STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145336	A. BUILDING _____ B. WING _____	C 9/7/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR PAVILION	**66 WEST OAK STREET CHICAGO, IL 60610**

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F9999	FINAL OBSERVATIONS Surveyor: 15169 300.690(a) 300.1210(a) 300.1210(b)(6) 300.1220(b)(3) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each residents's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided	F9999		

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F9999	Continued From page 7 to each resident to meet the total nursing and personal care needs of the resident. 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. The DON shall supervise and oversee the nursing services of the facilty, including: Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements are not met as evidenced by: Based on interviews, record review, review of facility policy and procedures, the facility failed to update and amend a plan of care and allow for increased supervision for one resident (R1) at mealtime who had a known and documented swallowing problem, and a recent history of choking . Based on swallowing problems, the physician ordered a diet recommendation for R1 to receive a pureed diet. R1's family then requested that R1 be upgraded to a Mechanical soft diet because they felt R1 would not like a pureed diet. The facility had a waiver from the family drawn up on 07/07/04 to waive facility responsibility to provide the pureed diet based on family request not to serve resident the	F9999		

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F9999	Continued From page 8 recommended puree diet. . On 8/20/04 R1 was eating in a routinely unsupervised dining area and choked on food. The Heimlich Maneuver was done by staff , but was unsuccessful and R1 continued in respiratory distress and expired. The death certificate documents cause of R1's death as :Asphyxia and Aspiration of food bolus. The failure of the facility to supervise and revise the treatment plan after agreeing to upgrade the diet resulted in R1 being in dining room without close monitoring of staff. R1 was known to facility to be at risk for choking from previous episodes that required Heimlich Manuever while eating . Findings include: R1 was an 89 year old who was readmitted to the facility on 02/16/04, with diagnoses of; Dehydration, Pneumonia, Alzheimer's Disease, Hypertension, Osteoarthritis, Dementia with Behavior Changes and Agitation, Hypercholesterolemia, Syncope and Congestive Heart Failure. R1 was totally dependent on staff for all areas of care except that R1 was able to feed herself at times. A telephone interview was conducted with E7 (nurse) on 08/31/04 at approximately 11:05a.m. E7 stated that she had performed the Heimlich Maneuver on R1" several times in the past few months, due to her choking on food." E7 stated that R1's daughters insisted that R1 be fed a mechanical soft diet, but when she personally fed R1 she would feed her a pureed diet because she was concerned about the resident and her ability to swallow the mechanical soft diet without problem. An interview was conducted with Z4 (Diet Tech) on	F9999		

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F9999	Continued From page 9 08/31/04 at 11:56 a.m. Z4 stated that R1 had a history of swallowing and chewing problems for "about a year." The clinical record of R1 was reviewed on 08/30/04. The record contained nurse's notes dated 07/06/04 at 8:00 p.m., which stated, "Resident while eating dinner started to choke on her food. Resident could not free food particle from throat. Heimlich maneuver was performed and resident able to clear food from throat. Z1 (physician) notified and ordered pureed diet." On 07/07/04,the next day, the physician changed the diet order back to a mechanical soft based upon R1's family request. The record contained a waiver dated 07/07/04, which waived the facility of responsibility to provide R1 with a pureed diet. The waiver was signed by R1's power of attorney. Review of R1's clinical record contained a care plan dated 07/02/04 before the incident, that identified R1 with general swallowing problem. However, there was no evidence that the facility considered any plan of care that they needed to take after 7/7/04 after they were made aware that the resident had needed emergency intervention due to swallowing problems and that physician order to give a puree diet had been changed. Because the diet upgrade was made not based on resident need but family request, there was no plan or intervention documented on how they would monitor resident's acceptance of new diet and what type of supervision resident required from facility to ensure resident safety. The record also lacked documentation that the registered dietician evaluated resident after this episode, or that a swallowing evaluation was done.	F9999		

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F9999	Continued From page 10 On 09/01/04, at approximately 4:45 p.m., an interview was conducted with Z5 (police officer). Z5 stated, he arrived after R1 had already expired but during his investigation he discovered R1 choked eating a hamburger and bun as indicated on mechanical soft menu while unsupervised at told to him by staff. Staff performed Heimlich Maneuver but R1 continued having trouble breathing and was pronounced dead a few minutes later in the facility. Interview on 8/31/04 was held with E 9 (CNA) who found R1 on 8/20/04 at approximately 6pm in the dining room in distress and choking on her food. E9 who was not assigned to supervise the resident or the dining area, found R1 sitting with another resident and their family member and there was no staff assisting R1 with the meal. R1 laughed and began choking on her food. E 9 attempted the Heimlich Maneuver and claimed some food was coming out and that she stayed with the resident and sent a visitor for help. . E7(nurse) responded and per interview on 8/31 per phone, stated that she stopped passing medications and entered the dining room to help. E7 also performed Heimlich Maneuver and pieces of meat were removed. R1 continued in distress. 911 was called. E 8(ADON) applied oxygen. Paramedics and police arrived within a few minutes. R1 did not respond and was pronounced dead at 6:05pm in the facility. A review of the facilities, "Monthly Incidents/Accidents Reports," from 02/01/04 through 08/28/04 confirmed that no incident reports were filed to document the choking and Heimlich Maneuver episodes involving R1, on 07/06/04 and 08/20/04. The facility also lacked documentation	F9999		

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F9999	Continued From page 11 that the Illinois Dept. of Public Health was notified of the choking incidents. An interview was conducted on 08/31/04 with E2 (Executive Director) at approximately 10:35 a.m. E2 stated that R1 died after choking on food. E2 admitted that she did not report the death to the Illinois Dept of Public Health.	F9999		