Continued From page 24
behavior that could result in choking do not leave the dining area with food in their mouths or on their person.

> All day training staff will be inserviced on supervision of residents requiring dietary supervisions with special emphasis on residents who have been identified as being at risk of choking or have a behavior that could result in choking.

> The facility shall contact day training to discuss staff monitoring of residents. The day training program has agreed to initiate training for its staff regarding the monitoring of residents while at the day training program. The day training program has also agreed to re-inservice its staff on its monitoring policy. Special emphasis will be placed upon ensuring that residents at risk for choking or have a behavior that could result in choking do not leave the dining area with food in their mouths or on their persons.

While the Immediate Jeopardy was removed on 05/24/13 at 6:45 pm, the facility remained out of compliance as the facility had not had the opportunity to fully implement and evaluate the effectiveness of their plan.
**SUMMARY STATEMENT OF DEFICIENCIES**

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

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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 350.1210 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:

3) Periodic reevaluation of the type, extent, and quality of services and programming.

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:

2) Basic skills required to meet the health needs and problems of the residents.

g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their...
Continued From page 26 qualifications.

Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on observation, record review and interview the facility has failed to implement their system to prevent neglect for 1 of 1 individual whose 05/21/13 choking incident at the day training site resulted in death (R1) when then failed to:

1) Ensure R1 had sufficient safeguards and monitoring in place to prevent him from choking on food

2) Implement sufficient safeguards for 11 of 11 individuals who require some level of monitoring while eating for safety and who are on programs for eating too fast or other unsafe eating behaviors which may result in choking or other negative outcomes and attend the day training site.

Findings include:

A) In review of an Individual Service Plan dated January 17, 2013, R1 is a 37 year old male who has diagnoses which include Autistic Disorder, Impulse Control Disorder and Profound Intellectual Disabilities.
**ST MARY’S SQUARE LIVING CENTER**

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| R1’s ISP reports "(R1) arrives to day training during the summer months where he sits outside with his bucket of papers. Once the weather changed to colder weather he stays at his living facility and on occasion attends the winter program." It goes on to state that R1 comes inside the building at day training on occasion to ask staff for more paper, pop or his snack. R1 comes inside to eat his lunch and purchase pop or snack from the vending machine.

A section of R1’s ISP titled "Communication" states he has "profound expressive/receptive language deficits." It also states that R1 is non-verbal.

A section of R1’s ISP titled "Dietary" and "Functional Skills" reads he is on a general diet and requires a formal program for eating skills. R1 is said to require same table level of supervision when dining. It also states R1 requires staff assistance in cutting large pieces of food.

A section of R1’s ISP under Functional Skills - At Day Training reads, "Eating Skills: (R1) eats his own lunch but requires verbal prompts to clean his area and to throw his trash away."

A "Primary Needs" section of R1’s ISP has "Needs to increase his eating skills: Formal Program/Joint" listed as an area of need.

R1’s ISP has a "Program Goal" which includes "Eating Skills: (R1) will increase his eating skills by pausing between bites, given verbal prompts at each meal for 20 sessions a month for 5 of 6 months at both facilities combined by 12/31/13."
Continued From page 28

Opportunities to run this program for R1 is "Any mealtime."

An "Eating Skills Assessment" dated 10/27/12 states the following under "Consumption Skills" for R1: "requires verbal prompts in this area. He requires verbal prompts to slow his rate of eating. (R1) is on a formal program to pause between bites at each meal."

A "Resident Progress Note" dated 12/30/12 and completed by Z1, physician, reads, "(R1) has obvious difficulty understanding and following simple commands."

A Facility policy titled "Administrator's Investigative Committee" most recently revised 03/21/12 has a section titled "Definitions" and reads, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

A "Program Progress Note" written by nursing and dated 5/21/13 at 12:15pm reads, "DT (Day Training) phoned stated resident was being sent to (local) ER (Emergency Room) d/t (due to) a choking episode."

A "Program Progress Note" written by nursing and dated 5/21/13 at 12:45pm reads, "Hospital ER called, reported (R1) has expired."

A "Nutritional Assessment" on January 1, 2013 does not have any of the following areas checked to indicate a problem: "Needs prompt, Swallowing, Chewing, Choking." A note from the Dietary Clerk reads "Feeds, self - general diet."

A "ISP Review Addendum" for R1 dated 1/8/13
Continued From page 29

states, "(R1) eats at a rapid rate and is currently on an eating skills program to pause in between bites at each meal. His eating program will be revised to ensure that (R1) will consume his food and drink items with staff sitting at the same table to provide verbal prompts and assistance as needed." This Addendum was provided by Z4, Director of Rehabilitation Services at Day Training.

A fax to the Department dated 5/22/13 and written by E2, Director of Quality Assurance, reports R1 "apparently choked on his sandwich during lunch while attending his (day training program)."

The report which states R1 was monitored while eating and prompted to swallow his food goes on to say R1 went outside where he "initially sat and then laid down." Day training staff noted that his face was blue in color and called 911. These statements differ from the statement given by Z3, DTII, who was said to have witnessed R1 leave the building after lunch.

E2's report to the Department also states R1 passed away while at the hospital.

An Emergency room report dated 5/21/13 has a section titled "Disposition" and states: "Deceased on arrival."

During observation on 5/24/13 at 11:30am, this surveyor was shown where R1 exited the building and where he was laying in the grass. This distance was approximately 100 feet.

A "Prehospital Care Report Summary" dated 05/21/13 recounts Emergency Medical Services
Continued From page 30

(EMS) notes from the call which was received at 11:59 am on 5/21/13 involving R1.

The report states EMS arrived on the scene at 12:03 pm and left the scene enroute to the hospital at 12:23 pm.

The "Dispatch Reason" is Choking, "Chief Complaint" is Cardiac Arrest, Airway Obstruction, Apnea.

The "Initial Assessment" for Airway reads, "Completely obstructed." R1’s skin was recorded as "Cyanotic, cool."

R1’s heart rhythm was recorded as "P.E.A" (Pulseless Electrical Activity) and his pupils were dilated bilaterally.

A Narrative section of the EMS report states, "Dispatched for a male pt (patient) chocking (sic) on a sandwich not breathing." It goes on to state, "Staff members relate that the pt was found laying on the ground with food lodged in his mouth, the pt was blue and not breathing."

The narrative also states that staff was unable to dislodge food from the pt's airway and "did not know the last time that the pt had been seen."

Narrative charting reads, "Pt was found unresponsive, Skin: cyanotic, cool moist; Airway: completely obstructed, Breathing: Apneic, Circulation: agonal in nature." It continues on to say "slight cyanosis noted to the core of the thoracic region."

Under a section titled "Secondary Exam" the report reads, "Forceps used to clear large pieces..."
Continued From page 31

of food from oropharynx, suction was applied to the mouth and oral pharynx, copious amounts of food and fluid were removed from the airway.

A section titled "Vitals" shows that the EMS was not able to obtain a pulse or spontaneous respirations during the course of their call.

A report from the Emergency Department where R1 was taken dated 5/21/13 has a section titled, "Chief Complaint/History of Present Illness" which states the patient was triaged at 12:31 with no pulse. It also states R1 was in "full cardiorespiratory arrest."

A section titled "Physical Examination" states, "Heart sounds absent. No palpable pulse. No bp (blood pressure) no pulse no spontaneous respiration, fixed dilated pupils, no heart sounds."

A section titled "Clinical Impression" states, "1. unsuccessful cpr (cardio pulmonary resuscitation), pt (patient) pronounced dead at 12:48 pm."

A section titled "Disposition" states: "Deceased on arrival."

A note from "Nurse Documentation" dated 5/21/13 at 12:31 states that Z5 (Paramedic) reported "Copious amounts of bread and cheese were cleared from the patient's airway."

A "Discharge by Death" from the hospital states the diagnosis is "Cardiac Arrest (Choking)" and states the coroner is to do an autopsy.

During an interview on 5/23/13 at 2:16 pm, Z6, Coroner was asked if the cause of R1's death...
Continued From page 32

had been determined based upon his autopsy findings. Z6 stated his "findings are consistent with choking on food."

During an interview on 5/24/13 at 10:25 am, Z5, Paramedic, was asked if she participated in the call involving R1.

Z5 stated yes, they had been called out just before noon for a patient choking on a sandwich. Z5 stated as they pulled up to the scene, there was some staff near R1 and she could see from the ambulance that R1 was "obviously cyanotic." Z5 went on to say that R1 was deep purple in color.

Z5 stated R1 was laying outside behind a building and staff was attempting abdominal thrusts on the ground. R1 was said to be unresponsive, not breathing and choking on a sandwich.

Z5 stated when she arrived near R1, she noted some food on the ground which appeared to be food which the staff had removed from R1’s airway. Z5 stated it was approximately 1/4 of a sandwich. When Z5 attempted to clear R1’s airway, she found "a lot" of food affecting R1’s ability to breathe.

Z5 stated she performed a finger sweep and retrieved "quite a bit" of food, then used forceps to pull food from R1’s airway. Z5 then used the laryngoscope to open R1’s airway more and continued to attempt to clear his airway using portable suction.

Z5 stated a staff member was performing chest compressions and continuously pushed food out of R1’s airway and she would "scoop food" from...
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Z5 was asked how much food was retrieved from R1's airway and mouth. Z5 approximated 1/2 of a sandwich was brought from R1's airway and mouth including "big chunks". Z5 stated "Two chunks were 1/2 dollar size at least."

Z5 stated R1 had no response, no spontaneous breaths and no pulse during the time she cared for him.

Z5 was then asked how long R1 was down. Z5 stated she doesn't know and further stated, "I couldn't get anyone to tell me."

Z2, Float Trainer/Driver, was interviewed on 5/23/13 at 3:50pm and asked if she sat with R1 while he ate his lunch on 5/21/13. Z2 stated yes. She further stated she sat right by R1 and he chewed his food and paused between bites.

Z2 stated lunch time is 11:30 am and R1 came in later to eat at around 11:40. Z2 stated R1 took 5-10 minutes to eat, then stood up to go outside.

Z2 stated "both sandwiches were consumed and I ensured he swallowed and chewed before he went out."

Z2 was asked if she watched R1 consume both sandwiches how he got another sandwich like one sent in his lunch which resulted in his airway obstruction and death outside in the yard. Z2 stated, "I have no idea."

Z3, DTII, was interviewed on 5/23/13 at 4:02 pm and asked if she was working the day that R1 choked. Z3 stated yes and that R1 came in for...
Continued From page 34

lunch and she asked Z2 to run his program. Z3 stated after R1 was finished eating he came to the back porch where her office is. Z3 states she seen R1 didn't have anything in his mouth but did have crumbs on his face. Z3 was unable to recall times of her observations.

Z7, Trainer/Driver, was interviewed on 5/23/13 at 3:20 pm and asked if she was present when R1 was choking. Z7 stated she is 1 of 2 individuals who initially responded to Z3's calls for help.

Z7 stated at approximately 11:55 am she arrived at the back of Unit 14 and seen R1 who was limp, blue and not breathing.

Z7 asked why R1 was not breathing. Z7 stated R1 had choked on food. Z7 was asked what food R1 was noted to have been choking on. Z7 stated the "pieces were like chewed bread and cheese."

Z7 further stated, "The ambulance people used tongs to pull out bread and cheese, one piece was the size of 1/2 dollar and there were smaller pieces like pea size."

Z7 was asked how R1 had obtained the food he choked on outside. Z7 said she didn't know.

Z7 was asked how long R1 was down. Z7 stated she got there about 11:55 am and the ambulance left with him around 12:20 pm. Z7 stated R1 was not breathing during that time.

Z8, Trainer/Driver, was interviewed on 5/23/13 at 3:34 pm and asked if she was present when R1 was choking on 5/21/13. Z8 stated yes, she had responded to Z3's call for help.
Continued From page 35

Z8 was asked what time R1’s Unit ate lunch. Z8 stated they ate around 11 am.

Z8 stated at approximately 11:55 am when she arrived a bystander was holding R1 from behind. R1 was in a sitting position on the ground but limp. Z8 states the bystanders "wife" called 911.

Z8 was asked what R1’s supervision level was at meals. Z8 stated, "1:1 because he eats fast and stuffs food."

Z8 was asked how he got food outside. Z8 did not know.

Z8 further stated the EMS members were not able to intubate because of food blocking R1’s airway.

Z8 was asked what type of food was seen in R1’s mouth or airway. Z8 stated it looked like pieces of sandwich - yellowish in color and about 1/2 dollar size. Z8 continued that staff pulled out smaller pieces of food with finger sweeps and EMS pulled out additional food.

Z3 states R1 went down the steps and walked across the yards to his bucket while she followed. Z3 was asked if R1 had anything in his hands. Z3 stated, "I don't know, I can't say for sure."

Z3 stated she did not usually follow R1 but did on this day for an unknown reason. Z3 states R1 was not noted to be coughing or gagging. Z3 states she called R1’s name two times and he didn't turn around which is unusual.

Z3 stated R1 went to his bucket and laid down. At that time she noted "his face was blue and his
W9999 Continued From page 36:

eyes were closed.*

Z3 was asked if she was sure R1 had nothing in his mouth when he left her area, how did his airway become obstructed with a sandwich matching the description of what he had for lunch. Z3 stated she didn't know.

Z3 was asked again if she noted R1 had anything in his hands. Z3 did not know.

During an observation of Unit 12 on 5/24/13 at 11:22 am, it was observed there were 13 residents and 2 staff members. There were 3 residents at one table with a staff member and 2 residents at another table with a staff member. The remainder of the residents were said to be finished and had been removed from the table and sitting along a wall.

Z3 was asked on 5/23/13 at 11:30 am why the residents were sitting along the wall. Z3 stated they were done eating and are removed from the table so there is less congestion.

During interview on 5/23/13 at 3:50 pm, Z2 stated Unit 12's lunch began at 11:30 am yet during this observation, most residents were finished by 11:22 am.

Z8 had stated during interview on 5/23/13 at 3:34 pm Unit 12 ate lunch around 11 am.

Z3 also stated during interview on 5/23/13 at 3:50 pm that R1 typically came in for lunch about 10 minutes after the residents started because he didn't like to eat with a large group.

A Compact Disc was obtained containing the
Continued From page 37

actual 911 call placed. According to the recording, a female bystander called 911 and requested an ambulance for "a kid choking to death."

The 911 dispatcher asked what the subject was choking on. When the female caller relayed the question someone in the background said "a sandwich."

At 1 minute 12 seconds into the call, there was a sound that appeared to be slapping of bare skin and a female voice in the background said "sweep."

The dispatcher asked if R1 was standing and the female caller reported no, he was "lifeless on the ground."

After direction of the 911 dispatcher, the female bystander instructed the staff to push on R1's chest. This was 1 minute 28 seconds into the call.

The female caller reported that food was "coming slowly" when asked by the dispatcher.

At 1 minute 47 seconds a female voice in the background stated she was going to sit him up again and sweep.

The 911 dispatcher continued instructing the caller to push, give a good quick thrust and finally to roll him over.

At 2 minutes 32 seconds after the call began, ambulance sirens could be heard in the background. The 911 dispatcher advised to keep giving compressions even if he wasn't breathing to keep blood circulating.
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There were numerous voices in the background and a female voice saying, "Come on (R1), Come on (R1)!" There was additionally a female crying which could be heard.

At 3 minutes 8 seconds after the call began, a female voice in the background could be heard counting while administering CPR.

At 3 minutes 38 seconds, the call ended as the EMS arrived.

Z9, witness, was interviewed on 5/24/13 at 12:03 pm and asked if he was present for the choking incident on 05/21/13. Z9 said yes.

Z9 was asked what he witnessed. Z9 stated he was walking into a neighboring business when he heard a woman call for help and seen her running down the steps toward a man laying in the grass.

Z9 went to assist the female and stated the man in the grass was dark blue when he got there with "ice blue lips."

Z9 went on to state he asked Z10, witness, to call 911 which she did.

Z9 stated that the staff didn't know what to do for R1 or didn't act like they knew CPR. Z9 stated he didn't know CPR but attempted abdominal thrusts although R1 was limp and laying on the ground.

Z9 stated CPR did not begin by staff until the ambulance was pulling up. This statement coincides with what can be heard on the 911 recording.
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GALESBURG, IL  61401

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Z9 further stated, "There was no reason R1 should have been left out there. There was no reason he should have died."

E3, Program Director (PD), was interviewed on 5/23/13 at 3:10 pm and asked "What was the purpose of putting (R1) on an eating program which prompts him to pause between bites?" E3 stated if he didn't pause, it could cause choking.

E3 was asked what measures were put in place to prevent R1 from choking. E3 stated the facility wrote a program to prompt R1 to pause and for R1 to have same table supervision.

E3 was asked on 5/24/13 at 2 pm why R1 was put on a formal eating program. E3 stated it was due to R1's behaviors, that he was sometimes non complaint with waiting to eat, to help prepare his tray and to pause between bites.

E3 was asked if R1 was considered to be high risk. E3 stated, "Yes, since he is same table (supervision) it would indicate he is at increased risk."

B) In review of an Individual Service Plan dated January 17, 2013, R1 is a 37 year old male who has diagnoses which include Autistic Disorder, Impulse Control Disorder and Profound Intellectual Disabilities.

R1’s death resulted after an incident at day training on 5/21/13 when he was found outside of the day training building with a sandwich from his lunch obstructing his airway.

R1 had an "Addendum" dated 1/8/13 which
Continued From page 40

W9999 reads, "(R1) eats at a rapid rate and is currently on an eating skills program to pause in between bites at each meal. His eating program will be revised to ensure that (R1) will consume his food and drink items with staff sitting at the same table to provide verbal prompts and assistance as needed."

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E3 was asked if R1 was considered to be high risk. E3 stated, "Yes, since he is same table (supervision) it would indicate he is at increased risk."

Per a 5/22/13 inservice R4 is on a program "to decrease her rate of eating."

Per a 5/22/13 inservice R5 is on a program "to decrease her rate of food consumption."

Per a 5/22/13 inservice R6 is on a program "to help slow his rate of eating."

Per a 5/22/13 inservice R7 is on a program to prompt him to slow down and eat at a slow rate.

Per a 5/22/13 inservice R8 is on a program "for impulsive eating and cued to slow."
### Statement of Deficiencies and Plan of Correction

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

- 14G049

**Date Survey Completed:**

- 06/05/2013

**Multiple Construction**
- A. Building ___________________________
- B. Wing ___________________________

**Name of Provider or Supplier:**

**St Mary's Square Living Center**

**Address:**

- 239 South Cherry
- Galesburg, IL 61401

**Summary Statement of Deficiencies**

- (Each deficiency must be preceded by full regulatory or LSC identifying information)

**Provider's Plan of Correction**

- (Each corrective action should be cross-referenced to the appropriate deficiency)

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**Event ID:**

- W9999

**Description:**

Continued From page 41

- Per a 5/22/13 inservice R9 is on a program to monitor her "rate of consumption."

- Per a 5/22/13 inservice R10 is on a program due to "being a fast eater and putting too much food in his mouth."

- Per a 5/08/13 inservice R11 is on a program because he "may eat at a rapid rate, stuff his mouth with food."

- Per a 5/22/13 inservice R12 is on a program for "eating too quickly."

- Per a 5/22/13 inservice R13 is on a program because she may "consume food and/or drink items too quickly."

- Per a 5/22/13 inservice R14 is on a program because he "will attempt to take meal items from others and will stuff his mouth with an excessive amount of food. (R14) will also eat too quickly, not chew adequately."

Although these residents have been placed on formal programs and given a level of supervision, the facility has not ensured residents who are at high risk while eating do not obtain food outside of monitored mealtimes or outside of their monitored dining area.

A Facility policy titled "Administrator's Investigative Committee" most recently revised 03/21/12 has a section titled "Definitions" and reads, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."
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