STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 03/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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
F 354	Continued From page 7 staff person as the director of nurses. This section of the form was not completed. The Facility Data Sheet identified that E3 as the "acting director of nursing."	F 354		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b)6) 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by the following:	F9999		

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F9999	Continued From page 8 Based on closed record review and interviews, facility staff failed to ensure that residents receive the necessary care and services to maintain adequate nutritional intake and to decrease the risk of aspiration for one resident (R2) that was fed a pureed diet through a large (50cc) syringe. As a result of this failure, R2 was admitted to the hospital with a diagnosis of aspiration pneumonia and sepsis and expired. Findings include: R2 was an 87 year old resident with diagnoses including Alzheimer's Disease, hypertension and asthma. According to the most recent resident assessment dated 9/24/06, R2 had difficulties with long and short term memory recall. Facility staff also identified that R2 had severely impaired cognitive skills for decision making. R2 was totally dependent on facility staff for all of her care needs. During a telephone interview on 3/8/07, Z1 stated that she had concerns regarding the method in which facility staff used to feed R2. Z1 stated, "they were not feeding her the right way." Z1 stated that facility staff would use a syringe to feed R2. Z1 stated facility staff informed her, via telephone, that they were feeding the resident with a syringe. Z1 stated that she was very disturbed when she saw the manner in which staff fed R2. Z1 stated that facility staff filled a large syringe (50cc) with pureed foods. Z1 stated that staff used the same size syringe that is used for flushing gastrostomy tubes, to syringe feed R2. Z1 stated, "I didn't know they were shooting food through her mouth." Z1 stated that on 11/7/06, she walked in while staff were syringe	F9999		

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F9999	Continued From page 9 feeding R2 and the resident was "aspirating." Z1 stated that the resident was coughing and choking. Z1 further stated the certified nursing assistant continued to feed the resident, although she was having difficulties. Z1 requested that staff stop feeding the resident, because she was "aspirating." Z1 also requested that facility staff call the doctor and have the resident sent out to the hospital. Z1 stated that facility staff suctioned the resident, but did not send her out to the hospital. R2 was not transferred to the hospital until 11/8/06, the following day. R2 was admitted to the hospital with a diagnoses including aspiration pneumonia and sepsis. R2 expired on 11/23/06. On review of the clinical record, there was documentation that the physician gave a telephone order on 1/27/06 for a swallow evaluation. There was no documentation in the clinical record indicating that the swallow evaluation was done. Facility staff were not able to present documentation of the swallow evaluation. On 6/6/06, the physician ordered another swallow evaluation. It was documented on the physician's order sheet on 6/9/06 that the swallow evaluation was completed. The following recommendations were made: Change liquids to nectar thick; begin dysphagia treatment for oral motor exercises; compensatory strategies; diet modification and diet recommendations 5 times per week for four weeks. On review of the clinical record, R2 had physician's dietary orders for a pureed diet with nectar thick liquids, med pass supplement 60cc four times daily, ProMod 1 scoop by mouth twice daily, and supercereal.	F9999		

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F9999	Continued From page 10 On 7/7/06, Z2 (former speech language pathologist) documented, "resident monitored during AM feeding coughing noted on puree consistency; spoke with certified nursing assistant regarding aspiration precautions and compensatory strategies for feeding resident to decrease risk of aspiration (will post at bedside)." Staff were syringe feeding R2 without having a physician's order. The physician did not write an order for syringe feeding until 9/27/06. According to the physician's instructions, "may feed resident using a syringe." During an interview on 3/7/07, E10 (speech language pathologist) confirmed that she observed certified nursing assistants feeding R2 with a syringe. E10 stated that staff used a large syringe filled with pureed foods. E10 further stated that she had concerns regarding the feeding method that was used (syringe) for R2. E10 denied that she was ever involved with feeding R2. E10 also denied that she ever gave staff specific instructions on the proper techniques of syringe feeding. There was no documentation supporting that staff were trained on proper techniques for compensatory feeding strategies (syringe feeding). The facility was not able to present any guidelines or protocol for syringe feeding. In addition, facility staff were not able to present any inservices for teaching methods for syringe feeding. On review of the clinical record, there was documentation to confirm that the certified nursing assistants fed the resident by syringe. During an interview on 3/8/07, E12 (certified	F9999		

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F9999	Continued From page 11 nursing assistant) stated that she put the food in a large syringe and mixed it with liquids. During an interview, E11 (certified nursing assistant) stated that she would put the pureed foods in the syringe and feed the resident. E11 stated that she would alternate between food and liquids. Facility staff were not able to demonstrate consistency in the proper feeding method for syringe feeding. On review of the clinical record, there was no protocol for syringe feeding. Facility staff were not able to present a facility policy for syringe feeding. In addition, on review of the in-services for one year, there were no in-services on proper feeding techniques for syringe feeding. Facility staff were not able to demonstrate that staff were trained on the proper techniques for syringe feeding. The facility failed to ensure that R2 received the necessary care and services to meet her nutritional needs. (A)	F9999		