STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510179	A. BUILDING: _____ B. WING _____	C 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENTREE AT MT VERNON	208 ZACHARY ROAD MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident 10/18/24 IL179837 The allegation can be substantiated. Violation 295.3000 cited.	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Violation Type 1 Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) Based on interview and record review, the Establishment failed to ensure staff were efficiently trained in recognizing signs of choking during meal service and properly trained in supervision at meal times; these failures resulted in death of R1 and has a significant negative impact on the delivery of emergency services to all residents residing at the facility. Findings include: The Establishments resident roster, dated 10/30/24 documents 84 residents that reside in the facility. The Establishments Medical Emergencies policy, dated 11/2029, documents, "Policy, It is the policy of this community, that all team members will be	A3000		

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A3000	Continued From page 1	A3000		

familiar with policies and procedures for handling minor and major emergencies. Team members will respond in a timely and efficient manner when a medical emergency occurs."

R1's Service Plan, dated 3/1/24 documents R1 is an 89 year old man with the diagnoses of Hypertension, Valve Replacement, and Acid Reflux and has a DNR in place. R1's Service Plan also documents he is independent with all of his ADL's including Eating. R1's Physician Assessment dated 4/16/24 documents he has no special dietary needs.

R1's incident report, dated 10/18/24 at 11:25 AM documents, "At 11:25 AM, staff member E5/Care Partner called writer/E2/Director of Wellness to dining room for emergency with resident. Resident presenting seizure like activity with left eye droop and lips cyanotic; 911 was notified; Resident was moved in the chair to the hallway away from other residents; finger sweep to rule out choking performed; writer with the assist of staff member E5 and E3/Dining Assistant placed resident on the floor and placed vital monitoring equipment on resident, no vitals noted 11:31AM, resident with active DNR in place; Z6/Ambulance arrived and placed EKG monitor on with no vitals noted and they notified the Coroner/Z1 at approx (sic) 11:41AM Coroner, Police/Z2 and son/Z3 arrived at approx (sic) 12PM. Daughter/Z4 arrived at approx (sic) Body will be released to (Local Funeral Home)/Z5 and MD notified of passing at 12:25PM this day."

The Establishment's menu, dated 10/18/24 at Lunch documents: Green Salad, Meatballs with marinara sauce, Angel Pasta, oven roasted broccoli, baked roll and peanut butter brownie.

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A3000	Continued From page 2 The EMS report, dated, 10/18/2024 documents " Called to (Establishment) for report of unresponsive person, possible a DNR PT, upon arrival found deceased 88 year male pt lying in hallway. FD (fire department) is obtaining EKG, no pulse or respiration, poor color, staff reports pt had just shortly before left lunch, fell to floor, he is DNR pt, they do have it for the pt. FD had PD contact (10-79) coroner, staff wanted to move the pt out of the hallway to the (unknown) a few feet way where they could shut the door. FD wanted to move pt out of hallway to his room around the corner. Pt moved to sheet, then to his room. Onset 11:27 AM at pt: 11:35 AM Impression: Obvious Death." The BLS (Basic Life Support) website documents: Choking is a common preventable cause of cardiac arrest. The correct response for a choking person depends on the degree of airway obstruction, whether the person is responsive or not, and the age of the person. Severe Obstruction signs: Clutching the neck, weak or no cough, unable to make noise or talk;may make high-pitched noise, little or no breathing, appears cyanotic (blue around the lips and finger tips) Rescuers reaction: stay with the person, try to keep them calm, encourage them to cough, call ems if worsen, use abdominal thrusts to attempt to remove obstruction, begin Basic life support if person becomes unresponsive. If you can see a foreign object in the individuals' mouth and can easily remove it then do it. Watch and feel for breathing to begin. If the individual does not begin breathing, continue to provide rescue breaths until help arrives." R1's Death Certificate, dated 10/18/4 documents	A3000		

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A3000	Continued From page 3	A3000		

Cause of Death, a. Asphyxiation, b. Aspiration of food bolus, c. Choked on food while eating."

E2/Director of Wellness on 10/30/24 at 8:20 AM E2 stated that she was notified on 10/18/24 at 11:25 AM that there was an emergency on the assisted living unit. I gathered my equipment and ran towards the AL and I was met by one staff member and R1 table mate R3 and was told there was an emergency with R1 in the dining room. E2 stated that he staff had moved R1's chair away from the table and around the corner. E2 stated that R1 was sitting in his chair with his head back, his lips were blue, I knew it was lunch time but lunch had just began and it did not appear that he had eaten. I did do a blind finger sweep, I did not see any food or feel any food, I wasn't sure if he had taken a bite, there were no food particles, we got him to the floor and I did a sternal rub he had no vital signs, I thought it might have been a seizure or a heart attack, no Heimlich/Abdominal Thrust was done. I knew he was a DNR he had no vitals when the EMT's arrived, they double checked his DNR status and sheet wrapped him and took him to is room."

On 10/30/2024 at 8:32 AM E4 Dining Service Director that oversees the kitchen stated that she was alerted about R1 but when she arrived R1 had already been moved to the hallway and was on the floor with the E2/Nurse doing sternal rub, there was no vitals signs, multiple people called 911, I got the defibrillator, there was no signs of life, there was no food in his mouth. and no signs of choking.

On 10/30/24 at 8:46 AM E3/Dining Services stated that she did not serve R1 his plate that day but as she was walking through the dining area, R1's table mate /R3 flagged me down, R1 was

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A3000	Continued From page 4	A3000		

not acting right, I looked at him, there was a plate at the table with some spaghetti, not sure how much but meatballs are served whole. E3 stated there was no sauce around his face, I checked if he was breathing, he looked at me with no response, I went to kitchen and got another staff, we went back to the table, pulled the chair out to get a better look at him, he began to shake, I thought it was a seizure. We grabbed chair and moved it to the hallway and shut the door for privacy. I checked for a pulse and didn't find anything and we put him on the floor."

On 10/30/2024 at 9:10 AM, R3/R1's table mate stated "When she arrived for lunch on 10/18/24 it had appeared R1 had already eaten, he's a good eater, he may have had some food left, maybe 1/2 of it was left on his plate. He did not talk that day, he seemed normal, I don't know when it started but he was sitting like a statue starring, I waved for someone and no one saw me, I said "Sir" and the gentleman came and took his chair and moved him down the hall, staff arrived immediately at that time. I don't know what happened after that."

On 10/30/24 at 9:30 AM, R2 stated that R1 was sitting at another table, I looked over thought he was having trouble breathing, it was around the noon hour, I raised my hand up and all of he workers came and pulled him to another room, he had been eating but I don't know what, I thought he may have choked but I wasn't sure. I didn't hear him choke but it seemed like he was trying to get more air. R2 stated that we we do get meatballs served whole but they are not real big."

On 10/29/24 at 11:20AM, Z1/Local Ambulance Representative stated "They were called out on 10/18/24 at 11:27 AM for an unresponsive

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A3000	Continued From page 5	A3000		

person, A DNR . We responded however upon our arrival, the fire department and police arrived before us and the fire department was doing an EKG without any pulse. Unfortunately he had passed away and we did not transport."

On 10/29/24 at 1:23 PM, Z1/Coroner stated that he was told that that the resident had went to lunch and had only eaten a few bites before an unknown person (resident) at the table alerted staff. I was told that staff had did a blind finger sweep. The food was down very far down in in esophagus/trachea and it would of been very hard to see. (it was noted on the CT scan conducted after death) He had a very large amount of food bolus in the trachea. The residents plate had already been removed and cleaned but I did notice other residents plates that had spaghetti and a meatball, broccoli and maybe a brownie for dessert. When I arrived he had been moved to his room and that staff had began CPR until the code status was presented.
Z1 was asked if a blind finger sweep should have been done in this situation, Z1 stated that unless you see the object a blind sweep should not be done." Z1 further stated that "an abdominal thrust should have been initiated in this case."
Z1 further stated that choking should have been suspected since it was during lunch time."

On 10/30/2024 at 10;40 AM, Z8/Registered Dietician stated that that anyone can choke on anything at anytime, I would hope that the staff would be able to recognize the indications and get help, Z8 further stated that sometimes there are no obvious signs of choking as such as someone grabbing their throat, coughing etc, and that during a choking event it may appear that the resident is having a seizure.. E8 stated that if a resident is in the dining room and presents with

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A3000	Continued From page 6 not normal behavior and becoming non responsive and lips turning blue, one should suspect the resident is choking." On 10/30/2024 at 8:57 AM, E1/Executive Director stated that the Establishment does not have a policy on Choking that the staff receive Basic Life Support training (includes choking) through an on line course and no hands on training is done with their staff."	A3000		