STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G286	A. BUILDING _____ B. WING _____	C 06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROUP HOME #4	**314 BACHMAN LANE GODFREY, IL 62035**

(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 04/24/11 / IL53336	W 000		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to report to Illinois Department of Public Health (IDPH) the results of their investigations for 1 of 2 individuals (R1) in the sample who had choking incidents. Findings Include: Group Home #4 Client Information (no date) identifies R1 as a 56 year old individual who functions at the severe range of Mental Retardation. Facility's notification to Illinois Department of Public Health (dated 4/25/11) states, " (R1) .....was transported to (local hospital) emergency room via ambulance on 4/24/11 for evaluation following choking on a piece of ham during lunch. The group home staff simultaneously called 911 and began the Heimlich maneuver until nursing staff arrived on the scene and took over care. Nursing staff continued care until EMT (Emergency Medical Technician) arrived. (R1) was transported her to the emergency room.	W 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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W 156	Continued From page 1 (R1) was admitted and remains there at this time." (typed as written) Facility fax to IDPH (dated 4/30/11) states, "(R1) expired at 17:36 on 4-29 (typed as written) at (local community hospital) ICU (Intensive Care Unit)." In an interview with E1/ Administrator on 6/15/11 at 11:44 AM, E1 confirmed that the facility did not send a five day final report of their investigation related to the incident of of R1 choking on 4/24/11 or of the faciliy's review of R1's death on 4/29/11.	W 156		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to implement supervision/ monitoring throughout the meal time for 1 of 2 individuals (R2) in the sample who had a choking incident. Findings Include: Group Home #4 Client Information (no date) identifies R2 as 68 year old individual who functions at the profound range of Mental	W 249		

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W 249	Continued From page 2 Retardation. R2's Transfer Sheet (no date) states, "Prompt to slow down, stuffs mouth then chokes." Individual Habilitation Plan (dated 3/9/11) states, "(R2) continues to require monitoring throughout his meals and will need the reminders to slow down which is addressed concurrently." Internal Review (dated 5/20/11) states, "This is a review of an incident that occured on 5/15/11 around lunch time (R2) choked while eating lunch." The Internal Review identifies that E1/ Administrator interviewed E5/ Direct Support Professional on 5/16/11, who stated that R2 tries to stuff food into his mouth and that he had difficulties with his bread during lunch on 5/15/11. E5 stated that she was in the medication room when R2 began choking and that she did not let other staff know that she was leaving R2. E1 also interviewed E4/ Direct Support Professional on 5/16/11, E4 stated she heard R2 coughing and when she looked in on him she saw him sitting alone with liquid coming out of his nose and mouth and that he continued coughing. E4 further stated she gave 4 back blows then stood R2 up from his chair and began the Heimlich maneuver on him. In an interview with E1/ Administrator on 6/15/11 at 11:44 AM, when asked by surveyor if staff had monitored/ supervised R2 throughout his lunch on 5/15/11, E1 stated, "It was the last bite, she (E5) was in the med (medication) room, which is right accross the hall." E1 could not provide evidence that staff had monitored/ supervised R2 throughout his lunch on 5/15/11 as identified in	W 249		

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W 249	Continued From page 3 his Individual Habilitation Plan.	W 249		
W 342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on record review and interview facility's direct support staff did not recognize the need for evaluation by the licensed nurse for 1 of 1 individual (R2) who demonstrated choking at the completion of a meal. Findings Include: Group Home #4 Client Information (no date) identifies R2 as 68 year old individual who functions at the profound range of Mental Retardation. R2's Transfer Sheet (no date) states, "Prompt to slow down, stuffs mouth then chokes." Individual Habilitation Plan (dated 3/9/11) states, "(R2) continues to require monitoring throughout his meals and will need the reminders to slow down which is addressed concurrently." Internal Review (dated 5/20/11) states, "This is a review of an incident that occured on 5/15/11 around lunch time (R2) choked while eating	W 342		

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W 342	Continued From page 4 lunch." The Internal Review identifies that E1/ Administrator interviewed E5/ Direct Support Professional on 5/16/11, who stated that R2 tries to stuff food into his mouth and that he had difficulties with his bread during lunch on 5/15/11. E5 stated that she was in the medication room when R2 began choking and that she did not let other staff know that she was leaving R2. E1 also interviewed E4/ Direct Support Professional on 5/16/11, E4 stated she heard R2 coughing and when she looked in on him she saw him sitting alone with liquid coming out of his nose and mouth and that he continued coughing. E4 further stated she gave 4 back blows then stood R2 up from his chair and began the Heimlich maneuver on him. E4 stated that she did not call the nurse to report the incident. E4 stated that E5 said, "You don't have to call if you have it cleared up." In an interview with E1/ Administrator on 6/15/11 at 11:44 AM, when asked by surveyor if staff had notified a licensed nurse to evaluate R2 immediately after the choking incident of 5/15/11 in which staff did back blows and the Heimlich maneuver, stated, "No."	W 342		