

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.1220b)2) 300.1220b)3) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that</p>	S9999		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>6) All necessary precautions shall be taken</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>Section 300.3240 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)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interviews and record review the facility failed to implement interventions and adequate supervision for 1 resident (R3) to reduce the risk of choking/aspiration. (1). The facility allowed R3, to be fed on an unsupervised unit by (Z6) spouse who had no knowledge of who/how to contact the nursing staff during a medical emergency. (2.) The facility failed to implement interventions consistent with R3's needs, goals, plan of care and current standards of practice. This failure resulted in R3, choking while being fed by Z6 on the 4th floor. R3 was taken by Z6 via the elevator to the 2nd floor to get emergency help. When Z6 arrived to the second floor and got off the elevator R3 was unconscious, pale with blue lips and head leaning forward. Z6 stated he must have fed her too fast, that R3 would not swallow food. R3 was transported to the local hospital and died of Aspiration, cardiac arrest and severe anoxic brain injury.</p> <p>Findings Include:</p> <p>Facility's Incident Report: Dated 12/11/2013, completed by E3 (nurse) Where did this occur: on the 4th floor How did this occur: Z6 (spouse), I don't know, I was feeding her, I fed her too fast and she did not</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>swallow. I brought her down to the nurse. Report to Illinois Department of Public Health (IDPH): December 11, 2013 at 12:30 pm, R3 was brought from the 4th floor to the 2nd floor nursing station sitting in a special wheel chair, unconscious, leaning forward with blue lips by Z6 (spouse) who was feeding resident on an unsupervised 4th floor. The final report faxed over to IDPH noted that the root cause of the choking episode was due to Z6 feeding R3 outside food. Social Service Note: Dated 07/22/2013 Ask family to provide cultural/ethnic foods, encourage activity participation. Z6 was asked to bring outside food into the facility to feed R3. Nursing Notes/Interviews: R3 a 77 y/o, was readmitted to the facility on July 22, 2013 with diagnoses of : Failure to Thrive, Diabetes Mellitus, Gastroesophageal Reflux (GERD), Alzheimer's Disease and Hypertension. R3 refused to wear her dentures during meals. R3 was at risk for choking/aspiration. R3 was carried to the 4th floor by Z6 daily to be fed lunch. The facility was aware that R3 was being carried off the unit daily by Z6 to an unsupervised floor to be fed lunch. Dietary recommendation Sheet, dated 3/22/13: Resident having difficulty chewing, husband requested diet to be downgraded from a general diet to a mechanical soft diet. Dietary Progress Notes - dated 03/20/13 at 1:28 pm: Resident family here yesterday and noticed resident (R3) was having difficulty chewing chicken, they discussed their concerns with Russian Coordinator and wish the diet to be downgraded from general to mechanical soft. Diet changed Physician Order dated 03/2013: Downgrade diet from general to mechanical soft.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>January 3, 2014 at 12:15 pm, writer requested of (E1) to speak with the dietician who recommended the downgrade on 03/20/13. Writer was told dietician is no longer employed and there was no contact number for her. E1 was asked why a care plan was not initiated to address the concerns/risk of R3 eating slowly, difficulty chewing and eating without dentures in mouth. E1 stated she does not know. Care plan dated, 12/11/13 - date of choking incident stated I have upper and lower dentures but I usually refuse to wear lower dentures, I spit them out despite encouragement.</p> <p>January 3, 2014 at 12:30 pm, E1 (Director of Nursing - DON) was asked during interview why the interdisciplinary team did not address the concerns for the diet downgrade. E1 stated that the practice of the facility is to give the resident their chose of diet. Z6 fed R3 daily on another floor away from monitoring of staff and asked that (R3)'s diet be downgraded because of complications with chewing. No dietary assessments or nursing notes were initiated to see if R3 was having a chewing or swallowing problem. There was no documentation that the facility considered the development of care planning interventions for the risk of choking/aspiration.</p> <p>Feeding Policy and Educating families feeding residents: Family members wishing to participate in the feeding of their loved ones will be educated as to safe feeding techniques by the nurse, dietician, speech therapist or food service manger. Education may be interpreted for non English speaking families.</p> <p>February 11, 2014 at 1:30 pm, E1 was asked for the education/documentation regarding feeding residents and aspiration precaution risk for Z6. E1 did not have any documented information that</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>Z6 received education on feeding and aspiration precautions.</p> <p>February 13, 2014 at 11:55 am, the Russian Coordinator (E10) was interviewed and stated she is the only one who is able to communicate in Russian for Z6, who speaks only Russian. (E10) stated she was on vacation when the choking incident happened. (E10) stated that she would often come back up to the fourth floor about 1:20 pm when she finished helping with residents during lunch on the second floor and would find (Z6) feeding her still on the 4th floor. (E10) stated she often would remind (Z6) not to put too much food in her mouth and wait for her to swallow. (Z10) was asked if there is any documentation of evidence that Z6 assumes all responsibility for taking R3 off the unit during meal time to feed her. Z10 responded no she does not have anything documented.</p> <p>Physician Interview: February 13, 2014 at 1:45 pm, Z7 (Primary Physician) was asked why an order was given to downgrade R3 from a general diet to a therapeutic diet (mechanical soft). Z6 stated because the patient was not able to chew her food per the call he received on 03/22/13. The woman is very dementiated and would not understand. "The woman requires 100% feeding by staff or someone to be done. " She does not take solid foods well, I have heard it before and when I got the call this time. I gave the order for soft foods because she does not wear her denture.</p> <p>January 3, 2014 at 12:55 pm, E3 (nurse) stated that Z6 was feeding R3 on the 4th floor by the patio. E3 nurse stated that Z6 would take R3 up to the 4th floor for lunch every day. E3 stated that around lunch time, the nursing assistants (E4, E6 and E7) brought R3 to the nursing station. E3</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6003511</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/27/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GROSSE POINTE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6601 WEST TOUHY AVENUE NILES, IL 60714</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 7</p> <p>stated that Z6 brought R3 down from the 4th floor to the 2nd floor. E3 stated that R3 was unresponsive, and pale with blue lips. February 11, 2014, E5 (nurse) stated he came from the 3rd floor via stairs to the second floor in response to a code blue. E5 stated when he arrived he saw E3 suctioning R3. E5 stated he asked what happened and was told by E3 that R3 choked on food. E5 stated that R3 was unresponsive, pale with blue lips and head leaning forward. E5 stated that R3 did not respond to verbal and tactile stimuli. February 11, 2014 at 12:20 pm, E4 stated that Z6 came off the elevator with R3 from the 4th floor where Z6 was feeding R3. E4 stated that R3 was slumped forward in the wheel chair, lips were very blue and face was pale. E4 stated that Z6 said he doesn ' t know what happened that he must have fed R3 too fast, and that R3 would not swallow. February 21, 2014 at 3:35pm, E1 (Nursing Director) and E14 (Administrator) was asked if the facility has a safety mechanism in place to protect/identify residents at risk for choking/aspiration from being fed in an unsupervised area. E1 and E14 responded no. February 21, 2014 at 3:45 p.m. E14 and E1 stated that the 4th floor bathroom has a call cord that will buzz at the 3rd floor nursing station. E14 and E1 were asked is there any posted information that the visitors would know to go to the 4th floor bathroom and pull the cord for medical emergencies. E14 and E1 responded no they would not know and no we do not have anything posted.</p> <p>(B)</p>	S9999		
-------	---	-------	--	--