STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G045	A. BUILDING _____ B. WING _____	C 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLYDE L. CHOATE MH & DEV CTR	1000 NORTH MAIN STREET ANNA, IL 62906

(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
W 000	INITIAL COMMENTS Incident Investigation Incident of 12/23/15/IL82868-W154	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to thoroughly investigate an incident of choking for 1 of 1 (R1) individual in the sample. Findings Include: Review of the facility unit roster dated 01/14/16 documents R1 is a 52 year old female who functions at a Moderate Level of Intellectual Disability. Review of the facility significant event report dated 12/23/15 documents, "R1 was eating lunch in Cedar Upper dining room. She was eating pureed diet, 1:2 supervised pacing, small maroon spoon. R1 got up from table and appeared to be choking at 11:25 AM. E3 began abd (abdominal) thrusts with no success. R1 began to loose (sic) conciousness and stop breathing. E3 lowered her to the ground and began CPR (cardiopulmonary resuscitation). 911 was called by E4 at 11:25 AM. Abd thrusts began at 11:25 AM. CPR began at 11:28 AM. O2 at 2 L (liters) per ambu bag was applied at 11:29 AM. At 11:29 the food was expelled and CPR continued until R1 began (sic) responsive and talking at 11:32. (name of physician) arrived at 11:34 AM ambulance arrived	W 154		2/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/05/2016

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W 154	Continued From page 1 at 11:43 AM and left (facility) at 11:53 AM." Review of the History and Physical from local hospital dated 12/23/15 documents "The patient (R1) is a 52 year old female with a history of long-term tendency for aspiration, who was at lunch table today, started to have a blank stare. The staff figured out that she was choking, did the Heimlich maneuver, followed CPR which dislodged a piece of food after which she resumed spontaneous breathing and activity... The patient has little if any recall of this episode and denies any complaints currently. She is awake and alert. No respiratory labor. It was felt safest to observe her overnight in the hospital for late complications." Review of R1's Individual Support Plan dated 8/14/15 documents under Nutritional, "Diet is puree, no concentrated sweets, no seconds, 1:2 supervised pacing program, large maroon spoon, plate guard, clothing protector, 10 cc dysphagia cup." Review of the facility Internal Investigation Report documents; "Incident: On December 23, 2015 at approximately 11:25 am, a medical emergency was called for Individual served (R1), who was taken to (local hospital) for evaluation and treatment following an episode of choking. Synopsis: R1 is a 52 year old white female diagnosed with moderate mental retardation, schizophrenia, and other health conditions, including epilepsy. She has a chronic history of aspiration. She resides on Cedar Upper Unit....According to statements, R1 was in the dining room having her lunch of pureed food. She	W 154		

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W 154	Continued From page 2 is 1:2 during meals for pacing reasons and her staff was beside her. Upon taking her first bite, which was described as, "small", she blankly looked at her staff and rose from her seat, pulling off her clothing protector. Her staff followed, when she turned to look at him, in distress. Her staff recognized she was choking, calling out, "She's choking!" to other staff. Her staff and another staff took turns performing abdominal thrusts until R1 went limp and appeared to have stopped breathing. Her staff lowered her to the floor and called a medical emergency at 11:25 AM. One staff was calling 9-1-1 (11:26 AM). Nursing staff arrived at 11:27 AM and took over CPR. At 11:29 AM, 2 L (liters) oxygen was administered via ambu bag, but no AED was necessary since a thread pulse was located. At 11:32 AM, R1 coughed up a "half dollar sized" amount of pureed food. She immediately began crying and talking. The doctor arrived at 11:34 AM and the ambulance arrived on the unit at 11:41 AM. R1 was placed on the stretcher and the ambulance left for (name of local hospital) at approximately 11:53 AM. Vital signs were taken throughout the incident... Conclusion: Upon compilation and review of all relevant information obtained through documents and statements from staff and the individual, it is determined that there is no evidence of any abuse or neglect in the incident surrounding R1's unscheduled hospital visit. The nurses responded immediately and appropriately once R1 began choking. The medical emergency was carried out as expected, however the doctor took nine minutes to arrive on the unit. Following the episode, R1 was sent to the hospital for further evaluation, observation, and treatment....R1's meal during the incident consisted of applesauce, puree pizza burger, puree Italian blend, mashed	W 154		

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W 154	Continued From page 3	W 154		

potatoes, beverage, milk, and water which was according to her individual service plan. In addition requires training on pacing herself during mealtime and uses's a 10 cc dysphagia cup, clothing protector, plate guard, and large maroon spoon. This plan was being followed at the time of the incident except R1 uses a small maroon spoon. It is recommended that the ISP be changed on the following pages to reflect the use of a small spoon..."

Review of the ambulance service report dated 12/23/15 documents, Dispatched for a 911 scene at 11:24 AM. To (name of facility) for a female resident choking and not breathing. On arrival patient was conscious per normal. Report from staff that she was eating her normal meal when she became choked. She was unable to breathe. They attempted the Heimlich maneuver several times without return of spontaneous respirations. They then performed CPR for 2 to 2 1/2 minutes. Following CPR the patient started breathing on her own. She was sitting on the floor when we arrived. Patient was talking and did not appear in any distress. Patient placed on the cot and secured. Pulse ox showed 99% and her lung fields were clear. Evidence of emesis on her clothing..."

During interview on 1/21/16 at 2:15 PM E2 (Registered Nurse) stated when asked what R1 expelled, "looked like thick white oatmeal. It was not in a clump, thicker consistency was slowly trickling out of her mouth."

During interview on 1/21/16 at 11:58 AM E4 (Qualified Intellectual Disability Professional) stated, "No," when asked if she had seen what R1 was eating and if she saw what R1 had

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W 154	Continued From page 4 expelled. During interview on 1/21/16 at 11:50 AM E3 (Mental Health Technician) stated, R1 had been served a pureed diet of mashed potatoes, a vegetable, and meat. When asked what the staff do if the puree diet comes to the dining room and is not pureed correctly, E3 stated, "We send it back and ask them to replace it." During interview on 1/28/16 at 9:15 AM when asked what R1 expelled, E5 (Licensed Practical Nurse) stated, "it was mushy and creamy in color." During interview on 1/28/16 at 8:30 AM Z1 stated when asked if he saw what R1 expelled, "It was chunks of food. I thought of bacon and eggs. I can't say for sure what it was." During interview on 1/28/16 at 9:45 AM Z2 stated the food R1 expelled was, "a yellow substance, not pureed, it had particulate matter." During interview on 1/27/16 at 4:09 PM E6 (Internal Investigator) stated, "No," when asked if she had seen or taken a picture of what R1 expelled. When asked if the facility had a copy of the emergency transport report from the local ambulance service, E6 stated, "I don't believe we get those." The facility failed to thoroughly investigate an incident of R1 choking, becoming unconscious and having CPR and the Heimlich maneuver performed when they failed to, verify the food R1 expelled was of puree consistency and when they failed to follow up with the emergency medical transport team from the local ambulance service.	W 154		

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