STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145874	A. BUILDING _____ B. WING _____	C 10/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - NAPERVILLE	720 RAYMOND DRIVE NAPERVILLE, IL 60563

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F 000	INITIAL COMMENTS Complaint Investigation: 1373991/IL65655 no deficiencies Incident Investigation: IRI of 09/21/13/IL65739- F309	F 000		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide physical assistance and or supervision during meal-time as care planned for a resident with a known feeding deficit. As a result the resident (R1) choked on a 3-4 inch piece of hot dog while feeding himself and had to be sent to an area hospital where he was diagnosed with extensive anoxic brain injury related to cardiac and respiratory arrest. Immediate Jeopardy was identified on 10/8/13 at 1:00 PM. The facility's Administrator (E1) and the Director of Nursing (E2) were informed on 10/8/13 at 2:16 PM. The Immediate Jeopardy began on 9/21/13 when R1 was given his meal tray in his room and allowed to feed himself despite his care plan intervention for extensive physical assist with meals. This applies to one (R1) of three residents	F 309		10/19/13

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

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reviewed for Activities of daily living (ADLs) help, in a sample of three.
The findings include:
R1 is a 45 year old resident originally admitted to the facility on 2/28/10. At the time of his admission R1 was alert and oriented. Admitting diagnoses include, advanced Multiple Sclerosis, depression, neurogenic bladder, anxiety, insomnia, psychosis, hyperlipidemia, and chronic encephalopathy.
According to a facility self-reporting incident sent to the state survey agency on 9/25/13, R1, while feeding himself in his room choked on a three inch piece of hot dog. At the time of the incident there was a Certified Nurse's Assistant/CNA (E8) in the room feeding R1's roommate. The facility report stated when the CNA heard R1 choking he ran to get a nurse. A code blue was subsequently called and CPR initiated. When the hot dog was removed from R1's airway he was found to be unresponsive. After being revived by paramedics R1 was taken by ambulance to an local hospital where he was admitted.
According to emergency department records (9/21/13) obtained from the treating hospital, R1 was diagnosed with cardiac arrest, acute respiratory failure, anoxic encephalopathy, aspiration pneumonia and severe metabolic acidosis. R1 has since been admitted to an unknown facility and placed on hospice care.
Review of multiple documents found in R1's medical record, including ADL functional assessment (9/9/13), Minimum Data Set (9/9/13), Dietary care plan (9/13), self-care deficit for eating care plan (9/9/13), Nursing admission/re-admission assessment (8/10/13) and Restorative nursing assessment (9/9/13) all indicated R1 required extensive physical assistance during meals.

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F 309	Continued From page 2 On 10/1/13 at between 3:15 PM and 4:05 PM the nurse (E4) assigned to provide care for R1 stated during interview, "I have never known this resident to be fed by staff." E4 also stated he wasn't aware of R1's care plan that required R1 to received one person extensive physical assistance with meals. On 10/2/13 at 2:58 PM, the CNA (E8) who heard R1 choking stated during interview, when he heard R1 choking he was feeding R1's roommate behind a pulled privacy curtain. He stated he was never directed or assigned to feed or supervise R1 on 9/21/13. He stated R1 usually ate in his room alone and unsupervised. On 10/1/13 at 4:13 PM, on interview the facility's Director of Nursing (E2) stated, "I just started in this facility. I' am not aware of his (R1) assistance with feeding." E2 stated, "For a resident who requires assistance with feeding her understanding is to have someone provide a hand over hand assistance from start to finish." E2 stated there was no formal list of residents requiring assistance with feeding who eat in their rooms. She also stated the facility had no policy or procedure for feeding residents in their room. During her investigation E2 stated she only spoke to the nurse (E4) assigned to R1 on the evening of 9/21/13 and read a written statement by the CNA (E8) present in the room feeding R1's roommate. There were no other interviews conducted although there were ten other nursing staff members working on the unit that evening. Following this incident, the facility did not implement any new policies or interventions to prevent future occurrences of residents choking while eating in their rooms. There are 11 other residents currently residing in the facility who require physical assistance with meals and eat in their rooms.	F 309		

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On 10/3/13 at 12:50 PM, R1's physician, stated during interview that he hadn't been informed by the facility that R1 required extensive assistance during meals. He volunteered additional information, stating he also was not informed by the facility, until recently R1 had a habit of "force feeding" himself large amounts of food at one time. He stated, " I saw the picture of the hot dog taken from his mouth. It was about 4 inches. " " It was obscene. " He went on to say if the hot dog would have been cut into a smaller piece R1 probably wouldn't have choked. The physician stated swallowing difficulty (dysphasia) can be a complication of advanced MS, the resident's primary diagnosis.

On 10/3/13 at 1:10 PM, the facility's in-house speech pathologist (E11) stated he had performed a dysphasia evaluation on R1 in January of 2012. He stated the results of the evaluation were R1 was capable of eating all food consistencies with thin liquids using a straw and following safe swallow strategies and aspiration precautions (90 degree position during meals and for 30 minutes after, chin tuck, double swallow and sips of thin liquids). E11 stated some time later he found out from CNAs and nurses R1 was not following aspiration precautions during meals. He stated he also heard the resident was putting large bites of food into his mouth, eating at a rapid rate and refusing to maintain appropriate positioning during meals. E11 stated, " Based on R1's non- compliance following safe swallowing strategies to avoid risk of aspiration; supervision during meals/assistance would be helpful to avoid aspiration risk.

On 10/2/13 at 12:45 PM, R1's Social Services Designee (E3) stated although she was assigned to R1 for the past three years and attended his care plan meetings, she was not involved in any

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formal or informal discussions regarding the safety of R1 eating in his room.
On 10/8/13 at approximately 3:45 PM, E1 presented the facility's abatement plan. According to the abatement plan the facility will take the following steps to abate the Immediate Jeopardy:
1. A policy and procedure related to resident eating in their rooms has been implemented. This was initially done on 10/7/13 by the Director of Nursing. On 10/8/13, the policy and procedure was revised and staff will be inserviced on the new Policy and procedure beginning 10/8/13 and will be completed on 10/9/13.
2. Staff education was completed as follows:
- 10/4/13 - Providing assistance and supervision during mealtimes
- 10/4/13 - Room tray monitoring and physical assistance during meals.
- 10/7/13 - Room tray policy and procedure; Quality assurance for room trays and residents who need assistance during meals
3. Review listing of all residents to determine which residents eat in their rooms either at all times or occasionally.
4. Develop from the review of #3 above, a listing of those residents who eat in their rooms. The listing will include the resident's name, room number, diet, assistance required, and any other pertinent information related to meal service. This listing will be maintained on each nursing unit.
5. Restorative department reviewed and updated the special needs care sheets for all residents who eat in their rooms to ensure that ADL eating status and assistance required are reflected for staff reference.
6. A resident room tray quality assurance tool was developed and implemented on October 7, 2013. CNAs/Nurses have been assigned to monitor residents who eat in their rooms and require

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more than set-up help and to complete this tool to verify that all required areas are being addressed regarding resident's meal service safety. This tracking tool will be returned to the nursing supervisor who will submit to the Administrator or Director of Nursing.
7. The facility has begun re-screening those residents who eat in their rooms. These screenings will continue to be conducted by the facility's Speech Therapist. Re-screening of these individuals began on 10/4/13 and will be completed 10/9/13.
8. Additionally, the facility is implementing a quality assurance (QA) tool to verify that all aspects of resident eating are consistent. This will include a review of the physician order sheet, dietary notes, speech evaluation, care plans, Minimum Data Set, and resident individual diet slips. This tool will be completed by the Administrative staff to ensure that all documentation for these individuals is consistent
9. If an individual with difficulty in swallowing or with diagnosis of dysphasia request to eat in his/her room, but has been deemed unsafe to do so by the Speech Pathologist and other facility assessment tools, the facility will proceed as follows:
- Provide education to the resident as to the risk involved if resident would continue to eat in his/her room;
- Solicit assistance from family members to encourage the resident to eat in the dinning room to ensure safety;
- The Interdisciplinary team will meet with the resident and/or family member to reinforce the safety issues involved with resident eating in his or her room;
- Contact the physician to discuss the risk of eating in the room with the resident and/or family

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F 309	Continued From page 6 members. 10. Interdisciplinary team members will receive additional instruction in accurate coding and assessment of residents. This will be completed by 10/10/13 and quarterly or as needed thereafter. The facility's abatement plan was accepted on 10/8/13 at 8:30 PM. All elements of the abatement plan were initiated prior to its acceptance and completion has been verified.	F 309		