three times a week for four weeks, then weekly for four weeks. The results of the QA Audits shall be reviewed monthly by the Facility QAPI team to determine any necessary changes. The QA meeting is held at least quarterly and PRN. An emergency QA meeting was held on [DATE] by (V1) with the Interdisciplinary Care Team and Medical Director. Topics included residents at risk for choking, diet downgrades, and in services for physician orders and shift to shift report. The Medical Director and IDT approved this removal plan. This will be monitored by V1, V2, V3 (Assistant Director of Nursing).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, facility staff failed to implement physician's orders for a resident's (R2's) downgraded diet to mechanical soft, resulting in R2 experiencing a second choking episode. R2 expired in the local hospital on [DATE] from complications of aspiration pneumonia and choking on food. This applies to 1 of 3 residents reviewed for specialized diets in the sample of 8. This failure resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when R2 experienced a choking episode and R2's nurse practitioner ordered for R2 to receive a mechanical soft diet until he was evaluated by speech therapy. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 1:30PM. While the immediacy was removed on [DATE], noncompliance remains at a Level Two due to additional time needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R2's electronic face sheet printed on [DATE] showed R2 has diagnoses including but not limited to Parkinson's disease, dementia without behaviors, dysphagia, congestive heart failure, and muscle weakness. R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment and does not receive a mechanically altered diet. R2's physician's orders audit report for [DATE] showed, Mechanical soft texture, thin liquids. (This order was entered on [DATE] at 3:55PM after R2 was sent to the hospital following a choking episode). R2's nursing progress notes dated [DATE] showed, Resident was choking at dinnertime, and he was able to remove all the food. (V7-Nurse Practitioner) here and saw resident at the time after he was done with episode of choking. (V7) referred resident to re-evaluate for swallow study. R2's nurse practitioner visit note dated [DATE] showed, Patient seen and examined RN (Registered Nurse) requested he be seen due to choking during mealtime this PM. Seen sitting upright in wheelchair. He is currently being fed 1:1 with nursing staff. He remains aspiration risk. Patient on a modified diet .assessment: dysphagia discussed with nursing staff repeat speech therapy evaluation. Continue 1:1 feeding. Slow feeding. On [DATE] at 2:09PM, V7 (Nurse Practitioner) stated, I saw (R2) after his initial choking incident and staff were told to feed (R2) a mechanical soft diet until speech therapy could evaluate him the next day. I was very specific with the nurse on what I ordered so I'm not sure why none of my orders made it into his chart until after (R2) was hospitalized . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:00AM, V8 (Licensed Practical Nurse-LPN) stated, I worked on [DATE] and was present during (R2's) choking incident. I was sitting at the nurse's station charting and (V5-LPN) was passing medications outside of the dining room when she began yelling Help! Help! I looked in and (R2) was blue and looked lifeless .I didn't know there had been a choking incident the night before or that he needed a downgraded diet or 1:1 supervision. This is the first I'm hearing about this as it was never provided to me in nursing report. That is a significant event that should have been reported to me so that I could monitor him closely and make sure the correct interventions were implemented. From what I remember, (R2) had regular food on his plate and had been choking on sausage that was not ground up. On [DATE] at 9:51AM, V14 (LPN) stated, On [DATE] one of the aides notified me that (R2) was coughing while he was eating and looked like he was choking. I had (V7) assess him and she wanted me to downgrade his diet to a mechanical soft diet, but I never entered the order because I got busy. I was going to enter it in the morning when I came back so I thought it wasn't a big deal. I told (V8) about (R2) coughing, but I did not report any of (V7's) orders to him so he would have no way of knowing what (R2) needed. Looking back, I should have called the kitchen right away and notified them to downgrade (R2's) diet to mechanical soft .The orders should have also been entered into the medical record, so all staff were aware. R2's death certificate dated [DATE] showed, Cause of death: complications from aspiration pneumonia, choking on food. On [DATE] at 2:42PM, V24 (Corporate Registered Nurse) stated, We didn't know (V7) gave orders to the nurse until you told us. It never came out in our investigation. It is absolutely unacceptable that the nurse didn't enter the orders or tell the oncoming nurse of the changes with (R2). If a resident is supposed to have a mechanically altered diet or receive 1:1 supervision at meals, then that is what we must provide for them. The facility's policy titled, Physician's Orders dated ,d+[DATE] showed, 1. Verbal telephone orders may be accepted form each resident's attending physician/Nurse Practitioner/Physician's Assistant by licensed nurses or pharmacists. Verbal orders must always be based on actual conversations with the prescribing practitioner or on approved written protocols .Verbal orders are documented in the resident's medical record with the date, time, and signature of the person receiving the order. The facility's policy titled, Diet Consistency/Texture Change Protocol dated ,d+[DATE] showed, Licensed nursing staff, after thorough assessment, may use their discretion in ordering the following diets for residents, without initial physician order. 2. Modification in texture (puree, mechanical soft) .A diet modified in texture may be provided on a short-term basis as requested by speech therapy or a licensed nurse. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the immediate jeopardy: (Facility) respectfully submits this Removal Plan which also represents the facility's allegation of compliance for F808 on this date [DATE]. The facility requests the immediacy be removed as of [DATE]. Submitted on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents who have suffered, or are likely to suffer, a serious adverse outcome because of the non-compliance: F808. o A verbal order to downgrade diet for R2 was not carried out by the nurse. o The nurse failed to relay new orders at shift-to-shift report. o This failure had potential to impact all residents with a change in diet orders. Action the facility will take: F808. On [DATE] education listed below was started by (V2-Director of Nursing), with all nursing staff that were working and those that were scheduled to work upcoming shifts on [DATE]. Education will continue to be conducted prior to the start of the next shift for each nursing staff and on an ongoing basis until all nurses scheduled to work have been educated and demonstrate understanding of the education through written quizzes and/or return demonstration of competency. Education will focus on all nursing staff with the potential to be impacted by the non-compliance and not limited to staff involved in the actual incident. On [DATE], a review of all residents who are at risk for aspiration, choking and/or noted with swallowing difficulty was conducted. All nursing staff were educated by (V2) or designee on the facility's Diet Consistency/Texture Change Protocol policy. Initiated ,d+[DATE]-ongoing. All nursing staff were educated by (V2) or designee on facility's policy physician orders. Initiated ,d+[DATE]-ongoing. -Physician orders audited by (V2) or (V3-Assistant Director of Nursing) or designee. Initiated , d+[DATE]-ongoing. -Shift to shift will be audited by (V2) and (V3) daily to ensure completion. Audit tool will be utilized to ensure compliance. Initiated [DATE]. Systems, Policies and Procedure: F808 On [DATE] the facility DON, and Administrator reviewed policies and procedures on shift-to-shift report and physician orders with the medical director. This review included but is not limited to staffing, addressing risk factors, assessing changes in conditions related to swallowing ability. The following policies were reviewed with no changes made. Diet Consistency/Texture Change Protocol policy Physician Orders -Shift to shift report (continued on next page)

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F 0808 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitoring, Audits, QAPI, and Facility Assessment. (V2) and (V3) conducted a review of compliance using Quality Assurance Audit tool for monitoring of implementing physician orders. The audits will be done for 5 residents three times a week for four weeks, then weekly for four weeks by (V2) or (V3) until compliance is maintained. An audit of shift-to-shift report will be completed by (V2) or (V3) for 10 residents 5 days per week for 4 weeks. The results of the QA Audits shall be reviewed monthly by the Facility QAPI team to determine any necessary changes. The QA meeting is held at least quarterly and PRN. An emergency QA meeting was held on [DATE] by the Administrator with the Interdisciplinary Care Team and Medical Director. Topics included residents at risk for choking, diet downgrades, and in services for physician orders and shift to shift report. The Medical Director and IDT approved this removal plan. This will be monitored by the Administrator, DON, ADON.