### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

ST MARY'S SQUARE LIVING CENTER

**Street Address, City, State, Zip Code:**

239 SOUTH CHERRY
GALESBURG, IL  61401

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<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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</thead>
</table>
| W 240     |       | Continued From page 54 pneumonia as well as GI bleed.*  
E4, QIDP, was interviewed on 1/8/13 at 4pm and asked if R3 had a swallows study on 12/6/11 with specific recommendations ordered by the physician. E4 stated yes.  
E4 was asked if R3 was in an Eating Group or provided monitoring as indicated by R3's need for verbal prompting in his swallow study recommendation. E4 stated no, R3 ate in Family Style dining.  
E4 was asked if R3's ISP addressed any interventions for his primary need of safety when eating as recommended in the swallow study or per the physician order. E4 stated no.  
E4 was asked if R3 needed monitored when eating for safety. E4 stated yes.  
E4 was asked if there was an objective for R3's physician order. E4 stated no. | W 240     |     |                                                                                                               |                |
| W9999     |       | FINAL OBSERVATIONS                                                                                             | W9999       |     |                                                                                                               |                |

### License Violations

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<th>Code</th>
<th>Description</th>
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| 350.620a   | 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 |
| 350.1210   |                                  |
| 350.1230b(5)(6)(7) |                                  |
| 350.1230d(1) |                                  |
| 350.3240a  |                                  |
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 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1230 Nursing Services

b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:

5) Training in habits in personal hygiene and activities of daily living.

6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.

7) Modification of the resident care plan, in terms of the resident's daily needs, as needed.

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

1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

Section 350.3240 Abuse and Neglect
<table>
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<th>(X4) ID PREFIX TAG</th>
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<td>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</td>
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<td>These requirements are not met as evidenced by:</td>
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<td>Based on record review and interview the facility failed to implement their policies to prevent neglect when they failed to implement safeguards and provide sufficient monitoring for 2 of 2 individuals in the sample, who were identified as at risk for choking and choked on food which resulted in their death. (R1, R3)</td>
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<td>Findings include:</td>
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<td>1. In review of R1's October 2012 Physician Order Sheet (POS) he was a 72 year old male with diagnoses including Severe Intellectual Disability and Impulse Control Disorder.</td>
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<td>R1's POS has a &quot;General/Mechanical Soft, High Fiber, 1200 ml Fluid Restriction, Liquid Supplement once daily, Fortified Foods&quot; diet ordered.</td>
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<td>A Facility Policy titled &quot;Administrator's Investigative Committee Policy # 1.23&quot; last revised on 3/21/12 reads, &quot;Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.&quot;</td>
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<td>A Dental exam dated 8/17/11 for R1 reads, &quot;Patient is edentulous in the upper arch and has 18, 22 and 23 remaining in the lower arch.&quot;</td>
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### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 14G049

**Date Survey Completed:** 03/01/2013

**multiple construction**

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| W9999         | Continued From page 57

A "Nutritional Assessment" dated 2/1/12 states R1 has few teeth with "none in the upper arch."

An "Incident Investigation" dated 12/29/11 and completed by the facility states R1 had a "complete airway obstruction while in the dining room" on 12/29/11. R1 was described to have been "lowered to the floor where he was noted to be cyanotic with no respirations and CPR was initiated". Nursing was reported to have done finger sweeps on R1 to remove the food and R1 was breathing on his own when the paramedics arrived.

The investigation revealed it appeared the obstruction consisted of bread and tater tots. R1 was transported to the emergency room and returned to the facility with no new orders. As a result of the 12/29/11 choking incident the facility placed R1 "in an eating group" for meals.

A "Patient Assessment Report" dated 1/3/12 from a Modified Barium Swallow Evaluation was completed after R1 was "referred for a swallow study secondary to choking episodes with solids."

Page 5 of 6 of this swallow study has handwriting from nurses to the physician which reads, "FYI: Swallow study ordered d/t (due to) resident choking having complete airway obstruction."

Page 5 of 6 states, "Recommendations - Mechanical soft diet / thin liquids. If patient cannot adhere to below precautions, then it is recommended patient consume a pureed diet/nectar thick liquids to reduce his risk of choking (and) aspiration."
This 1/3/12 statement is followed by, "Swallow precautions: Small bites, small sips, NO STRAWS, monitor rate, aspiration precaution, upright 90, supervised feeding."

E1 was interviewed on 1/3/13 at 9:35 am and asked for a facility Meal Monitoring Policy. E1 stated the facility does not have a policy on meal monitoring - monitoring is specific to the individual. When asked where the individuals monitoring needs are addressed, E1 stated, "It will be in their ISP."

On 1/3/13 at 5:30 pm, E4, Qualified Intellectual Disability Professional (QIDP), was interviewed and asked if all residents on a mechanical soft or pureed diet were monitored. E4 stated, "If their ISP indicates." E4 was asked how an individual's specific needs of monitoring were related. E4 stated through their ISP.

R1's February 17, 2012 Individual Service Plan (ISP) page 3 has a section titled "Dietary" which reads he is on a general/mechanical soft diet and has "No major concerns at this time."

Page 6 of R1's ISP states, "(R1) has good eating skills but will at times require verbal prompts and/or staff assistance to cut his food if needed." It also states, "He may also be offered pureed foods, but is not offered bread at this time. When consuming these items, staff should be present for the safety of others as (R1) may not safely dispose of the containers and/or remainders of these items." There is no mention of special precautions recommended on the 1/3/12 swallow study.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**ST MARY'S SQUARE LIVING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

239 SOUTH CHERRY

GALESBURG, IL 61401

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<th>(X2) MULTIPLE CONSTRUCTION</th>
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<td>W9999</td>
<td>14G049</td>
<td>A. BUILDING _____________________________</td>
<td>03/01/2013</td>
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<td>B. WING _____________________________</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

**ID PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION**

**CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

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A "Eating Skills Assessment" dated 2/23/12 for R1 states in the area of "Consumption skills (slow/fast eating rate, places too much food in mouth, etc.)...(R1) requires verbal prompts to use his napkin and may drink out of bowls and eat with fingers at times."

Recommendations from the 1/3/12 swallow study, objectives or guidance to caregivers of what to specifically monitor or specific safeguards recommended for R1 are not written in R1’s ISP or Eating Skills Assessment.

E4 was asked during interview on 1/3/13 at 530 pm if R1's ISP identifies him as being at risk of choking. E4 stated "It does not specifically say he is at risk of choking."

E4 was asked if R1’s recommendation from his January 2012 swallow study was included in his February 2012 ISP. E4 stated no.

A "Program Progress Note" written on 11/18/12 by E8 Licensed Practical Nurse (LPN) reads "Nursing called to assess resident for partial airway obstruction. Resident found standing in dining room with labored breathing was encouraged to cough and then developed full airway obstruction, no pulse, started CPR / called 911."

The facilities "Incident Investigation" dated 11/18/12 regarding R1 states that he "experienced an airway obstruction while in the dining room". It states initially R1 appeared to be choking, his eyes were watering an he had a greenish/clear drainage coming from his nose.
Continued From page 60 and was making an odd gasping sound."

The investigation reports after nursing arrived, R1 progressed to a full airway obstruction. Nursing lowered R1 to the floor and suctioned R1's airway. E14's (LPN) report stated "through the suctioning process, meat, peas and green pureed looking substance were retrieved from his airway."

At 5:39pm First Responders arrived and paramedics arrived at 546pm. R1 was transported to the emergency room at 557pm.

The investigation also states E11, Team Leader (TL), served R1 his tray consisting of chopped pork, peas, sliced potatoes, canned apricots and jello.

The investigation states R1 had a swallow study on 1/3/12 following an incident on 12/19/11. It reads, "Following this incident, R1 was placed in an eating group so that he could be monitored while eating his meals. This is when R1 also stopped receiving bread at his meals. The swallow study precautions were to take small bites, small sips, monitor the rate of intake, supervise feeding, no straws, aspiration precaution, and stay upright for 90 minutes."

A released document regarding the First Responders call dated 11/18/12 indicated they attempted to place an airway without success. The patient "had to be continuously suctioned."

A "Prehospital Care Report Summary" by paramedics dated 11/18/12 reads "Patient was found choking while eating supper and went..."
Continued From page 61

unresponsive." This report states First Responders were unable to establish an airway due to patients vomitus in mouth. "Patient was noted as to having copious amounts of vomit in trachea and esophagus." Patient was in asystole.

The Paramedics unsuccessfully attempted intubation and suctioned vomitus out of the airway again. "Noted that chunks of potatoes and carrots were visible and were removed." A second attempt at intubation was successful.

A "History and Physical" dated 11/18/12 and written by Z4, physician states, "Apparently he was eating and choked on some large pieces of chicken...During the course of intubation multiple large pieces of chicken were removed from his pulmonary track."

A "Consultation" dated 11/18/12 by Z4, physician covering for primary physician (Z3), reads, "On arrival (Z6, Emergency Room physician), had told me that his mouth was full of pieces of food and chicken, and he had quite a time getting that out."

A "Consultation" written by Z7, physician, on 11/19/12 reads, "(R1 apparently began choking on a large piece of chicken...they attempted to dislodge this but the patient went into respiratory arrest". It goes on to say 15 to 30 minutes of CPR was performed and he was intubated during this time. "During the intubation process, he described multiple large pieces of chicken were removed from the pulmonary tract."

E6's Emergency room report dated 11/18/12 reads, "When intubating pt (patient) a large amount of food and chicken pulled from the oral
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<td>W9999</td>
<td>Continued From page 62 pharynx. The ETT (endotracheal tube) placed by the EMS crew was removed due to poor O2 saturations. ETT may have been clogged. Difficult to visualize due to large emesis in airway.</td>
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In an interview with Z1, paramedic, on 1/9/13 at 820am recalled R1 was found laying pulseless without breaths and copious amounts of fluid in his mouth mixed with stomach contents. There were "chunks of potatoes and carrots."

Z1 was asked if he recalled what was blocking R1's airway. Z1 stated "It was definite that his pulmonary track was impacted. There were copious amounts of food materials."

Z1 also stated that after they established an airway, it had to be changed in the emergency room due to becoming clogged with food in the airway.

Z2, paramedic was interviewed on 1/9/13 at 850am. Z2 reported R1 had "significant amounts of food in his mouth and back of his throat." Z2 stated there were 2-3 potato chunks "approximately the size of butter pads" and green beans. Z2 said there was approximately 1/4 cup of food blocking R1's airway and in his mouth.

Z6, Emergency Room Physician, was interviewed on 1/11/13 at 1115am. Z6 stated he recalled the code situation resulting from a choking incident with R1. Z6 stated R1 had aspirated food and it was "really packed in there, I was surprised to see so much." Z6 stated he couldn't see a thing and literally stuck his hand in there and pulled hand fulls of emesis and food out.
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| W9999             | Continued From page 63
Z6 stated, "Packed under all that was a chunk of chicken." Z6 was asked about the size of the piece of meat. Z6 stated it was a "big piece" and approximately 3 inches by 2 inches.
Z6 reported after the chunk of meat was pulled out and suctioned, a 5th round of Epinephrine was administered, patent airway was achieved and patient was successfully coded. R1 was transferred to Intensive Care from the emergency room.
Z3, (R1's primary care physician) dictated a "Discharge Summary" on 11/26/12 which reads, "Admitting diagnosis: Acute cardiopulmonary arrest with anoxic brain injury." The "Final Diagnoses include: Anoxic encephalopathy, Status post cardiopulmonary arrest and Status post choking episode on food as previously noted with obstructed airway."
Z3's dictated report included the following, "Subjective: (R1) was brought to the emergency room after he had choked on food and apparently was down for at least 20 to 25 minutes. He was able to be successfully resuscitated."
Z3's dictated report includes the following, "Hospital course: He was placed on a ventilator. The patient remained comatose from the time of his admission." It also states, "It was ultimately determined that there was no chance of any recovery, and the ventilator was discontinued. The patient's course was one of very rapid deterioration and he subsequently expired."
Z3's dictated report lists R1's "Cause of Death: Anoxic Encephalopathy." | W9999 | | |
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 14G049  
**State:** Statement of Deficiencies and Plan of Correction  
**Date Completed:** 03/01/2013

**Name of Provider or Supplier:** St. Mary's Square Living Center  
**Street Address, City, State, Zip Code:** 239 South Cherry, Galesburg, IL 61401

### IDs and Completion Dates

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**E2 (RN Nurse Trainer):** Interviewed 1/3/13 at 1015am and after reviewing R1’s chart was asked if R1 had a specific level of supervision ordered. E2 stated there was "None in the ISP or POS."

E2 was asked if the dietary assessment as part of the Comprehensive Functional Assessment dated one month after R1’s swallow study with new recommendations addresses his supervision level needs. E2 stated no. E2 was asked if there were any addendum's added to R1’s ISP regarding dietary. E2 stated no.

E2 was asked if there were any specific recommendations on R1’s ISP or orders per the physician instituted by nursing to prevent further choking incidents after R1 choked on 12/29/11? E2 stated no.

**E11, Team Leader (TL):** Interviewed on 1/3/13 at 335pm and asked if she was present when R1 choked on 11/18/12. E11 stated yes.

E11 was asked if R1 was monitored. E11 stated R1 was in an eating group and a team leader was watching two tables of residents in eating groups. E11 stated the other team leader was standing between the two "eating group" tables.

E11 recalled the meat which was served seemed dry that night when she cut it for R1. E11 stated the pork was served in pieces that were "approximately the size of a nickle and pretty thick."

E11 was asked what team leaders monitor R1 for...
**NAME OF PROVIDER OR SUPPLIER**

**ST MARY'S SQUARE LIVING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

239 SOUTH CHERRY

GALESBURG, IL  61401

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### SUMMARY STATEMENT OF DEFICIENCIES

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<td>E11 stated R1 receives a sippy cup. E11 was asked if R1 had an eating program. E11 stated &quot;not that I know of.&quot;</td>
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<td>E11 was asked if there was anything specific that R1 was to be monitored for. E11 stated no.</td>
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<td>E10, TL, was interviewed on 1/3/13 at 340pm and asked if she was present when R1 choked on 11/18/12. E10 stated yes and that she was the TL watching R1’s table along with another table. E10 stated she was standing between the two tables.</td>
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<td>E10 was asked what R1 was specifically to be monitored for. E10 stated R1 would eat too fast and had a condition which made him shake. E10 stated R1 was required to be within eyesight.</td>
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<td>E10 was asked if they were to monitor R1 for anything different than anyone else. E10 stated R1 had &quot;general monitoring&quot;. E10 stated R1 &quot;wasn't high risk, he usually eats well.&quot;</td>
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<td>E10 was asked about R1’s meat on his tray. E10 stated it was pork and it was chopped. E10 described the meat as &quot;stringy.&quot;</td>
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<td>E10 stated she advised the Program Director in the cafeteria once she noticed R1 choking.</td>
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<td>E14, LPN, was interviewed on 1/3/13 at 445pm and asked if she was present during R1’s 11/18/12 choking incident. E14 stated she was present and assisted in the CPR for R1 on that date.</td>
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|               | E14 stated R1 was suctioned and they got "quite
**ST MARY’S SQUARE LIVING CENTER**

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<td>W9999</td>
<td>Continued From page 66 a bit“ out. She also related First Responders arrived and when trying to achieve an airway, they pulled out a piece of meat. E14 was asked what the meat looked like and she stated it was a chunk, it looked like a string. E13, Program Director (PD) was interviewed on 1/3/13 at 410pm and asked if she witnessed the food on R1’s tray on 11/18/12. E13 stated R1 had &quot;chopped meat, green jello and a drink in a regular cup.&quot; This was all that E13 could recall. E4, QIDP, was interviewed on 1/3/13 at 3pm. E4 was asked if according to his chart R1 experienced a full airway obstruction on 12/29/11. E4 stated yes. E4 was asked if R1 had a swallow study done on 1/3/12 which stated specific recommendations to ensure R1’s safety. E4 stated yes. E4 was asked if R1 was being supervised on 11/18/12 when he choked which led to his death. E4 stated yes. E4 was asked specifically what team leaders were to monitor for to ensure R1’s safety while eating. E4 stated R1’s ISP states &quot;staff will be present and monitor while he eats.&quot; E4 was asked if staff were taught the specific recommendations from the swallow study done on 1/3/12. E4 stated there was not an inservice outlining these recommendations for team leaders. E4 was asked if any specific recommendations on R1’s ISP or POS were put in place to prevent further choking after the 12/11/11 incident. E4</td>
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## Statement of Deficiencies and Plan of Correction

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**Street Address, City, State, Zip Code:** 239 SOUTH CHERRY GALESBURG, IL 61401

### Summary Statement of Deficiencies

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W9999 was continued from page 67. It stated, "No, other than general monitoring and eliminating bread from his diet."

During an interview on 1/3/13 at 530pm E4 was asked, "What did your facility do above and beyond services generally provided to other residents after R1 was identified to have experienced a full obstruction in the past?" E4 stated, "Increase the level of monitoring by adding him to an eating group."

E4 was asked, "Is this increased level specific to ensure sufficient safeguards to prevent future occurrences?" E4 stated, "He was monitored."

2. R3, according to a Physician Order Sheet (POS) dated September 12, 2012, was a 86 year old male who had diagnoses which include Profound Intellectual Disability, seizure disorder and history of Pneumonia.

R3’s September 2012 POS has a "General/Pureed" diet with honey thick liquids, no added salt, (supplement) 1 can twice daily.

R3’s "Diet Order Form" dated 12/06/11 has him on a Puree Honey Thick liquid diet.

R3’s medical record had a "Video Fluorographic Swallow Study" done on 12/6/11 with the following recommendations: 1) Recommend diet change to puree and honey thick liquid. 2) Patient to take smaller bites and allow time for swallow function. Verbal cues will assist with the patient’s swallow. Should the patient appear to have a delayed swallow, use an empty spoon to trigger a second swallow."
### Statement of Deficiencies and Plan of Correction

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**Address:** 239 SOUTH CHERRY, GALESBURG, IL 61401

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| W9999         | Continued From page 68 Z3, R3's primary care physician signed the swallow study on 12/9/11 and wrote, "follow recommendations." An "In-Service Education / Meeting Report" dated 12/7/11 for "Department: Programming" reads, "Objectives: After having a swallow study done, (R3) is now honey thickened liquids and may only eat pureed food." A "Nutritional Assessment" dated 03/1/12 states R3 "Needs Assistance" with his eating skills. An "Eating Skills Assessment" signed by E4, Qualified Intellectual Disability Professional (QIDP) and dated 3/26/12 states R3 "eats in family style dining but needs staff assistance to open condiments and bust (sic) his tray when he is done." The "Eating Skills Assessment" dated 3/26/12 states in the area of "Consumption Skills (slow/fast eating rate, places too much food in mouth, etc.) Summary: (R3) may be prompted to use a napkin." In the area of "Special Considerations (has mobility issues, requires assistance with some aspect of dining such as feeding, adaptive devises, etc). Summary: There are no special considerations at this time."
| W9999         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |

**Event ID:** MY4611  
**Facility ID:** IL6009039  
**If continuation sheet Page:** 69 of 80
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| W9999 | | | Continued From page 69 consensus. (R3) eats independently. This level of intervention has been sufficient in preventing any eating issues."

R3's Individual Service Plan (ISP) dated 3/26/12 has under the section "Dietary: (R3) is on a pureed diet with honey thickened liquids." It also states R3 has no indications of chewing or swallowing problems.

The ISP states R3 participates in family style dining.

The ISP states, "At day training: Eating Skills: (R3) eats independently. He eats an appropriate rate and displays good table manners."

Listed under "Primary Needs" for R3 are Glasses care, money skills, language expression, oral hygiene, self-medication skills, repositioning skills and passive range of motion.

Listed under "Secondary Needs", the last of 18 entries is "Increase Eating Skills: Verbal Prompts to use napkin."

A "Program Progress Note" written by nursing on 8/31/12 at 330pm states R3 had congestion and was given a respiratory treatment.

A "Program Progress Note" written by nursing on 8/31/12 at 7pm reads "Rubbing heard over all lung fields". It also states, "Resident has mild productive cough of white frothy sputum, Respirations increased, reported resident eat dinner, sent to ER for evaluation."

A "Program Progress Note" written by nursing on
Continued From page 70

9/1/12 reads, "Resident admitted to (hospital) at 1202am with Aspiration Pneumonia."

A hospital record for R3 which was printed on 9/1/12 and includes patient demographics states the admitting diagnosis of "Aspiration Pneumonia."

According to a "Discharge Summary" written by Z3 (Primary Care Physician) on 9/25/12, during the course of hospitalization, R3 had a bronchoscopy, developed recurrent respiratory distress then was intubated and placed on a ventilator. During his hospitalization, R3 had a swallow study which revealed he was unsafe for oral intake. After consultation, a feeding tube was placed to which after R3 developed hypotension and bradycardia. An EGD was performed at the bedside but R3 continued to bleed and while being taken to surgery, R3 coded and expired.

Z3’s Discharge Summary dated 9/25/12 has an "Admitting Diagnosis: Aspiration pneumonia."

Z3’s Discharge Summary has R3’s "Cause of Death: Respiratory failure secondary to aspiration pneumonia as well as GI bleed."

E4, QIDP, was interviewed on 1/8/13 at 4pm and asked if R3 had a swallow study on 12/6/11 with specific recommendations ordered by the physician. E4 stated yes.

E4 was asked if R3 was in an Eating Group or provided monitoring as indicated by R3’s need for verbal prompting in his swallow study recommendation. E4 stated no, R3 ate in Family Style dining.

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<td>W9999</td>
<td>Continued From page 70 9/1/12 reads, &quot;Resident admitted to (hospital) at 1202am with Aspiration Pneumonia.&quot;</td>
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**STATEMENT OF DEFIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

14G049

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING _____________________________

B. WING _____________________________

**(X3) DATE SURVEY COMPLETED**

C 03/01/2013

**NAME OF PROVIDER OR SUPPLIER**

ST MARY'S SQUARE LIVING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

239 SOUTH CHERRY
GALESBURG, IL  61401

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E4 was asked if R3's ISP addressed his primary need of safety when eating as recommended in the swallow study or per the physician order. E4 stated no.

E4 was asked if there was an objective for R3's physician order. E4 stated no.

E4 stated R3 had "no outward signs of delayed swallow". E4 was asked if R3 was hospitalized with the diagnosis of Aspiration Pneumonia on 9/1/12. E4 stated yes. This hospitalization resulted in the death of R3.

E4 was asked if the recommendations from R3's 12/6/11 swallow study were addressed. E4 stated yes, he was on the correct diet. E4 was asked if the recommendation for the patient to take smaller bites and allow time for swallow function using verbal cues was addressed or if staff using an empty spoon to trigger a second swallow was taught or followed. E4 stated no.

E4 was asked if R3's Eating Assessment as part of his Comprehensive Functional Assessment reflected all of his ordered safety needs. E4 stated no.

E4 was asked if R3 needed monitoring while eating for safety. E4 stated yes.

E4 was asked if there is a policy on monitoring of high risk individuals when eating. E4 stated they are assessed individually and put in place. The monitoring assessments could not be found in the ISP or program section.
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239 SOUTH CHERRY
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<td>W9999</td>
<td>Continued From page 72 E4 was asked if R3 had any indication of need for monitoring in place in his ISP. E4 stated no.</td>
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350.620a)  
350.700a)  
350.700b)  
350.700c)  
350.3240a)  
350.3240b)  
350.3240d)  

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 350.700 Incidents and Accidents

a) The facility shall maintain a file of all written...
### ST MARY'S SQUARE LIVING CENTER

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<td>Continued From page 73 reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, &quot;serious&quot; means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a</td>
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

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These requirements were not met as evidenced by:

Based on record review and interview the facility failed to implement their policies to prevent neglect when they failed to ensure they had a system to track fractures which resulted in failing to investigate, report to the administrator or to the Department for 1 of 3 individuals in the sample with fractures. (R7)

Findings include:

R7, per Physicians Order Sheet (POS) of 12/12 is an 81 year old female with diagnoses of contractures of both hands and osteoporosis.

A History and Physical completed by Z3 (R7’s personal care physician) dated 11/26/12, under the section titled "Chief Complaint" states, "Lethargy, unsteady gait with 2 falls, and reported slurred speech prior to admission."

Under the section titled "History of Present Illness" the History and Physical of 11/26/12 states, "The patient is an 81 year old female, resident of (the facility) who on this particular occasion was reported by staff to have apparent unsteadiness of gait and fell twice the morning of admission (to the hospital). She was also noted to be more lethargic and reportedly had slurred
Continued From page 75

speech." It continues, "She was brought to the emergency room where a CT of her head was done which revealed no acute intracranial changes. She also did have a chest x-ray done which revealed a possible fracture of the sternum."

Under the section titled Assessment number 2 states, "Possible fractured sternum reported on x-ray with no evidence of any tenderness in that area present." An "Imaging Report" dated 11/27/12 states, "In comparison with the lateral view of the chest of November 26, re-demonstrates deformity of the mid part of the body of the sternum. Could relate to nondisplaced impacted fracture."

A "Progress Note" written by Z3 (Primary Care Physician) and dated 12/02/12 states, "The patient was recently hospitalized with episode of lethargy and slurred speech with 2 associated falls." The progress note continues, "Her chest x-ray and subsequent x-ray of the sternum also revealed evidence of a fractured sternum although the patient really did not have any significant tenderness in that area." Under the section titled "Assessment" it states, "3. Fractured sternum."

Facility policy 1.71 "Resident Incidents and Injuries" with a revised date of 01/12, under the section titled Policy states, "Staff shall report all incidents and accidents to their supervisor and to nursing. All reported incidents shall be reviewed by the Quality Assurance committee. The facility shall investigate incidents of residents who incur injuries of unknown origin and any other matters that relate to the health, safety, and welfare of its
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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Residents and staff including patterns and trends.

Under the section titled "Procedure" Policy 1.71 states, "1. A facility employee or agent who becomes aware of a resident with an injury of known or unknown origin shall have that resident examined by a facility nurse and report the injury to the supervisor on duty. 2. The facility nurse shall report that injury to the Administrator and the Health Services Supervisor to be reviewed by the Quality Assurance committee. 3. The Administrator shall direct the Director of Quality Assurance to investigate the injuries of unknown origin and any other matters pertaining to the health, safety, and welfare of facility residents and staff, including patterns and trends which may have been identified by the Quality Assurance committee."

Facility policy 1.46 "Quality Assurance Committee" with a revised date of 2/13/02, under the section titled Purpose states, "The Quality Assurance Committee assists Administration by ensuring practices and policies regarding nursing services, facility environment and individual's safety meet regulatory standards and quality outcomes." Under the section titled Procedure policy 1.46 states, "1. The Administrator chairs the Committee." Number 4 states, "Review all incidents and accidents, including injuries and bruises of unknown origin, involving individuals and staff to ensure that no patterns or trends are occurring. Action will be taken when necessary to prevent future incidents or accidents."

E16 (Health Services Supervisor) was interviewed on 1/09/13 at 10:20am. When asked if she was aware of R7's sternum fracture of
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11/26/12, E16 stated yes. E16 stated that she was aware of it from the reports received from the hospital. When asked if R7's sternum fracture was reported to E5 (Administrator), E16 stated, no. When asked if R7's sternum fracture was reviewed by the Quality Assurance Committee, "I'm going to have to say no. It would have been me that reported it."  
E3 (Director of Quality Assurance) was interviewed on 1/08/13 at 2:45pm. When asked if she was aware of R7's sternum fracture of 11/26/12, E3 stated no. E3 stated, "That's the first I've heard of it."  
In a Quality Assurance Meeting note dated 12/26/12, R7 was "noted to be bleeding from middle and 3rd finger - small laceration above cuticle noted - x-ray revealed fracture."  
An Incident Investigation dated 12/19/12 reads R7 presented to a team leader with bleeding from her left middle and 3rd fingers. The report goes on to say that R7's left hand was X-rayed on 12/20/12 at 830am which revealed a fracture to the left 3rd finger.  
E2 provided an undated handwritten list titled "Hospitalizations". The 2nd page of this listed fractures. There was an entry which stated R7's first name with a dash (-). There was no further entry.  
E2 was interviewed on 1/2/13 at 330pm and asked about this entry. E2 stated R7 had fractured her finger on 12/19/12 and she just had not finished the handwritten entry. | W9999 | | | |
Continued From page 78

E3 was asked for all fractures and investigations of fractures since September 2012 upon initiating the survey. E3 provided a number of fractures and investigations. E3 was asked if these reports are a complete compilation of all fractures from 9/1/12 to present. E3 stated, "As far as I know, yes".

E3 was asked again on 1/2/13 if there were additional fractures since 9/1/12, this was asked in the presence of E2. E3 stated she had provided all fractures and investigations.

The information regarding R7's 12/19/12 fracture was not provided by the facility when all fractures and investigations were requested at the initiation of the survey.

E3 was interviewed on 1/13/13 at 1130am and asked, "What is the facilities system for tracking fractures?". E3 stated she writes down fractures monthly and forms a list at the end of each month.

E3 was asked if R7's 12/19/12 fracture and investigation were provided upon request. E3 stated no.

E3 was asked, "Does this demonstrate a flaw in your tracking method?" E3 stated yes.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING 
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(X3) DATE SURVEY COMPLETED
C 03/01/2013

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FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: IL6009039
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