STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032

(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 485	Continued From page 36	W 485		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 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 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interview the facility failed to ensure individuals in the facility who may potentially steal food and eat it in an unsupervised location (R2-R16) are provided	W9999		

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	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 37 sufficient safeguards. R1 was known to steal food when left unattended, and was allowed in the kitchen with access to prepared food without supervision. R1 filled his mouth with food, choked and later expired from this incident. This impacts 15 of 15 clients (R2-R16) remaining in the facility and 1 expired client (R1) when the facility failed to: 1) Implement their policy on neglect for (R1) while he was unsupervised in the kitchen, ate prepared food, choked on food and later expired at the hospital. 2) Ensure potential allegations of neglect are thoroughly investigated with a reproducible report and corrective actions to ensure client supervision and safety. 3) Ensure individuals with a behavior program for stealing include documentation of specific identified stealing behaviors that also included food. 4) Ensure individuals who have access to food are provided sufficient supervision. 5) Ensure staffing to meet the supervision needs for the clients during the time prepared food is accessible for client consumption. Findings include: On 11-30-11 an Immediate Jeopardy was identified to have begun on 11-11-11 when the facility failed to ensure individuals residing in the facility are provided adequate supervision when food is prepared and accessible, including completing a thorough investigation and sufficient corrective actions, based upon the incident which occurred on 11-11-11 when R1 choked on food at	W9999		

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	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

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W9999	Continued From page 38	W9999		

the facility while unsupervised and expired at the hospital.

The Individual Service Plan dated 9-29-11, R1 is a 47 year old male who is ambulatory. R1 functions in the Moderate Range of Mental Retardation. R1's list of diagnoses includes Intermittent Explosive Disorder, Kleptomania, and Impulsive Control Disorder.

According to the undated Flow Sheet for R1 given to the surveyor on 11-29-11 is as follows:

After he ate dinner approximately at 6:00 p.m., R1 got up to do his dishes in the kitchen (R1 was unsupervised in the kitchen). E4 (Direct Support Person) was going to get seconds for R16 and went into the kitchen and saw R1 in the kitchen with his cheeks full of food. E4 asked R1 to spit out the food and he shook his head no. E4 asked R1 to go sit at the table so he wouldn't choke. R1 walked back to the table to his chair but wouldn't sit down. R1 was acting unusual, gagged a little. Thought he was going to throw up. R1 started walking toward the kitchen. E4 followed and walked back to the kitchen over the sink after showing signs of choking. E4 did back blows. Food started to come up. R1 kept swallowing food back down. Then started Heimlich and food was not coming up. E4 observed R1's ears turning purple and told E5 (Direct Support Person) to call 911. R1 then stepped away from the sink toward trash can and started to go down. E4 immediately started compressions and E5 (Direct Support Person) got gloves and performed finger sweep. E4 stopped compressions to do a finger sweep and to check for a pulse. No pulse and couldn't get large

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	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

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W9999	Continued From page 39	W9999		

chunks of food out. Restarted compressions. E6 left a message for E1 (Administrator) and E12 (Residential Service Director). Ambulance arrived and E4 continued compressions until they set up. Emergency Medical Technicians then took over compressions and tried to get an airway and get food out. R1 was taken to the hospital and later expired on 11-18-11.

According to the report of the Safety Committee dated 11-14-11 is as follows: Individual involved R1. Staff involved in the incident of 11-11-11 were E4 (Direct Support Person), E5 (Direct Support Person), and E6 (Direct Support Person) The committee members were E1 (Administrator), E2 (Qualified Mental Retardation Professional), E12 (Residential Service Director), E13 (Registered Nurse Consultant), and E14 (Regional Trainer). The summary of the incident states that the safety committee met by phone on 11-14-11 to review a choking incident. On the evening of 11-11-11, R1 finished his supper and put his dirty dishes in the dishwasher. While in the kitchen, R1 put an extra fish filet in his mouth that was covered in the kitchen. R1 began to choke on it. E5 (Direct Support Person) called 911 and E4 (Direct Support Person) began back blows and abdominal thrusts. The attempts to remove the fish were unsuccessful, R1 lost consciousness and cardiopulmonary resuscitation was started by E4. Cardiopulmonary resuscitation continued until Emergency Medical Services arrived. The documentation that was reviewed was the progress notes (GP-15). The committee findings were that "staff followed proper procedure for a choking incident according to training" done through company policy. The committee considerations were for "all staff to review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 40	W9999		

procedures for choking incidents at the next monthly staff meeting" (to be held on 11-14-11). This documentation was given to this surveyor. The only recommendation from the safety committee is to review procedures for choking at the next staff meeting. This surveyor was not given any documentation for safeguards and evaluation of or recommendation related to the supervision of clients during meals. There is no evidence that the remaining clients R2-R16 who are unsupervised in areas where food is left unattended is addressed by the safety committee ensuring appropriate safeguards are in place.

Per interview with E1 (Administrator) on 12-2-11 at 11:00 A.M., when asked if there are any other clients at this facility with an identified behavior of stealing food, E1 replied "all of the individuals will tend to steal food if it is available". When asked if any other clients at this facility have specific programming for food stealing, E1 replied he didn't know he would have to check.

Per interview with E2 (Qualified Mental Retardation Professional) on 11-29-11 when asked why did R1 take the extra fish E2 replied he just wanted it and it was there so he took it. When asked if there was an investigation to this incident, E2 replied we did a safety committee. When asked if food is around should R1 be monitored? E2 replied if he is eating you always monitor when eating. When asked what is being done to prevent this incident from reoccurring? E2 stated staff meeting reviewed policy. This was one of the things that we could not prevent from happening. When asked if R1 was alone in the kitchen? E2 stated yes it is possible that he was alone in the kitchen. When asked if any clients

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W9999	Continued From page 41	W9999		

were interviewed E2 stated no, not that I know of we had 3 staff that witnessed the whole thing and residents were involved enough as it was.

Per interview with R3 (Client) on 11-29-11 at 3:57 P.M. stated we saw the whole thing how it happened it was a fish he choked on.

Per interview with R2 (Client) on 11-29-11 at 4:30 P.M. when asked if anyone interviewed you or took a statement from you in regards to R1, R2 replied no one talked to me about him.

Per interview with R5 (Client) on 11-29-11 at 4:03 P.M. when asked what happened, R5 stated R1 went in there (pointing to kitchen) grabbed a piece of fish and got it lodged in his throat. R5 stated they called 911 and they could not get it out.

Per interview with E3 (Direct Support Person) on 11-29-11 at 5:40 P.M. when asked if R1 had a history of stealing food, E3 stated yes. When asked should he be monitored in the kitchen? E3 stated he should be, but he is quick. When asked if R1 had any choking issues? E3 stated sometimes yes, if he eats too fast we would have to tell him to slow down and put his hands on his lap. When asked what was R1's supervision level? E3 stated you would have to watch him very closely due to his issues, he is the one client, most watched due to stealing issues.

Per interview with E4 (Direct Support Person) on 11-29-11 at 1:34 P.M. when asked if R1 ever stole food before, E4 stated yes if he wanted to he would take it. When asked where were you when this injury occurred? E4 stated I was in the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	**2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032**

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W9999	Continued From page 42	W9999		

room and my back to the kitchen. E4 stated I did not see him go into the kitchen, it was an accident that I found him there was no cook on duty that day. When asked who was the first to see him? E4 replied I was the first to see him I had went into the kitchen and saw him. When asked if anyone had seen R1 put extra fish into his mouth? E4 replied no that is R1 he would like to take things. When asked who is responsible to supervise the kitchen E4 stated if we have a cook then she would have been. When asked any of the clients have a potential for choking? E4 replied several R1, R4, R16, R12, R10, R9, and R14 might. E4 stated "you gotta watch them."

Per interview with E5 (Direct Support Person) on 11-29-11 at 1:12 P.M. when asked if R1 ever stole food, E5 replied yes. When asked if this was part of his behavior, E5 stated he steals anything he can find. Where were you when this incident occurred? E5 stated I was facing the other direction and I did not see R1 go into the kitchen. When asked if R1 should be monitored in the kitchen, E5 replied we have to watch him all of the time.

Per interview with E7 (Direct Support Person) on 11-29-11 at 5:01 P.M. When asked if R1 had a history of stealing food, E7 stated yes. E7 stated that R1 had a compulsive disorder and if clients would have left half of their crackers at the table then R1 would take them if left unattended.

Per interview with E8 (Cook) on 11-29-11 at 4:14 P.M. when asked if R1 had a history of stealing food, E8 stated yes. When asked if R1 should be monitored in the kitchen, E8 stated R1 should be monitored in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	**2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032**

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W9999	Continued From page 43 Per interview with E9 (Direct Support Person) on 11-30-11 at 9:20 A.M. when asked if R1 had a history of stealing food, E9 replied yes. When asked if food is left unattended in the kitchen should R1 be supervised, E9 stated probably due to his history of taking food. Per interview with E10 (Direct Support Person) on 11-30-11 at 9:08 A.M. when asked if R1 had a history of stealing food E10 stated yes. When asked if she saw R1 steal food. E10 replied on numerous occasions. When asked if the kitchen should be supervised if R1 is in the kitchen, E10 replied I would say generally the kitchen is supervised. I knew he would be in there then I was there. Per interview with E11 (Direct Support Person) on 11-30-11 at 9:30 A.M. when asked if R1 has a history of stealing food, E11 replied yes. When asked if you have ever seen him steal food, E11 replied yes in the breakfast time he would take the sausage if he could. When asked if R1 is in the kitchen should he be supervised, E11 replied we always tried. The following is a list of Progress Notes (GP-15) by facility staff E5, E6, and E4 on the incident day of 11-11-11: According to the Progress Note (GP-15) dated 11-11-11 written by E5 (Direct Support Person) is written R1 was coming out of the kitchen where he stuck a piece of fish in his mouth. It was apparent that he was choking at that point. R1 was directed to the kitchen. According to the Progress Note (GP-15) dated	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	**2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032**

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W9999	Continued From page 44	W9999		

11-11-11 written by E6 (Direct Support Person) is written R1 went into the kitchen to wash his dish and he took a left over piece of fish and put it all in his mouth. He then left the kitchen and went to the table but did not sit down. Then we noticed he was starting to choke and we took him into the kitchen.

According to the Progress Note (GP-15) dated 11-11-11 written by E4 (Direct Support Person) is written after R1 had eaten supper he went to the kitchen to do his dishes. At this point he took an extra piece of fish. Staff then walked in and saw his cheeks full of food. R1 was asked to sit down so he wouldn't choke. At the table he began choking. E5 called 911 and staff assisted R1 to the floor and started compressions. E6 attempted finger sweeps.

Per record review of the Individual Service Plan dated 9-29-11 states R1 is often anxious, he is independent in mobility and activities of daily living are done with supervision. R1 requires 24 hour supervision and active treatment services due to his limitations displayed in the life areas of Self Care, Self Direction, Learning, and Capacity for Independent Living. The ISP states that R1 will receive a formal program in the dietary area. The ISP states E15 (Psychologist) diagnostic impressions indicate that R1 has Severe Mental Retardation. This is a two dimensional diagnosis : IQ and Adaptive Behavior, both of which were currently assessed and fall in the severe range. This evaluation strongly suggests that R1 will continue to require 24 hour supervisions and active treatment services due to deficits in adaptive behavior and cognitive functioning. Under behavior in the ISP it states that R1 has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032

(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
W9999	Continued From page 45	W9999		

had a few incidents of stealing. R1 would collect pictures, steal pop, and magazines from other residents as well as the library and any other public place. Due to his increase in stealing R1's formal program was implemented in 2000. Primary behavior priorities for R1 were compulsive drinking, stealing, and non - compliance agitation.

According to the record review of the Stealing Behavior Program Form dated 10-1-10 states R1 has a history of stealing from others. In the past, he would tear pictures out of magazines and collect them. He would go into other people's room and steal their magazines or movie covers and tears them into pieces. R1 has also been observed stealing food or pop when it is unattended. When R1 is confronted with his stealing, he sometimes becomes angry at staff for identifying that the items are not his. R1 does not like to be confronted about stealing. R1 needs to be approached in a gentle manner. When R1 engages in the targeted behavior, staff will inform him that this is unacceptable and remind him that he is unable to receive his reward for that day.

Per record review of the Maladaptive Behavior Recording Form dated 11-1-11 through 11-30-11 states Stealing for R1 with dates 11-1, 11-5, 11-6, and 11-8 as only a check mark. The interventions are return stolen item and one on one with staff. This documentation does not specify what R1 steals, if it was food or something else. This documentation does not identify R1 stealing on 11-11-11.

Per interview with E12 Resident Service Director on 11-30-11 at 2:25 P.M. when asked on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	**2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032**

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W9999	Continued From page 46	W9999		

Maladaptive Behavior Recording Form the last check mark for stealing was on 11-8-11 for R1. Why was it not documented on 11-11-11? E12 stated "I can not answer that."

According to the Compulsive Drinking Behavior Program Form dated 8-1-11 states according to staff observation and day training reports, R1 will compulsively drink excessive fluids whenever he has an opportunity to do so. R1 will go to extreme measures to drink excessive fluids. R1's fluid consumption will be monitored through communication with staff and daily conversations with R1.

According to the Prehospital Care Report dated 11-11-11 is written R1 had a chief complaint of choking for five minutes. The patient was in cardiac arrest for 2 minutes. Upon arrival R1 was unresponsive and cyanotic. R1's airway did not improve with positioning of airway. Attempted to clear some of the food in R1's throat and mouth with forceps, removed as much as could, also attempted suctioning. R1 transported to hospital with continuation of cardiopulmonary resuscitation.

Per record review of the Hospital Brief Progress Note dated 11-11-11 is written R1 is a 47 year old man with developmental delay who lives in a group home. This evening at approximately 5:50 P.M. he aspirated a large pieces of fish and showed signs of choking, quickly losing consciousness. R1 has sustained a prolonged hypoxemic cerebral insult as a consequence of near asphyxiation after aspirating a large piece of fish. He very likely has an element of negative pressure pulmonary edema and we can assume

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032

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W9999	Continued From page 47	W9999		

that he has also aspirated oropharyngeal secretions. The facility did not provide this surveyor any documentation of an investigation into the amount of fish that R1 had consumed.

Per record review of the Hospital Adult Illness form dated 11-11-11 is written R1 47 year old man with mental retardation lives in a group home. R1 ate supper then left with a large piece of fish which he crammed into his mouth. R1 choked and collapsed. Paramedics arrived with R1 in cardiac arrest. They performed airway but could not intubate due to large food / fish. Upon arrival R1 was cyanotic, asystole and cardiac pulmonary resuscitation in progress.

According to the Hospital Patient Registration Form dated 11-11-11 is written principle diagnosis for R1 cardiopulmonary arrest, aspiration pneumonia, anoxic encephalopathy, and developmentally disabled moderate severe.

Per record review of the Facility Policy Number 5.39 dated 11/08 states the facility shall provide appropriate supervision for all individuals served. Staff shall be aware of the location and activities of all individuals in their care whether in direct visual contact or not. The proximity of the supervision shall provide reasonable safety and yet afford the individual sufficient independent activity and judgement to foster growth. Where risks of injury are high and likely benefits to the individual are low, staff shall exercise greater supervision. The facility failed to implement this policy by R1 being unsupervised and allowed access to food unattended in the kitchen where the risk is considered high for a client with a food stealing programing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGE TERRACE	2911 HIGHLANDVIEW DRIVE FREEPORT, IL 61032

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W9999	Continued From page 48 Per record review of the Facility Policy Number 5.57 dated 09/09 states neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. In the case of abuse, neglect, or injury of unknown origin, the staff who witnessed or first became aware of the incident shall report the incident. This documentation shall be given to the Qualified Mental Retardation Professional for review and follow up. The QMRP/ Administrator shall conduct any necessary interviews or inquiries to establish the probable cause of injury and document the findings on the Progress Note. The facility failed to implement this policy by not conducting the necessary interviews to establish the probable cause of injury for R1 being unsupervised in the kitchen with food left unattended. Per record review of the Facility Policy Number 5.29 dated 11/08 the facility shall have a quality assurance committee to review medical issues and individuals incident reports. The quality assurance committee assists administration by ensuring practices and policies regarding nursing services, facility environment and individual's safety meet regulatory standards and quality outcomes. The committee consists of the following members Administrator, registered pharmacist, registered nurse, physician, and qualified mental retardation professional. The committee is to review all incidents and accidents including injuries involving individuals and staff to ensure that no patterns or trends are occurring. The committee will implement a plan of correction when necessary to prevent future incidents or accidents. This surveyor was not given any	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

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(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
W9999	Continued From page 49	W9999		

reproducible evidence that this policy was implemented.

Per record review of the Facility Policy Number 5.24 dated 5/11 is to establish an Investigative Committee to assist in the protection of individual rights and to provide a liaison between the individual and the administration of the facility. The definition of neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The investigative committee shall be responsible for the following to identify, review and determine if alleged violations of any individuals rights including abuse and neglect have occurred. To investigate allegations in a professional and impartial manner. To protect individuals from further harm. The policy states under procedure that if the allegation is one of the following situations the Administrator or designee will contact law enforcement by calling 911 or the local emergency number: when a resident's death has occurred other than by disease processes. The administrator shall call a meeting of the investigative committee. The committee members shall meet to review the allegations, conduct interviews and examine the information available that is pertinent to the incident. Upon completion of the committee investigation, a report containing the findings shall be presented. The administrator shall make the final decision as to the appropriate action required, taking into consideration the findings and recommendations of the committee. The committee shall meet on an as needed basis and reports of meetings shall contain findings, recommendations, and a plan for implementation, as appropriate. The frequency is whenever knowledge or suspicion of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G184	A. BUILDING _____ B. WING _____	C 12/12/2011

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W9999	Continued From page 50	W9999		

any violations of rights, abuse, or neglected is reported. This surveyor was not given any reproducible evidence that this policy was implemented.

Per record review of the Facility Policy number 5.49 dated 07/08 is written, the facility shall have a safety committee to review all incidents and accidents occurring involving residents and/or employees that result in injury. If the injury is suspected to be abuse / neglect or of unknown origin then implement Policy 5.24. The policy states that the committee shall conduct any necessary interviews or inquiries to identify if patterns or trends exist. The committee will attempt to determine the cause of injury and provide a list of considerations relevant to prevention of further incidents / accidents. If the safety committee determines that the injury is a result of abuse or neglect or of unknown origin, the safety committee will refer the matter on to the investigative committee. This surveyor was given this documentation but the facility failed to conduct any necessary interviews as based in their policy. The facility failed to provide a list of considerations relevant to prevention of further incidents, with the only recommendation given to this surveyor, was to review procedures for choking at the next staff meeting. The facility failed to recognize this incident as neglect in supervision and therefore the facility did not implement this policy.

According to the Safety Committee progress notes dated 11-14-11 they state: The committee findings were that "staff followed proper procedure for a choking incident according to training" done through company policy. The

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W9999	Continued From page 51 committee considerations were for "all staff to review procedures for choking incidents at the next monthly staff meeting" (11-14-11). There is no evidence that the safety committee reviewed this client's (R1) lack of supervision while in the kitchen where food was left unattended or other clients needs for supervision during times when food is accessible. According to the interview with E1 (Administrator) on 11-30-11 at 12:10 P.M. when asked if there was any investigation, E1 replied a safety committee. When asked if any policies were revised E1 stated no. When asked if any supervision levels were revised E1 stated no we had 3 staff that night (11-11-11) and that more than meets the requirements. When asked if there were any recommendations as a result of the investigation E1 stated "this did not meet the requirement for the investigation policy." When asked but you had a negative outcome and based on your safety committee what are the results of this committee to ensure that this would not occur again. E1 replied continue annual in-service on cardiopulmonary resuscitation, keep staffing ratio at or above requirements, and assess people for potential choking hazards which R1 was not. (A)	W9999		