STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G279	A. BUILDING _____ B. WING _____	C 01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE	205 PARK AVENUE PANA, IL 62557

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W 249	Continued From page 16 before picking up the utensil again. Process is to be repeated throughout the eating time. His 10/1/09 Speech/Language Evaluation documents that R1 should be tactually cued by touching his hand so he knows to slow down his eating. Per the 12/28/09 facility investigation of R1's 12/26/09 death, E3 stated that on 12/26/09, at approximately 8:50 p.m., R1 had went into the kitchen and gotten an orange. E3 assisted cutting the orange for R1, then went into the laundry room to finish the laundry. E4's statement validated that she observed R1 eating an orange in the dining room, however, went back to the laundry room., not providing supervision or implementation of R1's eating program. Under the recommendation portion of the 12/29/09 facility investigation, E1 recommends disciplinary action for E3 and E4, for not following programs as written. "This training should include policies regarding redirection and the running of all programs, and not leaving any resident unmonitored while eating." In an interview with E1, on 1/6/2010, at 1:25 p.m., E1 stated that staff are to be in the dining room at all times when any individual who is on an eating program is eating.	W 249		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060c)1)2)	W9999		

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W9999	Continued From page 17 350.1060e) 350.1060h) 350.1060j) 350.1230d)2)3) 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 350.1060 Training and Habilitation Services c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. 2) Stated in specific behavioral terms that permit the progress of the individual to be assessed. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. 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	W9999		

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W9999	Continued From page 18 who is a Qualified Mental Retardation Professional. j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. 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 Regulations were not met as evidenced by: Based on record review and interview, the facility failed to prevent neglect for 1 of 1 individual with a documented history of a swallowing/choking disorder, and known food stealing behaviors, who expired on 12/26/09 due to Asphyxiation from choking on food (R1). The facility has failed to:	W9999		

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W9999	Continued From page 19 1) Implement their own policy for neglect when they failed to provide an adequate level of supervision to ensure the physical safety of R1, regarding his known food stealing behaviors. 2) Provide a specific program objective regarding R1's food stealing behavior. 3) Implement R1's safe eating program. 4) Prperly administer the Heimlich maneuver on R1 when he was found choking. 5) Ensure staff retraining in a timely manner. Findings include: In review of R1's 9/3/09 Individual Service Plan (ISP), the following is documented: R1 functioned in the moderate range of mental retardation, with additional diagnoses of Obstructive Pulmonary Disease, Hyponatremia, Paranoid Disorder, Bipolar Disease, Depression and Parkinson Disease. R1's 11/14/07 Stanford-Binet Intelligence Scale L-M documents an intelligence quotient of 53. Per the report, R1 continues to require 24-hour supervision due to limitations in self-care, self-direction and the capacity for learning. R1's 9/1/09 Inventory of Client and Agency Planning (ICAP) documents an overall age equivalency of 2 years and 11 months. R1's 9/3/09 ISP documents that R1 was edentulous and on a 1000cc fluid restriction diet. R1, "understands he is on a diet and the	W9999		

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W9999	Continued From page 20	W9999		

reasoning but chooses to not always follow his diet." R1 is on an eating program due to eating at a rapid pace and taking large bites. R1, "coughs frequently throughout the meal." R1, "is non-compliant with his diet at times he will sneak into the kitchen and stuff cheese or lunch meats down the front of his pants and take it to his room to eat it."

In review of R1's 11/09 Monthly Summary, it states, R1, "will sneak in the kitchen and get handfuls of cheese and make himself 2 sandwiches at a time right after his scheduled meals."

A 10/1/09 Speech/Language Evaluation documents R1 was evaluated for, "difficulty swallowing and chokes...is on a soft diet and he coughs and chokes frequently." This report states, "on oral motor, his labiolingual muscles range of motion, strength, rate, and sensation were decreased. For solid foods, he had chunks of food left and pocketed food. On thin liquids he gulped...had a gurgling sound and a gurgling vocal quality and coughed immediately and minutes after." Recommendations were made for a soft diet and nectar thickened liquids. Additionally, R1 is to be tactually cued by touching his hand so he knows to slow down his eating. R1 is to stay upright for a half hour after after eating, in order to prevent pocketing.

R1 subsequently received a 10/1/09 physician's order for a mechanical soft diet with nectar thickened liquids and no straw. The physician added an additional diagnosis of Mild Reoccurrence Aspiration.

1) Per a 12/28/09 facility report to the Illinois

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W9999	Continued From page 21 Department of Public Health (IDPH), on 12/26/09 at 9:02 p.m., staff heard a noise and found R1 slumped over and choking in his bathroom. Staff started the Heimlich, called 911 and R1 was transported to the emergency room (ER). An object was removed, but medical staff were unsuccessful in reviving R1. The 12/26/09 ambulance service report documents being called to the facility for a choking incident at 21:11 (9:11 p.m.). Upon arrival a female subject was, "holding large piece of salami stated she swept his airway and retrieved the salami... (no) obstruction visible in airway...continued assisting ventilation, unresponsive... attempted intubation... Removed more pieces of salami via... forceps... Initiated CPR... Removed more pieces of salami via... forceps...no pulse." Z1's (Police Officer) 1/10/10 report also documents his presence on the scene. This report states that Z1 arrived on the scene seconds after the ambulance service. Upon his arrival, R1 was upright on the toilet and unresponsive. Z1 removed more meat from R1's mouth while ambulance staff were at the back of the ambulance readying the cot. Z1's report documents that Z4 (emergency room nurse) stated they had pulled twice the amount of meat out of (R1's) airway than what was in the sink. The ER staff also said the meat was lodged very far down in his airway close to his lungs. Z1's (Police Officer) 1/10/10 report also documents that he obtained written statements from E3 and E4 (DSP's), and that they are attached to his report. E4's 12/26/09 handwritten/signed report is	W9999		

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W9999	Continued From page 22 attached to Z1's typed report. E4 stated that on this same date, R1 was slumped over the sink, gasping for air and turning grayish blue. E4 took him off of the sink and propped him up with pillows. E3 tried the Heimlich Maneuver. E3 and E4 then picked up R1 and sat him on the toilet. E3's 12/26/09 handwritten/signed report is attached to Z1's typed report. E3 stated after she called 911 and returned to the scene, E3 had already propped R1 up with pillows. E3 and E4 tried to get R1 up, but couldn't on the first try. "...then we got him up and did the hymlick (Heimlich) sat him on the toilet did the finger sweep in his mouth...." In review of the ER report dated 12/26/09, Emergency Management Service (EMS), "removed large amount of pieces of lunchmeat (whole) removed (with) forceps..."2140 Taken to ER - full cardio-pulmonary arrest with Cardiopulmonary Resuscitation (CPR). Hx (history) of choking on 'salami'...pronounced dead at 10:03 p.m." An undated Preliminary Coroner's Report stated that a large quantity of meat was removed and also found in a pocket of his clothing. The Certificate of Death (dated 1/15/10), documents cause of death as "Asphyxiation/Choking on Food." In an interview with E1 (Residential Services Director - RSD) on 1/5/10, at 9:30 a.m., E1 confirmed that E3 and E4 (Direct Service Persons - DSP) were the two staff on duty 12/26/09 when R1 choked and subsequently expired.	W9999		

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W9999	Continued From page 23 The facility's 12/28/09 investigation documents that on 12/26/09 at 9:05 p.m., E3 and E4 heard a loud thump and found R1, "slumped over the bathroom sink choking." The Heimlich Maneuvers were unsuccessful, but some meat was removed from R1's mouth with fingersweeps. 911 and E1 (RSD) were notified. Per E3's police interview, E3 and E4 heard a thump and found R1, "slumping and turning purple." By the time the ambulance arrived R1 was unresponsive. A couple of pieces of meat were removed from his mouth. "(R1) is notorious for getting into the fridge sneaking and eating drinking many times a day with staff telling him not to." Per E4's police interview, after hearing the thump, E3 and E4 found R1, "gasping for air. He was turning grayish blue in the face...(R1) was notorious for getting into the refrigerator and drinking from the water fountain when he knew better. He has snuck things it would be like 2 or 3 times a day, and staff had to get onto him." Z1's police report (01/10/10) documents he spoke with E1 (RSD), and E3 and E4 (DSP's). "They all stated (R1) had a history of sneaking food out of the refrigerator. They said tonight, (R1) took food down to his room and he choked on it." In a 1/6/10, 1:25 p.m., interview with E1, E1 stated that by March, 2010, she will have been employed at this facility 5 years. Regarding R1's food stealing, E1 stated that R1 had exhibited that behavior for as long as she has been an employee. R1 would steel cheese, stick it in his	W9999		

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W9999	Continued From page 24 pants and go to his room. In review of R1's 9/3/09 ISP, there is no evidence of a level of supervision to ensure the physical safety of R1 with regards to his food stealing behavior and documented swallowing/choking issues. In a phone interview with E1, on 1/26/10, at 9:52 a.m., E1 stated that the facility had not implemented a level of supervision to ensure the physical safety of R1, with regards to his food stealing behavior and documented risk factors of swallowing/choking issues. 2) R1's 9/3/09 ISP documents R1 was on an eating program due to eating at a rapid pace and taking large bites. Further, R1 will sneak into the kitchen and stuff cheese or lunch meats down the front of his pants and take it to his room to eat. His 10/1/09 Speech/Language Evaluation documents R1's difficulty swallowing and has choking episodes. His oral motor muscles are weak. He pockets solid chunks of food and gulps thin liquids. Subsequently, his physician, on 10/1/09 ordered a mechanical soft diet with nectar thickened liquids, and added a diagnoses Mild Reoccurrence Aspiration. R1's 9/3/09 ISP documents formal goals for: 1) self-medication; 2) decreasing verbal aggression and non-compliance; 3) oral hygiene; 4) bathing independence; 5) coin identification; 6) decrease rate of speed during eating; and, 7) laundry independence. There is no evidence of tracking	W9999		

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W9999	Continued From page 25 or providing a formal objective regarding R1's food stealing. In a phone interview with E1, on 1/26/2020, at 10:41 a.m., E1 confirmed that the facility did not track the frequency of R1's food stealing behaviors and did not provide an objective to decrease the frequency of the food stealing behavior. 3) R1's 9/3/09 ISP documents that R1 ate at a rapid pace and attempted to eat bites that were too large. R1 required verbal reminders to slow down. R1 had an objective to eat at an appropriate rate of speed. Per the methodology, during all meals staff will ask R1 to take only one bite of food, put down utensil, chew food completely and swallow before picking up the utensil again. Process is to be repeated throughout the eating time. R1's 10/1/09 Speech/Language Evaluation documents that R1 should be tactually cued by touching his hand so he knows to slow down his eating. Per the 12/28/09 facility investigation of R1's 12/26/09 death, E3 stated that on 12/26/09, at approximately 8:50 p.m., R1 had gone into the kitchen and gotten an orange. E3 assisted cutting the orange for R1, then went into the laundry room to finish the laundry. When E3 returned from the laundry, R1 was in his room getting ready for bed. Under the recommendation portion of the 12/29/09 facility investigation, E1 recommends disciplinary action for E3 and E4, for not following	W9999		

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W9999	Continued From page 26 programs as written. "This training should include policies regarding redirection and the running of all programs, and not leaving any resident unmonitored while eating." In an interview with E1, on 1/6/2010, at 1:25 p.m., E1 stated that staff are to be in the dining room at all times when any individual who is on an eating program is eating. 4) In a phone interview with E3, on 1/27/10, at 10:07 a.m., E3 stated she left R1 to call 911. E4 had placed 2-3 pillows under R1 and was positioned behind R1's head. "He (R1) was a dead weight." When they (E3 and E4) positioned R1 on the toilet, his back was facing the back of the toilet stool. R1 was facing forward, just as one would normally position oneself on the toilet. E3 stated she got on R1's side, between the sink and the toilet, "coming in from that way" to administer the Heimlich. The undated portion of the Student Manual (American Heart Association), relating to choking was faxed to the surveyor on 1/26/10. E1 confirmed, on 1/26/2010 at 9:50 a.m., that this is the manual utilized by the facility for training purposes regarding choking. Regarding abdominal thrusts with the victim standing or sitting, the rescuer is to stand or kneel "behind" the victim and wrap arms around the victim's waist (giving further directions to complete the abdominal thrusts). Additionally, the manual states, "...when a victim becomes unresponsive, the muscles of the upper airway relax, and a complete airway obstruction may become an incomplete obstruction...you may be able to deliver rescue breaths successfully past an incomplete obstruction...if the adult victim is	W9999		

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W9999	Continued From page 27 unresponsive...open the airway...." Per the training manual, there is no evidence that E3 and E4 would have been able to properly administer the Heimlich Maneuver (per training manual), with R1 sitting on the toilet stool facing forward. Additionally, there is no evidence that E3 and E4 attempted to open R1's airway when he became unresponsive. Facility documentation and staff signatures validate facility staff did not receive retraining regarding basic emergency care and the Heimlich Maneuver until 1/8/2010 (14 days after R1's death). The facility policy for abuse and neglect was reviewed. Per the policy, neglect is defined as, "failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness." (A)	W9999		