STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G306	A. BUILDING _____ B. WING _____	09/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVISION STREET HOME	317 WEST DIVISION STREET AMBOY, IL 61310

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W 460	Continued From page 6 dining room and she refused to return. None of the clients had their food cut up by E6. E3 went on to say that he had seen E6 work numerous times and knew that she had previously served the food appropriately and she knew that it had to be cut up. During evening meal observations on 8-27-08 at 4:51pm R3 took bread that was on a plate that QMRP E2 had brought to the table. The bread had not been cut up prior to serving. R3 took a large bite out of the center of a folded over piece of bread. E2 asked if R3 was allowed to have bread. E4 responded that she was not and E2 said to R3 that she couldn't have the bread and took the rest away from her. R3 consumed what was already in her mouth. During an interview on 8-28-08 with QMRP E2, she stated that she hadn't given R3 the bread, R3 had taken it from the plate that E2 had brought to the table for the other clients. During an interview on 8-28-08 at 11:57am with Supervisor E3, he stated that R3 can eat bread but she is supposed to have a pureed diet and the bread that she received on 8-27-08 should have been pureed.	W 460		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1060a) 350.1060d) 350.1060f) 350.1060g) 350.1060h)	W9999		

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W9999	Continued From page 7 350.3240a) 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. f) There shall be a functional training and habilitation record for each resident, maintained by and available to the training and habilitation staff. g) Appropriate training and habilitation programs shall be provided residents with hearing, vision, perceptual, or motor impairments, in cooperation with appropriate staff. 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 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	W9999		

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W9999	Continued From page 8 These Regulations were not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure that individuals who have history of choking (R3 and R4) received their specially modified diet with the potential to affect 6 of 6 individuals with modified diets, (R1, R2, R3, R4, R5 and R6). Findings include: According to the Facility Data Sheet dated 7-23-08, R3 is a 45 year old woman whose diagnoses include Profound Mental Retardation, Hiatal Hernia and Seizure Disorder. According to the Facility Data Sheet dated 7-23-08, R4 is a 42 year old man whose diagnoses include Profound Mental Retardation and Seizure Disorder. According to the Facility Data Sheet dated 7-23-08, R1 is a 74 year old man who functions in the range of Severe Mental Retardation and R's 2, 5 and 6 are women who all function in the range of Profound Mental Retardation. All 6 clients who live in the facility function at the Profound level of 3 years 0 months or less in adult functional age. During a review of Incident Reports from August 2007 through the present, one dated 9-7-07 records that R4 has a history of choking; it states that R4 choked on a piece of fruit and received the Heimlich Maneuver. During a review of R3's record, a Nurses Note dated 3-26-08 notes that R3 also had a recent	W9999		

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W9999	Continued From page 9 history of choking on 3-22-08 when R3 "choked on piece of meat, slumped over & started to drool, (Heimlich) procedure performed successfully...." During a review of the Facility Data Sheet dated 7-23-08, all 6 residents who live in this facility, R's 1-6, have "cut up meat" as a component of their diets. During a review of Incident Reports, one dated 8-1-08 noted that R3 "got ahold of a hamburger that was not yet prepared for the (consistency) her diet requires. She was having issues swallowing but was able to breathe and talk. She continued to try to swallow but was having issues. We then called the on call nurse to assist." They tried to give her warm liquids. The on call nurse directed them to take her to the emergency room where they found that she had food stuck in her esophagus. A review of R3's Person-Centered Plan dated 2-11-08 states that R3 has a service objective to "Maintain Hiatal Hernia protocol." Included in R3's record is a note signed by LPN E7 that states to address R3's Hiatal Hernia staff should "1. Encourage her to not eat fast or large amounts 2. Cut up food in small pieces or bites...." R3's record includes a Video Fluoroscopic Swallow Study dated 11-23-99. It states that the results of testing were R3 "demonstrated impulsive eating behavior taking excessively large bites of solid food items and large sips of liquids." It noted moderate dysphagia at the oral stage, mild dysphagia with aspiration risks at the pharyngeal stage and osteophytes...as well as	W9999		

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W9999	Continued From page 10 reduced peristalsis at the esophageal stage. The swallow study recommended that R3 "exhibited decreased swallow safety...secondary to impulsive feeding behavior, taking excessively large bites of regular diet items with inability to adequately masticate and transfer bolus for safe swallow. (R3's) diet should be downgraded to mechanical soft diet with added moisture...food should be cut in small pieces...(R3) should take small bites, one at a time and alternate bites and sips frequently." During a review of the facility's investigation of the 8-1-08 incident involving R3, it states that Administrator E1 was informed of R3's trip to the emergency room the evening of 8-1-08. E1 notes that E6, the Hab Technician who served the food to R3, as well as her peers, without ensuring appropriate cutting/consistency, initially told Supervisor E3 that R3 only had one bite of hamburger and then she stopped eating. The investigation goes on to note that when E1 talked to E6 the following week, E6 said that she did not think R3 ate anything off her plate, just started coughing and she did not know about the need to have the food prepared for their diets. E1 went on that "Since this appeared to be a lie, I asked the group home supervisor to meet with her and give her a written warning for not following the diets." During an interview on 8-28-08 at 2:58pm Supervisor E3 described the incident on 8-1-08 as he was present that night. E3 was returning to the dining table from the back of the house with R4. As he turned the corner and saw the dining table, he saw that the food had been served on	W9999		

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W9999	Continued From page 11 the wrong dishes and the food had not been cut up for all individuals, (R1, R2, R3, R4, R5 and R6). E3 said he immediately started the process of moving the dishes from in front of the clients to cut up the food. E3 said that R3 had already started to get up from her chair to leave the dining room and she refused to return. None of the clients had their food cut up by E6. E3 went on to say that he had seen E6 work numerous times and knew that she had previously served the food appropriately and she knew that it had to be cut up. During evening meal observations on 8-27-08 at 4:51pm, R3 took bread that was on a plate that QMRP E2 had brought to the table. The bread had not been cut up prior to serving. R3 took a large bite out of the center of a folded over piece of bread. E2 asked if R3 was allowed to have bread. E4 responded that she was not and E2 said to R3 that she could not have the bread and took the rest away from her. R3 consumed what was already in her mouth. During an interview on 8-28-08 with QMRP E2, she stated that she had not given R3 the bread, R3 had taken it from the plate that E2 had brought to the table for the other clients. During an interview on 8-28-08 at 11:57am with Supervisor E3, he stated that R3 can eat bread but she is supposed to have a pureed diet and the bread that she received on 8-27-08 should have been pureed. (A)	W9999		