		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G133	B. WING	G		C 6/2012
NAME OF P	PROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGH	IAM TERRACE			1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 485	speech therapist/ph secure orders and evaluations. Baseli	age 19 hysician notified by 4/23/12, to secure appointments for ine programming was h additional 4 individuals, with	W 48	.85		
	staff training as to c support.	change in supervision and				
	> All steps will be m Administrator and E	nonitored by the QMRP, Executive Director.				
	4/25/12, the facility the facility has not h	te Jeopardy was removed on remains out of compliance as had the opportunity to fully luate the effectiveness of their				
W9999	FINAL OBSERVAT	IONS	W999	999		
	Licensure Violatior	1S:				
	350.620a) 350.1060e) 350.1210 350.1230b)7) 350.3240a)					
	Section 350.620 Re	esident Care Policies				
	procedures governi facility which shall to involvement of the shall be available to public. These writte	have written policies and ing all services provided by the pe formulated with the administrator. The policies to the staff, residents and the en policies shall be followed in y and shall be reviewed at				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	-	PLE CONSTRUCTION	(X3) DATE SU COMPLE		
-			A. BU	LDIN	IG		C	
		14G133	B. WI	\G			6/2012	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
EFFINGH	IAM TERRACE				101 SOUTH THIRD STREET			
				E	FFINGHAM, IL 62401			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE	
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
		н П						
W9999	Continued From pa	ge 20	W9	999				
	Contine 050 1000 T	weining and Lipbilitation						
	Section 350.1060 1 Services	raining and Habilitation						
		effective and individualized ges residents' behaviors shall						
		mplemented for residents with						
		abusive behavior. Adequate,						
		d supervised staff shall be ster these programs.						
	Section 350.1210 H	lealth Services						
	0001011000.12101							
		ovide all services necessary to						
	maintain each resid	lent in good physical health.						
	Section 350.1230 N	lursing Services						
	Section 550.1250 N	ausing bervices						
		be provided with nursing						
		ance with their needs, which e not limited to, the following:						
	The DON shall part	icipate in:						
		ne resident care plan, in terms						
	or the resident's dal	ily needs, as needed.						
	Section 350.3240 A	buse and Neglect						
		-						
		ee, administrator, employee or						
	resident. (Section 2	nall not abuse or neglect a -107 of the Act)						
	, , , , , , , , , , , , , , , , , , ,							
	These regulations v	vere not met as evidenced by:						

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM. OMB NO.	10/30/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE SU COMPLE	
		14G133	B. WI	NG _			5 6/2012
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EFFING	IAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W9999	failed to implement when the facility faile eating skills prior to mechanical soft and mouth extraction, a a pureed diet; 2) pro- safeguards at meal physician prescribe when R1 refused as regular textured foor supervision levels, se texturally modified of re-evaluated; and 4 regarding the facility relative to assessm diets, for 1 individu choking resulted in individuals who reco diets/altered liquids additional 3 individu eating programs (R Findings include: 1. In review of R1's Plan (ISP), R1 was of birth). R1 function mental retardation, 50 (WAIS-III of 12/1 Independent Behavid document an overa of age. R1 had a si Diagnoses, per the Gastroesophageal	view and interview, the facility their policy to prevent neglect, iled to: 1) assess R1 for safe further diet upgrades to d regular texture, after a full nd his readmit to the facility on ovide and implement times, when R1 refused his d modified texture diets and asistance in cutting up his own ds; 3) ensure that current safe eating programs and diets/altered liquids were) review the need for revision y's policies and procedures ent of safe eating/modified al (R1) whose 3/25/12 death, for an additional 3 eive mechanically altered (R's 2, 4 & 5), and for an ials who are on formal safe 's 2, 3 & 6).	W9	999			

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		AND HUMAN SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G133	B. WI	NG _			C 6/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGH	HAM TERRACE				101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	ge 22	W9	999			
		t R1 was able to swallow soft glass and eat with utensils.					
	Committee," states with no compromise edentulous, having teeth two years ago "Investigation Final 3/3/10, R1 had surg Post Surgery Aspira	becument entitled "Safety that R1 was on a regular diet, e for texture, and that R1 was had surgery to remove his b. (The 3/28/12 facility Report," documents that on gical removal of his teeth, with ation Pneumonia on 3/4/10, on blood after the surgery).					
	(after 3/3/10 full mo a local nursing hom 3/26/10-4/1/10, then home. This evalua a swallowing disord pharyngeal phase. section, the followin Aspiration, Aspiratio Frequently coughin. Wet or gurgly voice liquids. Under the ' disorders - Oral foo additional hand writ solids." Under the ' (oral motor) movem recent extraction of noted with post-sur- to adequately use of swallowing. Under conditions," reduce is documented. Th R1 to tolerate safe	0 speech therapy evaluation buth extraction), conducted at he, R1 was hospitalized from in released to the nursing tion states states that R1 had der involving the oral and Under the "Definite risk of" ng areas are checked - on Pneumonia, Choking, g up food during swallowing, e quality after swallowing "Presence of oral motor of retention is checked with an tten note - "unable to chew "Postural difficulties" "poor om nents" is handwritten and the fall teeth and sore gums is gical reaction affecting ability propharyngeal structures in "Existence of other d or inadequate labial closure e goal of the treatment was for oral clearance of a pureed nechanical soft if gum					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULT	TIPLE CONSTRUCTION	(X3) DATE SL	IRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDI	NG	COMPLE	C
		14G133	B. WI	NG _			5 6/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGH	IAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W99999	Continued From pa soreness improved. Per the speech ther R1 received swallow exercises and safet 4 weeks. The 5/4/1 that R1 was to retur pureed diet and thir provided to the resid tolerate some mech prepared correctly." Per R1's "Physician readmitted to the fa 6/15/10 physician's as tolerated." In a 4/18/12, 9:30 a (Administrator), E1 orders for a regular In review of a 3/18/ "Investigation Final 3/25/12, at 5:55 p.m evening meal, which potatoes, peas, apr (direct service person	ge 23 rapy notes from 4/6/10-5/4/10, wing treatment, therapeutic y education 5 days a week for 0 discharge notes document in to his group home on a n liquids. Education was dential facility that R1, "can n (mechanical) soft foods if Certification" record, R1 was cility on 6/9/10, and there is a order for "Mechanical soft diet .m., interview with E1 confirmed that R1 received consistency diet on 4/20/11. 12 facility document entitled Report," it states that on n, R1 was consuming his h consisted of pork cutlets, icots and ice cream. E2 on - DSP) heard R1 cough	W9		DEFICIENCY)		
	and asked R1 if he respond, E2 provide E2 called for assista removed R1 from h abdominal thrusts. Pulmonary Resusci until the paramedica scene. R1 was take airlifted to another h	was okay. When R1 did not ed back blows, with no results. ance. E2 and E3 (DSP/cook) is chair and provided 911 was called and Cardio tation (CPR) was provided s arrived and took over the en to a local hospital, then nospital in Springfield.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		14G133	B. WI	NG _			6/2012
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EFFING	IAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	as Cardiopulmonar asphyxia. R1 was I protocol for 24 hour throughout his hosp with poor prognosis to withdraw care at Morphine and Ativa pronounced dead of Discharge diagnosi documented as Car secondary to asphy Mental Retardation Gastroesophageal In review of the 3/22 pieces of "peach" (a facility report) were pieces were descrite other section was do inches. In a 4/18/12, 1:20 p (Paramedic), Z1 co this report, and des dislodged as "large by 3 inches. Z1 fur fully occluded R1's In review of a 3/25/ "Safety Committee, surgery to remove H offered a pureed dia well. He requested requested that he c himself which he ha	y arrest secondary to kept under Hypothermia rs, remained on a ventilator bital stay, developed seizures, 5. The state guardian decided this time. R1 received n post extubation and was in 3/30/12 at 1736. s (4/2/12 hospital record) is rdiopulmonary arrest rxia secondary to choking, , Depression, reflux disease. 5/12 paramedic report, three apricot, as per the 3/25/12 removed. The two small bed as 1/2 inch chunks. The lescribed as 1/2 inch by 3	W9	999	9		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G133	B. WI	NG			C 6/ 2012
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFING	IAM TERRACE				101 SOUTH THIRD STREET FFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	mechanically soft d baby, and that R1 in and could do so. E R1's readmit to the home), R1 was rea was edentulous. E swallow evaluation upgrade in diets (pu 6/19/10 {per physic 4/20/11 {same above In a 4/18/12, 2:20 p (Dietary Consultant individuals who are regular textured foct stated that it is base also a broad spectr mechanical soft die dentition, a speech evaluation is where "better safe than so 2. R1's formal prog documented as folla and take medication crying), communicat self-care for toothom physical therapy ex and self-care for into Secondary priorities identified as: room making healthy nut clothes shopping, a	efused his pureed and iets, stating that he was not a nsisted on cutting his own food 1 further confirmed that after facility (6/9/10 from a nursing dmitted on a pureed diet, and 1 stated that R1 had not had a since his return, and since his ureed to mechanically soft on ian's order}, and to regular on <i>ve</i> interview}). .m. phone interview with E4), E4 stated that some edentulous can handle ods and some cannot. E4 ed on the individual. There is um in the definition of ts. When there is a change in therapist swallow/feeding e she would start and would be rry."	W9	999			

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		AND HUMAN SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G133	B. WI	NG _			C 6/ 2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGH	IAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W99999	Continued From pa	ge 26	W9	999	9		
	and secondary prio and implementation for R1 regarding his and his insistence in textured food. E1 was interviewed Regarding provision for R1, E1 stated s not" contained in th provide any evidence the exit of this surve	1/12/12 ISP, formal programs rities, there is no provision for n of safeguards at meal times is insistence of a regular diet, n cutting up his own regular on 4/18/12, at 3:35 p.m. n of safeguards at mealtimes such provisions were "probably e ISP. The facility did not ce of such provisions prior to ey.					
	functions in the mod retardation, with an	derate range of mental additional diagnosis of GERD, and requires nectar thickened					
	eating and drinking that after a swallow prescribed thickene	10/11 ISP, R2 has a formal program. The program states v evaluation, R2 was ed liquids. R2 also has a o big of bites does not chew					
	to slow down, take	2 will receive verbal prompts smaller bites and will be es when eating or drinking.					
	functions in the mo	3/12 physician's orders, R3 derate range of mental ditional diagnosis of GERD, diet.					

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DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICA					FORM	10/30/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVID	ER/SUPPLIER/CLIA	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
	14G133	B. WI	NG _			C 6/ 2012
NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGHAM TERRACE			-	101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYI	ECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
 W9999 Continued From page 27 Her 9/9/11 SIB-R documents a of 4 years and 2 months. Her 10/6/11 ISP documents a program is required, as R3 ha too big of bites and eating too is to be implemented at all me observed to be eating too fast slow down, take smaller bites food before taking another bite In review of R6's 3/12 physic functions in the moderate rang retardation and receives a reg R6 has a 12/1/11 formal eating addresses taking too big of bit fast. R6 is to be monitored at be verbally prompted to slow of bites and chew all of his food 1 another bite. R4's 3/12 physician's orders functions in the moderate rang retardation and requires a reg mechanical soft texture. R5's 3/12 physician's orders functions in the severe range retardation and requires a reg mechanical soft texture. In review of a 3/26/12 facility r Department, R1's choking dea have occurred on 3/25/12. Pe also states, "A Safety Commit determine strategies for prevention. 	formal eating s issues with taking fast. This program als. When R3 is , staff will ask R3 to and chew all of her e. ian's orders, R6 ge of mental ular diet. g program which res and eating too all meals and is to down, take smaller before taking document that R4 ge of mental ular diet, with document that R5 of mental ular diet, with eport to the ath was reported to er this document, it tee was held to	W9	999			

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		AND HUMAN SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G133	B. WI	NG _			C 6/ 2012
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EFFING	HAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	In a 4/17/12, 12:00 was asked what str the prevention of ch facility held an in-se would retrieve the co E1 then presented staff received re-tra 4/2/12. The following facilit 4/2/12 inservice, pr & 6, 3/25/12 Safety facility's 3/28/12 final In review of the above evidence that the fa supervision levels, individuals on altered R's 4 & 5), and (new and for individuals on programs (R's 2, 3) 4. Surveyor request dietary policy/policies "Food Service - Me Therapeutic Diets, The purpose of the of meals that are w satisfying, meet the allowances and hea In review of this pol criteria as to when evaluated for safet	p.m. interview with E1, E1 ategies were implemented for noking. E1 stated that the ervice for staff and that she documentation. documentation that direct care ining in First Aid and CPR on y documents were reviewed: ersonal charts for R's 2, 3, 4, 5 Committee meeting, and the al investigation report. ove documents there is no acility re-evaluated current programs and diets of ed diets - (mechanically soft - ctar thickened liquids - R2); with objectives for safe eating	W9	999			

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		AND HUMAN SERVICES				FORM	10/30/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G133	B. WI	NG			6/2012
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EFFINGH	IAM TERRACE				1101 SOUTH THIRD STREET EFFINGHAM, IL 62401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	ige 29	W9	99!	9		
	In review of the 3/2 meeting recomment Analysis" section of report, there is no ec- current dietary polic In a 4/18/12, 3:35 p confirmed that the for procedures as to precipitate the need eating skills, and th in solid or liquid tex The facility's 7/3 "in was reviewed. Per as, "Failure to provi	5/12 Safety Committee ndations, and the "Committee f the facility's 3/28/12 final evidence of any review of cies. o.m., interview with E1, E1 facility does not have policies o when or what factors would d for an evaluation of safe the possible need for alterations		995			

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