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	14G058	A. BUILDING _____ B. WING _____	C 04/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTS & FRIENDS OF THE SLC	1450 CASEYVILLE AVENUE SWANSEA, IL 62226

(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) COMPLETION DATE
W 149	Continued From page 18 a finger sweep and removed a portion of long spaghetti noodles. R1 was still not breathing and chest compressions were started. The EMT (emergency medical team) staff arrived and took over." According to the local hospital's admission history and physical and the facility's Nurse's Notes of 3/21---3/22, R1 was admitted to the Intensive Care Unit with a diagnosis of Acute respiratory failure secondary to aspiration and choking and acute febrile illness, ruling out aspiration pneumonia managed by ventilator support from 3/21---3/23. During this hospitalization, per operative reports, R1 had a surgical procedure of an inferior vena cavogram, inferior vena cava filter placement for a right deep vein thrombosis on 4/4/07 and a gastric tube placement on 4/10/07. Nurse's Note of 4/17/07 states that R1 returned to the facility from hospital, alert and oriented with a final diagnosis of Acute Respiratory Failure and Aspiration Pneumonia.	W 149		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060d) 350.1060h) 350.1840b) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the	W9999		

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W9999	Continued From page 19 involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.1840 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by the following:	W9999		

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W9999	Continued From page 20 Based on interviews and record review the facility failed to implement their policy to prevent neglect when they failed to ensure that outside services met the needs of one of one resident in the incident investigation (R1). R1 developed Respiratory Failure/Aspiration Pneumonia and required hospitalization from a choking episode after receiving a diet of the wrong texture and consistency at Day Training. The facility failed to ensure: a) the implementation of R1's diet order for pureed with honey thickened liquids at the Day Training site; b) the implementation of R1's pace consumption eating program at the Day Training site; c) the collection and monitoring of R1's eating program data at the Day Training site; d) that diet order changes for R1 were transcribed to the current physician order sheets; e) the implementation of the facility's Outside Resource Standards policy and procedure and the development of a specific dietary policy/procedure that ensured that programs and services meet the needs of each client. Findings include: 1) The 8/3/06 Individual Program Plan (IPP) states that R1 is a 46 year old ambulatory female whose diagnoses in part are Severe Mental Retardation (MR), Schizophrenia, Mood Disorder, Idiopathic Sinus Tachycardia and Peripheral	W9999		

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W9999	Continued From page 21 Edema of the extremities. This IPP further states that R1's communication strengths are that she responds to her name by looking, says no, gestures and does follow some directions. R1 appears to understand most directions and follows them when compliant. R1's language weaknesses are that she is nonverbal, does not sign and is noncompliant. R1, according to her IPP takes the antipsychotic medications of Haldol and Seroquel, the antidepressant Nortriptyline HCL and the anticonvulsant agent Depakote ER in conjunction with her behavior program to help control her aggression and self injurious behaviors (SIB). These SIB include hitting her legs and bottom area, pinching her arms and inner thighs, pulling her hair out, biting and scratching herself. R1's aggression is identified as pulling hair, scratching and pinching others. It is also stated in this plan that R1 displays disruptive behaviors such as yelling, screaming and loud unusual laughter and that she self-stimulates in the form of pacing, making odd noises, towel chewing and chewing on soap. Per the IPP of 8/3/06, R1 has had 3 episodes of choking in the past year (8/05--8-06). These include the following: a) choking momentarily on a donut which resolved without requiring staff or nursing intervention on 9/4/05, b) choking after R1 had cleared her arched palate with her finger resulting in her becoming unresponsive requiring the Heimlich maneuver and a hospitalization for aspiration pneumonia	W9999		

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W9999	Continued From page 22 from 3/17---3/18/06. Per hospitalization transfer form R1's diet consisted of a limited concentrated sweets, mechanical soft diet with no bread, which may be substituted with crackers. c) an episode of choking on a pancake she had taken from a peer's plate on 7/3/06 requiring the Heimlich maneuver by staff and an emergency room visit. These choking episodes were being managed by direct supervision and an eating training program that consisted of having R1 pause between two consecutive bites of food and by taking a drink between each bite. This training program was established at the 8/3/06 interdisciplinary team meeting and was to be implemented at the residential and day training sites. It was also identified in this IPP that R1 was on a no bread, mechanical soft, limited concentrated sweets, no added salt, benefiber with breakfast and supper diet. Per the Registered Dietician (Z16's) assessment for the 8/3/06 IPP, R1 "does not receive bread because she has a history of choking on bread." According to the facility's investigation of R1's choking incident of 3/21/07, it was identified that R1 had another choking incident on 11/18/06 when eating braunschweiger and tomato soup. The Heimlich maneuver was performed by staff and the choking was resolved. At this time, 11/22/06, the physician ordered a mechanical soft diet with no braunschweiger sandwiches. Per the dietician's recommendations, R1 had a Modified Barium Swallow (MBS) on 11/30/06 due	W9999		

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W9999	Continued From page 23 to her history of choking, an eight pound weight loss and her refusal to eat. This MBS impression was "INTERMITTENT TRACE PENETRATION AND ASPIRATION OF VOLUME SWALLOWED." This MBS report recommended that R1 have nothing by mouth and that an alternative method of nutrition be considered. The recommendation further states that "If not an option, rec (recommend) pureed foods + honey thick liquids with the understanding that this will not keep pt (patient) 100% safe from penetration/aspiration." A 12/9/06 physician's notation on this report states that the "Family didn't want feeding tube. Explained (that the) patient (is a) high risk for aspiration pneumonia, respiratory failure and death." A physician's order for R1 to receive a pureed with thickened liquids diet then followed the above notation. a) The facility neglected to ensure the implementation of R1's diet order for pureed with honey thickened liquids at the Day Training site. As determined by 4/12/07 1:50PM and 4/16/07 10:14AM interviews with Z9, the Day Training's (DT) Licensed Certified Food Server, and a 4/12/07 1:40PM interview with direct support staff Z8, and confirmed by a 4/16/07 2:15PM interview with DT's program manager Z1 , R1 was served the incorrect diet of a limited concentrated sweet mechanical soft diet on 3/21/07 instead of the 12/04/06 physician ordered pureed diet with honey thickened liquids. This meal, per review of the facility's 3/21/06 menu, consisted of spaghetti casserole, three bean salad, mandarin oranges and bread. Food Service Staff Z14, who was on the job for	W9999		

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W9999	Continued From page 24 the second day and who was being trained by the Licensed Certified Food Server Z9 at the time of the incident, stated on 4/12/07 at 1:19PM that she just followed the "white paper" (serving list). Z14 further stated that Z9 would come in and out of the kitchen to see if I needed anything and would ask questions of whether or not I was all right. Z9 stated per 4/12/07 1:50PM interview that she was taking care of room one and would periodically come to the kitchen's serving window to see if Z14 needed anything. Z9 further stated that she does most of the food service training at the Day Program and was training Z14. Z9 stated that before R1's choking incident that day she had called the facility requesting a new server list because a new food server staff was starting and the serving list the Day Program was following was dated 2/15/06. Z9 also stated that 2/15/06 was the last diet change sheet she had seen. E1 confirmed during 4/16/07 2:15PM interview that Z9 called the facility requesting an updated diet listing on the morning before R1 choked because the one they were using was dated 2/06. DT Program Site Manager Z7 stated to the surveyor on 4/12/07 at 2:35PM that the last time she remembers receiving a diet order change list from the facility was in November or December of 2006. Z7 further stated that she makes a copy of the new serving list and then gives it to the kitchen staff. During a 10:35AM phone interview of 4/16/07, Z7 stated when she went back to check the menus she had on file she had only three. One facility serving list was dated 2/13/06	W9999		

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W9999	Continued From page 25 and two were dated 2/15/06. Dietary Manager E3 stated on 4/16/07 during a 9:30AM interview that she would personally bring a new serving list to the DT kitchen staff every six months and/or whenever there was a diet order change. Rarely would a new serving list be sent by the DT bus monitors by vanilla envelope, maybe 2-3 times a year. Per review of E3's "Diet Change--Food Service" list and confirmed by 4/16/07 interview with E3 it was determined that there had been at least 38 diet order changes since 2/15/06. Z15 the former Food Service Supervisor, per 4/17/07 4:00PM phone interview, stated that E3 came to the DT/kitchen once or twice a week to bring food/supplies and that she did not know that E3 was the dietary manager from the facility. Z15 further stated that she had worked the DT kitchen from March of 2006 through March of 2007, Monday through Friday from 10AM--2PM and that the facility's menu list did not change. Z15 stated that they had the same diet everyday. Z15 further stated that she knew what they (clients) were suppose to have and if she did not know what they were suppose to have, someone in the classroom would know. Z15 stated that she used the same paper/serving list. If the serving list changed she did not know about it. Z15 stated that her supervisors were Z7, Z1 and Z17, but in general if she had any problems she went to Z7. Interview with direct support person (DSP) Z2, on 4/12/07 at 2:00PM revealed that Z2 has worked in room 2 with R1 for about one year. Z2 stated that she did not know that R1 was not to receive bread and/or that she was on an eating program.	W9999		

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W9999	Continued From page 26 Z2 stated we would just monitor her for choking and prompt her to slow her eating pace. b) The facility neglected to ensure the implementation of R1's pace consumption eating program at the Day Training site. IPP of 8/3/06 states that R1 was on a structured Pace Consumption training program that was to be implemented at the residential and DT sites. R1's current eating program objective was to pause between two consecutive bites of food (taking a drink between each bite) with verbal assistance on 10 trials a month for 3 consecutive months. Per 4/12/07 11:15AM interview with the DT's Qualified Mental Retardation Professional (QMRP) Z12 and per review of Z12's personal notes of R1's IPP meeting, R1's diet was for a mechanical soft with no bread. Z12 stated he did not receive any orders to change R1's diet to a pureed. Z12 further stated that DSP Z2 should have been implementing R1's eating program. c) The facility neglected to ensure the collection and monitoring of R1's eating program data at the Day Training site. Residential QMRP E7 stated, during 4/12/07 3:35PM interview, that R1 should have been on a structured pacing eating program at the DT since the IPP of 8/3/06 but that she had never received any data from the DT in regards to this program. E7 stated that she never contacted the QMRP Z12 to question the lack of documentation on this eating program from him. E7 further stated that the facility has had monthly I-team meetings (Interdisciplinary) with the DT since she has	W9999		

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W9999	Continued From page 27 worked at the facility (Dec. 27th), and that R1's diet of pureed-honey thickened liquids was discussed at those meetings each month. Z12 stated on 4/16/07 at 11:15AM, that he attends most of the I--team meetings and admitted that he did indeed have a least one copy (Jan. 07) of those notes that stated that R1 was on a pureed diet with honey thickened liquids. d) The facility neglected to ensure that changes in R1's diet orders were transcribed to the physician order sheets. The Physician's Order Sheets (POS) from 1216/06 through 3/21/07 state that R1 is on a limited concentrated sweets, no added salt, mechanical soft, benefiber with breakfast and supper. These POSs do not reflect the diet order changes that were made by the physician as follows: 1) On 3/18/06 hospital transfer form ordered that R1 was not to have bread and that crackers could be substituted. 2) After R1's choking incident of 11/18/06 the physician ordered a mechanical soft diet with no braunschweiger sandwiches on 11/22/06. 3) After a Modified Barium Swallow, completed on 11/30/06 which identified intermittent trace penetration and aspiration of volume swallowed, the physician ordered, on 12/4/06, R1 to have a pureed diet with honey thickened liquids. The Director of Nursing (DON) E6 confirmed per 4/12/07 interview that R1's POS does not reflect	W9999		

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W9999	Continued From page 28 R1's diet order changes. E6 further explained that it is the facility's policy to fax the diet order changes to the pharmacy to update the POS and to give the new orders to the QMRP and dietary. Z13, the pharmacist, stated on 4/12/07 that either the pharmacy did not receive the dietary order changes or they were missed. e) The facility neglected to implement their Outside Resource Standards policy and procedure and neglected to develop a specific dietary policy/procedure that ensured that programs and services meet the needs of each client. The facility's policy titled "OUTSIDE RESOURCE STANDARDS" under procedure 4. states the following: "The Facility works closely with the outside programs to ensure a comprehensive, integrated, consistent, and efficient program of intervention suited to each client's needs. Programs and services are focused upon the individual needs of the clients and are designed to achieve the client's treatment, training, and habilitation objectives." Based on the DT's neglect to implement R1's diet order, neglect to implement R1's eating program, neglect to collect data on R1's eating program and monitor diet, it was determined that the facility failed to implement this policy. Per review of the facility's Dietary policies and procedures and confirmed by 4/16/07 9:00AM interview with the Administrator E1, it was determined that the facility has no specific dietary	W9999		

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W9999	Continued From page 29 policy or procedure that addresses the day program services except their written DT program contract/agreement. The 1/1/07 contract under section number 3. MEALS states the following: "The FACILITY shall be responsible for providing a midday meal for each of their individuals attending the DAY PROGRAM as specified by the FACILITY dietitian. The DAY PROGRAM shall provide facilities for serving the meals. The DAY PROGRAM shall be responsible for correctly serving the meal. The DAY PROGRAM shall implement individualized feeding training program as prescribed by the IDT, utilizing the individual's adaptive feeding equipment, and shall assume responsibility for such equipment lost or damaged at the DAY PROGRAM. Additionally, DT PROGRAM will provide sufficient staff to ensure all clients are properly assisted/supervised at meal time." The facility failed to implement their policy titled MISTREATMENT OF CLIENT'S. This policy states "The parents and Friends of the Specialized Living Center do not tolerate any form of abuse, mistreatment and/or neglect of the clients in our care." This policy further states under the section titled NEGLECT the following: "Neglect means: a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a client or in the deterioration of a client's physical or mental condition. (Section 1-117 of the Act) This shall include any allegation	W9999		

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W9999	Continued From page 30 where: The alleged failure causing injury or deterioration is ongoing or repetitious, or a client required medical treatment as a result of the alleged failure; or the failure is alleged to have caused noticeable negate impact on the client's health, behavior or activities for more than 24 hours." Per facility's investigation of the 3/21/07 incident , "During the meal R1 stood up and walked towards staff. R1 appeared to be choking. The Heimlich maneuver was started. R1 was still unresponsive when Z1 arrived. Z1 stated she did a finger sweep and removed a portion of long spaghetti noodles. R1 was still not breathing and chest compressions were started. The EMT (emergency medical team) staff arrived and took over." According to the local hospital's admission history and physical and the facility's Nurse's Notes of 3/21---3/22, R1 was admitted to the Intensive Care Unit with a diagnosis of Acute respiratory failure secondary to aspiration and choking and acute febrile illness, ruling out aspiration pneumonia managed by ventilator support from 3/21---3/23. During this hospitalization, per operative reports, R1 had a surgical procedure of an inferior vena cavogram, inferior vena cava filter placement for a right deep vein thrombosis on 4/4/07 and a gastric tube placement on 4/10/07. Nurse's Note of 4/17/07 states that R1 returned to the facility from hospital, alert and oriented with a final diagnosis of Acute Respiratory Failure and Aspiration Pneumonia. (A)	W9999		