DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E169	A. BUILDING ______ B. WING ______	C 10/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON MANOR CNV & NURSING	2155 WEST PIERCE CHICAGO, IL 60622

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation: #2083173/IL 122322 - No Deficiency #2087503/IL 127034 - F689; F808. #2083904/IL 123086 - No Deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to supervise and monitor a resident, who was previously hospitalized for aspiration pneumonia, to prevent another choking incident. This failure affected one resident (R2) of two residents reviewed for resident injury. R2 choked on a peanut butter sandwich, resulting in R2 becoming unresponsive and later intubated in the hospital due to respiratory failure. Findings include: On 10/13/20, V2 presented the following records of R2: 1. R2's Hospital Records Discharge Summary, dated 9/29/20 written by V10, Hospital Physician, states, "Patient was unresponsive, tachypneic, and oxygen saturation was 50-60 percent (%) on	F 689	Winston Manor Convalescent and Nursing 2155 West Pierce Ave Chicago, Illinois 60622 Plan of Correction October 15, 2020 The statements made on the plan of correction are not an admission to, and does not Constitute an agreement with the alleged deficiency herein. To remain in compliance with all State and Federal regulations, the facility	10/22/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/23/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689 Continued From page 1

ambient air. Patient was immediately intubated in the ED (Emergency Department) by the ED MD (Medical Doctor) and Peanut Butter in the airway was suctioned out." The hospital record also states that R2's diagnoses at the hospital were: Respiratory Failure, Aspiration Pneumonia, and Hypoxemia. "Plan" states: "Secondary to hypoxemia, respiratory failure, and the patient required intubation essentially on arrival. I used a glide scope video-assisted device with success. He did require large amount of suctioning secondary to the large amount of peanut butter in his airway."

V10 also referred to the prior choking episode approximately one year ago on 9/13/2019, when R2 was hospitalized from 9/13/2019 to 9/16/2019, for Aspiration Pneumonia.

2. R2's Care Plan, dated 9/29/2019, states that R2 has a swallowing problem related to Dysphagia and needs extensive assistance when eating;

3. R2's Nutritional Risk Review, dated 2/27/2020, states that R2 is on Aspiration Precaution, and "needs extensive assistance in eating to ensure adequate PO (oral) intake";

4. R2's Incident Report, dated 9/12/20, that was sent to the State Agency on 9/13/20 and the investigation by the facility;

5. R2's progress notes which showed R2 was sent to the hospital for Aspiration Pneumonia about a year ago, specifically on 9/13/2019, and now, had this choking incident, for which R2 was intubated.

F 689

has taken the actions set forth in the following plan of correction.

The following Plan of Correction shall also serve as the Facility s written credible allegation of compliance that will be achieved by the stated date of completion.

F 689 Free of Accident Hazards/ Supervision/ Devices

The facility must ensure that resident environment remains as free of accident hazards as is possible and each resident receives adequate and assistance devices to prevent accidents.

I. Corrective action for residents identified in the alleged deficiency.

* R2 s diet was reviewed and currently receiving the diet as prescribed by physician. R2 s diet reflects the meal ticket on his tray. R2 is being supervised with meals and hs snacks. Care plan was reviewed to reflect prescribed diet and supervision with meals and snacks.

II. Identifying other residents with potential for being affected Residents in the facility on mechanically altered diets have the potential to be affected by this alleged deficient practice. Facility audit has been completed by the Director of nursing to ensure residents on mechanically altered diets are receiving the diets as prescribed by physician and supervise per plan of care.

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F 689

Continued From page 2

On 10/13/20 at 1:40 PM, V2 (Director of Nursing) stated R2 was in the hospital for over two weeks and is back at the facility.

On 10/13/20 at 1:45 PM, V2 stated that R2 had a behavior of grabbing food from another resident and might have grabbed another sandwich, however, no such behavior was documented on R2's care plan either before or after the choking incident.

On 10/14/20 at 3:43 PM, V11 (Licensed Practical nurse, LPN) was interviewed regarding R2's choking incident of 9/12/20. V11 stated that during his rounds, he saw R2 holding his neck and coming towards him. He realized that R2 was choking and he did the Heimlich maneuver, and there was no pulse, and 911 was called. V11 stated that V12 (CNA, Certified Nurse Assistant) had given R2 the evening snack which was a sandwich.

Facility's policy on "Aspiration Precautions", dated 1/1/2020, states in #3:
Residents that have been assessed to be a risk for aspiration will be monitored on a regular basis. Any further identified aspiration will be relayed to the MD for additional and treatment.

F 689

III. Systemic changes to reasonably assure alleged deficiency do not recur.

* Director of Nursing or designee re in-service nursing staff on the following policy and procedure

a. Aspiration Precautions which includes but notlimited to:

¿ * Signs of aspiration
¿ * Physician notification
¿ * Completion of plan of care

b. Assistance with Feeding which included but not limited to:

¿ * Appropriate positioning
¿ * Following of any feeding strategies
¿ * Reporting to nurse for eating difficulties or lack of appetite
¿ * Physician notification

c. Diet Orders and Changes which includes but not limited to:

¿ * charge nurse to verify diet orders upon admission/ readmission with the attending physician.
¿ * Charge nurse will send diet order slip reflecting residents diet to the dietary department.
¿ * Administrator or designee to ensure diet order slip matches the meal tray ticket and dietary department serves the correct diet as prescribed by physician

d. Diet Standardization
¿ Examples of standard diet orders

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F 689	Continued From page 3	F 689	* DON or designee will audit new/readmission charts within 24 hours to ensure prescribed diet is communicated to the kitchen department and appropriate assistance is provided to the resident. IV. How corrective actions will be monitored * QA tool was created for DON or designee to audit residents on mechanically altered diet to ensure compliance with POC. Audit will be done daily for 1 month then 3 times/ week x 2 months. * The results of these audits will be reviewed monthly by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and improvement. Completion Date: October 22, 2020	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by:	F 808		10/22/20

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F 808	Continued From page 4 Based on observation, interview, and record review, the facility failed to update the therapeutic diet order prescribed by the physician for a resident at risk for aspiration. This affects one resident, R2, of three residents, reviewed for diet orders. Findings include: On 10/13/20 at 11:40 AM, during lunch observation on the third floor of the facility with V3 (Social Services Director), R2 was observed being assisted with feeding by V5 (CNA, Certified Nurse Assistant). R2's meal tray ticket showed R2 was on mechanical soft diet with thin liquids. On 10/13/20 at 12:30 PM, V2 (Director of Nursing) presented R2's printed Physician Order Sheet (POS) that also states that R2 was on Mechanical Soft Thin Liquids diet. However, when V2 presented the list of residents on Mechanical Soft diet versus those on puree diet, R2's name was listed under puree diet. This was pointed out to V2, and V2 stated R2 was actually on puree diet, and V2 later presented another POS that was handwritten that shows that R2 was on puree diet. These discrepancies were pointed out to V2, who explained when R2 was sent back to the facility after the hospitalization from the choking incident, the mechanical soft thin liquids diet was changed to puree honey thick liquids diet. R2's progress notes showed that R2 was sent to the hospital for Aspiration Pneumonia about a year ago, specifically on 9/13/2019, and again, had this choking incident on 9/12/20, for which R2 was intubated in the hospital. On 10/13/20 at 1:10 PM, V8 (Cook) was interviewed about why R2's meal tray ticket showed that R2 was on the same mechanical soft	F 808	Winston Manor Convalescent and Nursing 2155 West Pierce Chicago Illinois, 60622 Plan of Correction October 15, 2020 The statements made on the plan of correction are not an admission to, and does not Constitute an agreement with the alleged deficiency herein. To remain in compliance with all State and Federal regulations, the facility has taken the actions set forth in the following plan of correction. The following Plan of Correction shall also serve as the Facility s written credible allegation of compliance that will be achieved by the stated date of completion. F 808 Therapeutic Diet Prescribed by Physician The facility must ensure that residents receive the therapeutic diets as prescribed by physician or registered / or licensed dietitian. I. Corrective action for residents identified in the alleged deficiency. * R2 s meal ticket was immediately updated to reflect his therapeutic diet as prescribed by his physician.	

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F 808	Continued From page 5 diet that was supposed to have been discontinued. V8 stated, "I can't change the ticket; the Dietician will fill out the form and send it to the company that prints the tickets so they would know that the diet has been changed. It could take up to two weeks after that before we get the meal ticket with the new diet. But we know that his diet has been changed to puree and we serve him puree." V8 was asked what if she was not on duty and a different staff who did not memorize the diet change was on duty for that day, how will R2 not get the wrong food order? V8 did not give a response to this question. On 10/14/20 at 2:47 PM, V9 (Dietician) was interviewed regarding the meal tray tickets. V9 stated, "The meal ticket should have the current diet that the resident is on. The kitchen staff serving the tray follows what is written on the meal ticket." On 10/14/20 at 4:50 PM, V13 (R2's Physician) was interviewed regarding how soon a resident's physician order sheet and meal tray ticket should be updated to reflect the current diet order. V13 stated, "When a diet order is changed, the current order should be reflected by the next meal or the next day. Usually, the nurse will call me or the Speech therapist will talk to me about the resident and the need for diet change." On 10/15 20 at 9:45 AM, V2 presented the facility's policy on physician orders, dated 12/2013, which states: 1. All medications and treatments administered to the resident must be ordered in writing by the resident's attending physician or Nurse Practitioner. 2. The Physician Order Sheet (POS) is to be	F 808	II. Identifying other residents with potential for being affected Residents in the facility on therapeutic diet have the potential to be affected by this alleged deficient practice. Facility audit has been conducted by the Director of nursing to ensure residents on mechanically altered diets are receiving the diets as prescribed by physician and reflected on their meal tickets. III. Systemic changes to reasonably assure alleged deficiency do not recur. * Director of Nursing or designee re in-service nursing staff on the following policy and procedure: a. Diet Orders and Changes which includes but not limited to: ¿ * charge nurse to verify diet orders upon admission/ readmission with the attending physician. ¿ * Charge nurse will send diet order slip reflecting residents diet to the dietary department. ¿ * Administrator or designee to ensure diet order slip matches the meal tray ticket and dietary department serves the correct diet as prescribed by physician. b.Physician Orders ¿ Verifying and transcribing diet orders * Administrator or designee re in service dietary department on Diet Orders and Changes.	

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F 808	Continued From page 6 faxed to the pharmacy upon receipt of new medication, and treatment orders. 5. The nursing staff member who took the order, or the one assigned to the resident is responsible to transcribe the order. 6. Transcribing the order includes: writing new orders on the Medication Administration Record (MAR), or Treatment Administration Record (TAR), or completing laboratory test requests, dietary notification form, or ancillary notification to inform others of the change in order as necessary. Another policy on Diet Orders and Changes, dated 12/2013, states in #1: Nursing services shall notify the dietary department of any changes in the resident's diet or meal service.	F 808	* DON or designee will audit new/readmission charts within 24 hours to ensure prescribed diet is communicated to the kitchen department and appropriate assistance is provided to the resident. IV. How corrective actions will be monitored * QA tool was created for DON or designee to audit residents on mechanically altered diet to ensure compliance with POC. Audit will be done daily for 1 month then 3 times/ week x 2 months. * The results of these audits will be reviewed monthly by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends, and continued recommendations for process monitoring and improvement. Completion Date: October 22, 2020	