STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G309	A. BUILDING ______ B. WING ______	08/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEARBORN COURT	520 SOUTH DEARBORN STREET KANKAKEE, IL 60901

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W 322	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure annual medical appointments are completed on a annual basis for 1 of 3 individuals (R1) out of a sample of 3. Findings include: R1's Individual Service Plan dated 4/26/2012 was reviewed and documented that her last physical examination by a physician was completed on 6/2/2011. R1's physical examination was outdated as of 6/3/2012 and no additional physical examination could be located in the record. R1's physician orders dated 7/2012 states that R1 is to have a mammogram completed annually. Record review noted her last mammogram was completed on 5/18/2011 and is outdated as of 5/19/2012 and no additional mammogram examination could be located in the record. E3, Qualified Mental Retardation Professional, was interview on 7/20/2012 at approximately 1:30 p.m. E3 was unable to any present documentation that a annual physical examination or mammogram was completed. E3 stated the physical examination and mammogram have been scheduled for R1.	W 322		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.3240a) 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 4 This regulation is not met as evidenced by: Based on interviews and record review the facility failed to prevent health/medical neglect for 1 of 6 individuals residing in the home, R3. R3 choked on his breakfast blocking his airway, staff failed to implement the emergency procedures for choking and cardio pulmonary resuscitation (CPR). Findings include: The Individual Service Plan dated 12/27/11 identifies R3 as a 54 year old male with medical diagnoses including Advanced Multiple Sclerosis, Dysphagia and Hx (history) of Aspiration Pneumonia. Medical history states," (R3) has limited, although audible speech. (R3) is presently wheelchair bound;" Physician's orders dated July 2012 include diet orders "General mechanical soft diet c (with)/thin liquids, meat cut into small bite size pieces, sit upright 30 minutes after meals, no straws." Review of the facility Investigative Committee Minutes dated 7/13/12, documents a summary of the findings: "On the morning of Monday, July 9, 2012 (R3) ate his breakfast as normal. (R3) then pushed himself away from the table and went into the bathroom at (the facility). (E4), DSP (Direct Support Person) entered the bathroom after (R3) and found him vomiting. (E4) offered (R3) a drink of water after vomiting and (R3) complied. After drinking, (R3) began coughing and showing signs of choking. (E4) called (E1), Facility Representative and reported that (E4) believed (R3) was choking and (E4) stated that (she) felt the need to call 911. (E1) instructed (E4) to do	W9999		

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so. Medics arrived shortly and (R3) was transferred to the local ER (emergency room) at (a local) hospital. He was later transferred to the ICU (Intensive Care Unit)."

Summary of interviews:
"(E4) states (through facility form) (R3) did enter the restroom after breakfast and that (E4) followed (R3). (E4) states that (R3) vomited, and was offered a glass of water. (E4) stated that (E4) gave (R3) a drink with a straw. After drinking, (R3) began showing signs of choking. (E4) stated that she panicked and became overwhelmed. (E4) called (E1), Facility Representative, who gave instructions to call 911. (E4) did so, and waited for EMS (emergency medical service) to arrive. (E4) admits that (E4) only provided minimal first aid ("slightly did the Heimlich"). (E4) did not begin CPR at any point prior to EMS arriving.

Upon EMS arrival, (R3) was asystolic (no pulse) and not breathing. (R3) was sitting in his chair in the restroom of (the facility). (R3) was intubated in the ambulance and given IV (intravenous) cardiac medications.
(E4) resigned from her position on 7/11/2012. Phone contact was attempted on 7/13/2012 at 12:25 pm. Left message."

E1's statement reads, "Around 7:09 a.m. Received a phone call from 3rd shift (E4). Stating that (R3) one of the residents was possibly choking and that she felt she needed to call 911. she then hung up and called 911. I then called staff from another facility, (E5) to get over to (the facility) to help (E4) and to go with (R3) to the hospital and a q (E2) to meet at the hospital as well and to notify the family. I also had informed

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the nurse (E6) to please go to the hospital...."

Findings of this investigation are founded. The committee finds that (E4) showed egregious negligence in not performing any life-saving measures when (R3) choked and subsequently stopped breathing. Furthermore, (E4) failed to follow the proper diet order ((R3) has an order for No Straws) and failed to follow the menus from the morning of this incident (scrambled eggs and toast were served per (E4); Eggs-o-muffin, Farina, and banana were on the menu). Lastly, (E4) did not follow policy 5.57 Physical Injury and Illness/Individual Medical Emergencies. 'Procedure a: As soon as the injury or illness is determined to be a medical emergency, the DSP is to call 911.' Instead, (E4) called (E1), Facility Representative prior to calling 911.

Training records indicate that (E4) most recent trainings were:
Policy 5.57 - 12/2/2011
CPR-1st Aid - 11/23/2011
(R3's) diet - 3/8/2012

Recommendations:
Re-train (facility) staff on all resident diet orders
Re-train (facility) staff on CPR-1st Aid measures
Re-train (facility) staff on "Hot Policies"

Surveyor interviewed E4 on 7/19/12 at 9:30 a.m. E4 said all of the 6 residents have special needs. R3 was on a special diet he needed a special diet with extra calories. E4 said R3 chews very well and his diet was regular texture as far as she knew he was supposed to use a straw if he requested. E4 said she had to improvise on the menu item that morning so she prepared eggs,

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juice, milk and bread. R3 put the eggs in the bread and made a sandwich. After breakfast R3 usually left the table and went to the bathroom. I didn't usually follow him to the bathroom because he was very independent. I followed him that day. I asked if he was o.k. He pointed to the toilet. I asked if he needed help. I noticed he was choking. I leaned him forward and did Heimlich, and food came out. I asked him if he was o.k., he shook his head yes. I got him water to drink with a straw. He seemed better. He was drinking the water after I performed Heimlich. I asked him if he was o.k. three times and he could not respond. I started crying hysterically. I knew something was not right. I called E1 and told her I was calling 911 for R3. I hung up when she said o.k. They came right away. They came in and I saw them take him out of the wheelchair and laid him on the floor. They got a stretcher and put him in the back of the ambulance, a second ambulance came and they were working on him. I came back inside to help the other clients, I was alone. E4 said there was usually a second staff who came into the facility at 5:55 a.m. I was the only staff there, it happened frequently. No one was scheduled that day. My hours were 11:30 p.m. - 9:30 a.m.

E1 was interviewed on 7/18/12 at 2:45 p.m. E1 said there was one staff in the home when the incident occurred on 7/9/12 at approximately 7:00 a.m. Normally on a Monday there is usually one other staff person present.

E5 was interviewed on 7/19/12 at 12:55 p.m. E5 said when she arrived on 7/9/12, R3 was already in the ambulance. I helped worker that was here and made sure everybody else was o.k. I went to

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the hospital to be with R3. The other residents were fine, I don't think they really knew what was going on. I got there between 7:00 a.m. and 7:30 a.m.

E3, Qualified Mental Retardation Professional (QMRP), was interviewed on 7/20/12 at 10:25 a.m. E3 showed surveyor a facility form posted when staff are needed to fill in empty shifts. No one signed up for the open 6:00 a.m. to 9:00 a.m. shift on 7/9/12. E3 said the facility has not hired a staff person to fill the Sunday 7:30 a.m. to 3:30 p.m./ Monday 6:00 a.m. to 2:30 p.m. position. It is a difficult shift.

Review of the ambulance report dated 7/9/2012 documents the paramedic arrival to (R3) was at 7:14 a.m. the narrative report reads, "called to the scene for unresponsive pt(patient), upon arrival found pt after aspirating his breakfast gasping for air. Pt went into respiratory arrest and no pulse. ALS care started with CPR and BVM (bag valve mask), attempted to intubate but found airway blocked with food. Airway cleared with suction and forceps. Intubation was then successful. IV established with rounds of EPI (epinephrine) administered. Continued after checking for a pulse, pt still in asystole (no pulse). Contacted (local hospital) and transported. Upon arrival in ED (emergency department) pt had a pulse back. Ambulance report information confirmed during interview with Z1 on 7/20/12 at 10:00 a.m.

Review of the hospital medical record discharge summary dated 7/15/12 notes R3 died on Sunday July 15, 2012 at 6:52 p.m. The report reads in part, "During breakfast he reportedly swallowed some scrambled eggs and subsequently was

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W9999	Continued From page 9 having a great deal of difficulty breathing. The emergency medical system was activated and they responded very quickly. At the time of their arrival he had sustained respiratory and cardiac arrest. They attempted intubation but there was mechanical obstruction of the airway...CAUSE OF DEATH AND AFTERCARE: The cause of death was directly attributed to aspiration of food (primarily scrambled eggs) causing airway obstruction which was followed by respiratory and cardiac arrest. ... . He sustained an anoxic brain injury with approximately 20 minutes of absence of oxygen supply to the brain." (A)	W9999		