STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

IONA GLOS SLC
Facility Name

0022996
I.D. Number

50 SOUTH FAIRBANK STREET ADDISON, ILLINOIS 60101
Address

4/18/2005
Date of Survey

COMPLAINT
Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.1230d)1)
350.1840b)
350.3240a)

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 the operation of the facility and shall be reviewed at least annually.

Direct care personnel shall be trained in, but are not limited to, the following:

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.

These regulations were not met as evidenced by the following:

Based on interviews, record review, review of incident reports, and the facility's incident investigations Reports, the facility failed to ensure staff implement policies and procedures to prevent neglect to R9. On 3/16/2005, during the evening 8:00 p.m. snack, R9 stole a peanut butter sandwich from another individual and stuffed it in his mouth. R9 chocked on the sandwich and the Heimlich Maneuver was performed to dislodge the sandwich. On 3/17/005, staff neglected to provide R9 a pureed diet which was an identify priority need due to his episodes of choking. R9 received an mechanical soft diet which consisted of a peanut butter and jelly sandwich, R9 choked on the sandwich, went into respiratory/cardiac arrest and subsequently died from the results of his injuries.

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Incident report dated 3/16/2005 was reviewed on 4/4/2005 which identified an incident regarding R9 choking. Incident report stated on 3/16/2005 at 8:40 p.m. "staff stated (R9) choked on a peanut butter sandwich. Heimlich was performed (no) loss of consciousness.... Sent to ER (emergency room) via ...ambulance." Interview with E4, direct care staff, on 4/4/2005, states he was present at the home when the incident occurred. E4 stated it was snack time at around 8:00 p.m. R9 sat at the table with 4 other individuals (3 individuals were on a mechanical soft diet; 2 were on a pureed diet and 1 on a regular diet). E4 stated R9 completed his snack and was just sitting at the table and proceeded to grab the sandwich. E4 stated R9, with verbal prompts from staff, usually will return the food he takes but he proceeded to stuff it in his mouth. E4 stated R9 was gasping (for breath) and E4 initiated the Heimlich and was able to get the sandwich up and out of his mouth. E4 stated R9 is quick and he normally will put it back or spit it out with prompts."

E3, Nurse, was interviewed on 4/4/2005 and stated she was the nurse who arrived first to the home. E3 stated R9 was alert and talking. R9 was transferred to the hospital per facility procedure for further evaluation of his choking incident. Review of emergency room transfer report states R9 returned to the home at approximately 12 midnight in the early morning of 3/17/2005.

Interview with E8, direct care staff, who worked the a.m. shift on 3/17/2005. E8 stated R9 stayed home on 3/17/2005 because he had choked the day before (3/16/2005) and slept most of the day until approximately 12:30 p.m. when he woke up.

E6, direct care staff/driver, who worked the a.m. shift on 3/17/2005 was interviewed on 4/4/2005 and stated the following events: E6 stated she was sent to Home 1 to relieve E8 for her lunch break for 30 minutes . E6 at approximately 12:55 p.m. "she entered through the kitchen and there was one lunch on the table with a sandwich, cut into little pieces measuring approximately 1 to 1-1/4 inches square. E6 stated there were 2 sandwiches and each were cut into approximately 20 pieces, liquids were poured into cups, lunch was a double portion and no lunch bag was present at the table. E6 stated she told E8, since she had set up the lunch, she will assist him with eating. E6 stated she sat with R9 since he eats independently and he took 2 to 3 bites of his cut up sandwich then he ate his 2 containers of cole slaw without any problems. E6 stated R9 then wanted her to open his cookies and she did. R9 proceeded to grab for another piece of sandwich and E6 offered him milk but he refused. R9 continued to eat bite size pieces and E6 stated she continue to offer him milk between bites but he continued to refuse to drink the milk. E6 said R9 began to start "smacking" as if the peanut butter was sticking to the roof of his mouth and E6 insisted that R9 drink his milk but he refused. E6 asked R9 to spit the food out but he did not, so E6 went into his mouth and was able to get some of the food out and he was trying to cough the food out of his mouth but he seem to be having trouble getting it out. E6 stated she went behind R9 and did the Heimlich 2 times and when this did not work, she ran to the phone and called "stat to Home 1". E6 said while she was on the phone, R9 wheeled his chair backwards to his room (client awake and alert at this time). E6 got off the phone and saw that R9 had wheeled himself to his room, she ran into his room and observed that his lips and earlobes were turning blue as she tried to get him to open his mouth so she could do a mouth sweep, but R9 refuse to open his mouth. R9 then became unconscious, body limp and slid out his wheelchair, E6 slid him to the floor. E6 checked for breathing and pulse and there was none. R6 did a finger sweep then started to initiate Cardiopulmonary Resuscitation and then the medical team arrived and took over until the ambulance arrived."

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E8, direct care, represented by legel counsel was interviewed on 4/11/2005. E8 states R9 was home from day training on 4/17/2005 because he had choked the previous day. At approximately 11:30 a.m. to 12:00 p.m., E14, coordinator, brought 3 lunches to the home. E8 stated E14 said she had to wait for R9's lunch to be made and she did not know if his (R9) name was on the lunch bag, but E14 identified the lunch bag belonging to R9. E8 stated the lunch bags for R10 and R11 had their names on the lunch bags. E8 states she set up R10's lunch at the table and was trying to get him to eat, R10 would eat a few pieces of the cut up sandwich, then throw some of the pieces on the floor. R10 drank a small amount of milk then refused to eat or drink anything else. E8 states it was evident portions of this meal had been eaten. E8 states she left R10's meal on the table to try to get him to eat it later.

E8 stated R9 slept most of the day and woke around 1:00 p.m. E8 proceeded to clean him because he was wet with urine. E8 received a call from E14 asking her if she needed a break and she said yes. E6 was sent to the home to relieve her for break. E8 stated she told E6, R9's lunch was in the kitchen with

his divided plate, before she left for break. E8 stated while she was on break she heard a call "Stat to Home 1" and she went immediately back to the unit. R9 was in his room on the floor, and staff were working on him. E8 stated R9 was blue in the face when she saw him. E8 then went to the dining room to start cleaning up the area because it was a mess and she observed E10's lunch on the table and E6 said she fed R9 that lunch. E8 went into the kitchen and R9's lunch was still there with his divided plate. E8 was questioned by the surveyor about checking if the clients have the appropriate diets. E8 said each home has something to identify the correct diet. In Home 1, the diets are in the kitchen on the cabinet and if anything unusual occurs with the clients in the home there is a log book which staff are to look in. E8 also states the procedure is to check the client diet to ensure it is the correct diet before giving them to the clients.

Additional review of (E8's) facility investigation statement on 4/3/2005, states the following events occurred:" (R9) was kept home from day program due to an incident of choking the night before. (E8) indicated that (R9) slept most of the morning. He woke about 1:00 p.m. She assisted him with changing his clothes when the coordinator called and asked if she wanted to take a break. (E8) indicated that she did want a break. She (E8) continued to assist (R9) with dressing. (E6) entered the home. (E8) informed her (E6) that she was going to give (R9) lunch because he just woke up. She (E8) indicated (E6) responded that she would assist him (R9) because she needed to leave to do a route as soon as she (E8) returned from break. (E8) responded by saying that his lunch bag and divided plate was in the kitchen. She then left for break. (E8) indicated that earlier she took out a divided plate and left it on the counter next to the lunch. (E8) was asked what kind of diet (R9) was on. She responded that he was on a puree diet. She was asked to describe the lunch. (E8) indicated that it was a piece of bread with meat but she was not sure what kind of meat. There was also a banana, a can of V8, and a thickened shake. She (E8)was asked if she had any discussion or informed (E6) about the type of diet (R9) was on. She (E8) responded "no", I thought she would see the lunch in the kitchen. (E8) was asked about the food on the table. (E8) responded that it was (R10's) lunch on the table...(E8) indicated (it was) a peanut butter and jelly sandwich. (E8) indicated that (R10) did not want to eat. .... (E8) was asked how she knows what diets the men were on. She replied that diets were posted on the kitchen. ...(E8) was asked when (did) she returned to the home from break. She heard the announcement "stat: Home One" and that's when she went back. (E8) ...observed upon her return to the home...nurses and several people were there and in (R9's) room working on him...she thought (R9) looked blue in the face."

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(E7), Food Service Coordinator, was interviewed on 4/4/2005. (E7) stated on 3/17/2005 for lunch, (R9) was sent pureed peanut butter and jelly sandwich. An example was shown to the surveyor. (E7) stated a pureed peanut butter and jelly sandwich is made as follows: Use 1 ounce peanut butter, 1 ounce jelly, 2 slices bread and blend (in a blender) with 2% lactate milk. This mixture is blended to a smooth liquid consistency then placed in a Styrofoam cup.

E7 also stated that on 3/17/2005, R9 choked on a mechanical soft peanut butter and jelly sandwich. This sandwich is made with 1 ounce of jelly, 1 ounce of peanut butter and spread thinly on 2 slices of bread. The mechanical soft sandwich is a whole sandwich and this is the type of diet R10 receives.

On 4/4/2005, R9's Speech/Language Pathology Consultation/Diet Texture Assessment dated 3/10/2004 was reviewed and states the following:

HX (History): diet texture change from general to Mechanical soft 10/17/2002 as a result of repeated episodes of coughing and/or overstuffing his mouth during meals....Efforts to ensure that mechanical soft diet is cut into small pieces and that 1:1 supervision is available have not been consistent and adequate to ensure (R9) safety. Puree diet texture was introduce during today's assessment and (R9) reported that he enjoyed his meal a great deal. Thin liquids were tolerated well (without) s/s (sign/symptom of) dysphagia. Recommendation: Diet texture change to Puree/thin liquids.

R9's Speech Language Pathology Consultation Assessment dated 12/1/2004 was reviewed and states the following:
Oral Peripheral Mechanism:
Dentition: missing (upper) left front teeth
Tongue, lips, palates: poor elevation, protrusion, poor lip retraction
Chewing, swallowing, diet modification: Puree diet introduced 3/10/2004 (2nd degree) to hx (history) of choking episodes and coughing, overstuffing mouth during meals.
Additional observations: Response to puree diet has been excellent, (R9) reports, It's good!
Recommendations: 1. Maintain puree diet texture/thin liquids, continue to monitor response.
2. Encourage participation in group conversation activities.

Review of Physician Order Sheets from 3/2004 to 4/2005 states: Diet: Pureed, Extra Late Night Snack Related to Low Blood Sugar, Thin Liquids.

Review of Annual Nutritional Assessment dated 12/10/2004; Dietary Acceptance and Eating Behavior:
Feeding Problems: Chewing; own teeth some missing
Consistency Needs: puree...to prevent choking/aspiration
Verbal Prompts: slow down
Mealtime Problems: h/o (history of) eating fast
Plan: Continue (with) current diet (puree) ...

Review of R9's Individual-Specific Support, Service and Supervision Requirements (IS4R) dated 12/2004 identifies under the area of Eating the following: Verbal prompts to eat slowly. All meals are Puree. Encourage liquids between bites. Monitor for choking.

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