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	14G026	A. BUILDING _____ B. WING _____	R 08/09/2016

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MEADOWS	**3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008**

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{W 000}	INITIAL COMMENTS FOLLOW UP TO ANNUAL CERTIFICATION SURVEY OF 3/16/16	{W 000}		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: REPEAT Based on interview and record review, the facility failed to implement their policy and procedures to prevent neglect of 1 of 1 client in the sample (R1) who sustained head injuries requiring emergency medical intervention in 3 of 8 falls, while not wearing his helmet. Findings include: The facility's Policy and Procedure (undated) titled "Resident Abuse/Neglect Policy/Procedure was reviewed. This policy includes the following: "Policy Statement: Resident abuse or punishment (physical, verbal, sexual, or psychological) and/or neglect by facility staff, another resident, family, or a visitor will not be tolerated at (facility). Prevention will be the focus in an effort to avoid any such incident. Definition of Abuse/Neglect: ... Neglect - failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a Resident's physical or mental condition. Neglect means the failure to provide adequate medical or personal	{W 149}		

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 149}	Continued From page 1	{W 149}		

care or maintenance, which failure results in physical injury to a Resident or in the deterioration of a Resident's physical or mental condition. This shall include any allegations where:
- The alleged failure causing injury or deterioration is ongoing or repetitious or
- A Resident required medical treatment as a result of the alleged failure or
- The failure is alleged to have caused a noticeable negative impact on a Resident's health, behavior or activities for 24 hours. ..."

The facility's Incident Reports for R1, dated 3/19/16 thru 7/8/16, were reviewed and noted the following falls:

1. 3/19/16 at 1715 - Nurse heard a sound, turned around and saw (R1) on the floor. R1 was laying on his back and his helmet was next to him. R1 had refused to wear his helmet and he was holding it.
E1 (RSD - Resident Services Director) documented that after viewing the facility video camera footage - R1 was witnessed walking in hallway A towards his bedroom. He turned to walk into his bedroom stumbled forward and then stiffened causing him to fall backwards into hallway A. R1 was carrying his helmet when the fall occurred. E11 (nurse) assessed R1 for injuries and none were noted. E11 noted that R1 did hit the back of his head when he had the seizure causing him to fall.

2. 4/1/16 8:35pm - R1 was walking down hallway A toward the dining room. He had his helmet in his hand. Staff asked R1 to return to his bedroom to get his shoes. R1 sat down in the middle of the hallway and would not move. Staff then noticed dried blood in R1's hair. E12 (DON -

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{W 149}	Continued From page 2	{W 149}		

Director of Nursing) noted an old laceration to the back right side of R1's head. 911 was called and R1 was transported to the Emergency Room where he received 2 staples to close the laceration.
E1 concluded in the facility's investigation that R1 had a fall and / or seizure in his bedroom. R1 fell backwards hitting is head on the dresser drawer that was opened.

3. 5/3/16 1615 - E1 documented, in the facility's investigation, that at approximately 4:15pm staff entered R1's bedroom to get him for dinner. Staff entered R1's bedroom and found R1 laying on the floor on his right side besides his bed. Staff notified nursing and R1 was assessed. A laceration to R1's chin was observed. R1 appeared lethargic and was non-verbal. 911 was called and R1 was transferred to the hospital. R1 received 3 sutures to his chin. E1 documented that R1 was not wearing his helmet when he was found on the floor. E1 concluded that R1 hit his chin on his roommates bed.
E1 documented that R1's bedroom floor is cushioned and his bed and dresser and covered with cushions to reduce the risk of injury to R1.

4. 5/19/16 0900 - R1 was walking from the living room to the dining room when he took 2 unsteady steps and started to fall backwards. E3 (QIDP - Qualified Intellectual Disability Professional) was with R1 and lowered him to the floor. R1 did not sustain any injuries.

5. 6/1/16 1155 - R1 was eating lunch and he got up from the chair and fell. E1 documented that R1 was eating lunch when he stood up from the table. R1 was adjusting his pants, he pulled them lightly down and then back up. R1 stumbled

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{W 149}	Continued From page 3	{W 149}		

backwards and fell backward. R1 did not his his head. R1 was assessed by nursing and no injuries were noted.

6. 6/1/16 1335 - R1 fell backwards to the wall and slid to the floor on his right side. R1 was not wearing his helmet. E1 documented that E13 (nurse) was at the nursing station when he observed R1 stand up from his bed. R1 stumbled backwards towards the wall and slid to the floor on his right side. E13 assessed R1 and noted redness on R1's right side of his back.

7. 6/24/16 0600 - E1 documented that E11 (nurse) was passing medication outside of the nursing station directly across from R1's bedroom. R1 started to scream loudly and ran out of his room. R1 was not wearing his helmet. R1 was ambulating with E11 back to his bedroom when R1 tensed up having a seizure and fell forward. E11 attempted to grab R1 before he fell, but was unable to. R1 fell forward hitting his chin on the garbage can in his bedroom. R1 sustained a 2cm laceration to his chin. 911 was called and R1 was transported to the hospital. R1 received 6 sutures to his chin at the hospital.

8. 7/8/16 7:10pm - R1 was found seated on the floor against the wall in his bedroom. E1 documented that nursing staff looked up from the nursing station and noted R1 to be sitting on the floor against the wall. Nursing staff assessed R1 and no injuries were noted. Nursing staff informed E1 that a piece of the cushioned mat flooring was raised and she thought R1 tripped over the raised flooring.

R1's 4/12/16 IPP (Individual Program Plan) was reviewed. R1's IPP identifies that R1 wears a

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{W 149}	Continued From page 4 helmet as a safety device. R1's IPP does not specify when R1 is wear his helmet. No schedule of use is identified in R1's IPP. E3 (QIDP) was interviewed on 7/29/16 at 1:15pm. E3 was asked if R1's IPP identifies a schedule as to when R1 is to be wearing his helmet. E3 reviewed R1's IPP and stated R1's IPP does not identify when R1 is to wear his helmet. E3 stated that R1 should wear his helmet when he is standing or walking. E3 stated that R1 does not have to wear his helmet in his bedroom. R1's clinical record was reviewed. R1 has a program titled, "Refusal to Wear a Safety Device (Helmet)" that was implemented on 10/20/15. This program notes that R1 is designed to help reduce R1's refusal of wearing his helmet. If staff observed R1 not wearing his helmet they are to verbally remind him that he needs to wear his helmet. Staff are to walk with R1 back to his room to get his helmet. E1 was interviewed on 8/2/16 at 10:27am. E1 was asked what changes have been implemented since March 2016 to ensure R1's safety due to falls. E1 stated that 2 In-Services were done with all staff. The first In-Service was to review R1's behavior program of 10/20/15. The second In-Service was ensure staff were documenting the amount of time spent with R1 until he wears his helmet and or sits down. E1 stated that R1's bedroom was padded on 5/10/16. E1 stated that sports cards and music cards are given to R1 as an incentive to wear his helmet. Review of both In-Services notes these were completed late March 2016 thru 4/15/16.	{W 149}		

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{W 149}	Continued From page 5 The facility's In-Services regarding R1 were completed 4/15/16. R1's bedroom was padded on 5/10/16. The facility has documented that R1 fell 6 times. On 5/3/16 R1 received 3 sutures, on 6/1/16 redness was observed and on 6/24/16 R1 received 6 sutures. The facility failed to implement their policy to prevent neglect of R1 and to ensure his safety when they failed to provide adequate care to prevent falls and injuries.	{W 149}		
{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: REPEAT Based on record review, observation, and interview, the facility failed to thoroughly investigate an incident of resident choking(7/13/16), involving 1 of 1 client in the sample(R10) who is on a mechanically altered diet with recommendations to alternate between solids and liquids, with staff assistance as needed. R10 choked on a burrito which was served whole, requiring emergency resuscitation services. R10 expired the following day in the hospital. Findings include: The Accident\Incident Report for R10 dated and timed 7/13/16 at 1625(4:25pm) was reviewed. It states that R10 was choking, so the nurse(E11) was called to R10's table to help. First aid was	{W 154}		

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started right away, then CPR(Cardiopulmonary Resuscitation). The report reads that R10 was on a diabetic mechanical soft diet with thin liquids. The investigation was performed by both E1(Administrator) and E2(Residential Services Director), but authored by E2. During the facility's investigation, E2's report indicates that R10 was served a soft taco that was a flour tortilla with ground meat inside. Because the taco was very soft, it did not need to be cut up for any individual who was on a mechanical soft diet. The meal also consisted of a serving of rice, and a serving of diced/cut up mangos. The rice did not need to be mechanically altered, and the mango pieces did not need to be altered other than being diced/cut up as they were already served. The facility investigation stated that each item was very soft in texture, and easily would slice when a finger was pressed into the food. The investigation notes that R10's most recent dysphasia evaluation from 2/20/16 recommends to continue R10's current diet(diabetic mechanical soft), alternate liquids and semi-solids, and staff to assist with meals as needed. Their conclusion notes R10 was sent to the emergency room for suspected choking on a small piece of taco. The soft taco was part of his mechanical soft diet, and was prepared properly for his diet.

The Paramedic Report from R10's choking incident on 7/13/16 was reviewed. The summary states that R10 was eating dinner when he started choking. Staff member was performing abdominal thrusts to dislodge object. Staff was not sure what R10 was eating. Paramedics noted tacos on the floor. The Emergency Department report for R10 dated 7/13/16 was reviewed. It reads that R10 was eating burritos tonight, and

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{W 154}	Continued From page 7 began choking. EMS was called, on their arrival R10 was awake, choking, they attempted Heimlich. In ambulance he coded. King LT inserted, paramedic thinks he pushed something down as it was difficult to pass, but was successful with air moving after insertion. Patient was admitted to ICU. The facility summary of hospital report, undated and un-authored was reviewed. The conclusion states that R10's brother made the decision to take R10 off his ventilator on 7/14/16, and R10 passed away at 15:14(3:14 pm), 7/14/16. R10's Dysphasia Evaluations were reviewed. R10's original evaluation from 1/25/14 notes that R10 had a choking episode while in the hospital/rehab, and his diet was changed from diabetic pureed to diabetic mechanical soft. Per review of nursing notes from the facility dated 1/26/14, the entry states that R10 had a bedside dysphasia evaluation performed on 1/25/14 due to a choking episode while at a rehab facility, with the clinical impression of mild oral dysphasia characterized by a edentulous short choppy bite pattern, and minimal residual remaining after the swallow. Recommendations are to change diet from pureed to mechanical soft, alternate liquids and semi solids,and encourage to eat slowly. A second Dysphasia Evaluation dated 7/22/15 was reviewed. It states to remain on his diabetic mechanical soft diet for his mild dysphasia characterized by decreased mastication skills secondary to edentulous and minimal residual remaining on his liquid surface after the swallow. Recommendations continue to alternate liquids and semi-solids, with staff to assist with meals as needed. The last Dysphasia Evaluation present in R10's chart is dated 2/20/16. Diet is to continue as diabetic mechanical soft, with	{W 154}		

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alternating of liquids and semi-solids, and staff to assist as needed with meals.

The video camera footage from the dining meal involving R10's choking episode(7/13/16) was observed. R10 was observed in the dining room, sitting in his wheel chair at the dining table. E8(Certified Nursing Assistant) was the staff member assigned to R10's table during this meal. R10 is observed eating his entire flour burrito without alternating a drink of liquid with his taco as recommended and ordered by his physician. After R10 had consumed his entire burrito, it is then that R10 is observed reaching for his water, and E8 assists R10 in reaching it. E8 does not offer any other assistance during the meal, until it is observed that R10 is choking, and the Heimlich maneuver and CPR are instituted.

During an interview with E8 on 7/28/16 at 2:30pm, E8 was asked if she could describe what happened on 7/13/16, when R10 choked on his soft burrito. E8 stated that she was the staff member assigned to R10's table. E8 stated that she has R10's table every day she works. E8 stated that R10 ate his entire beef burrito, and when he was finished eating it, he started to cough. E8 stated that R10 pointed to his water, and she helped him reach it. E8 stated he drank the whole cup of water, and then he stopped coughing. He had no exchange of air. E8 stated that he was not able to talk, did not verbalize any words, never gestured to his throat, only pointed to his cup of water. The supervisor, E9, came over to assist, and patted R10 on his back. R10 spit out his dentures, and continued to have no exchange of air, so E9 called the nurse, who started the Heimlich Maneuver. E8 stated nothing came out, and he was really struggling;

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R10 started to turn blue, and then very pale. E8 was asked if R10's burrito was cut up. E8 stated that none of the burritos for the clients who received a mechanical soft diet were cut up. They all came out whole. E8 was asked if she was trained on R10's diet, and what his recommendations are while eating. E8 stated that when she was trained she was told that R10 is very functional, and was an independent eater. If R10 needed a drink he could help himself. E8 stated that the only reason she assisted R10, was because he was reaching for his cup of water, and she assisted by bringing the cup within his reach. E8 was asked if she was aware that R10 should alternate between eating a bite of food, and drinking a cup of water. E8 stated that she is not aware of this recommendation, and never prompted R10 take a drink of water after eating a bite of food.

During an interview with E9(Certified Nursing Assistant) on 7/28/16 at 2:50pm, E9 was asked to give a brief interpretation of what happened during the choking incident on 7/13/16, involving R10. E9 stated that he knew R10 very well. E9 stated that he was the shift supervisor that day. When he went to R10's table, E8 stated that R10 was choking. He stated that E9 called for the nurse because he could not speak and was struggling. E9 was asked to describe his food. E9 stated that R10's plate just like all of the other mechanical soft diets, came out with a whole burrito. E9 stated that he thought that was ok; the burrito was soft.

E5(PM Cook Supervisor) was interviewed on 7/28/16 at 1:50pm. E5 was asked if he was present the day R10 choked on the beef burrito. E5 stated that he was off that day. E5 stated that

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E4(Cook) was the staff member who prepared the food that day for dinner. E5 was showed the picture of the plate of food that was recreated by E4, after E1(Administrator) requested her to make an identical plate of what was served to R10. E5 reviewed the picture of the food, and was then asked if this was the correct way to served a beef burrito, mangos and rice for someone on a mechanical soft diet. E5 stated that the rice is ok, but the mangos need to be grinded, and can't be in large chunks, and the burrito needs to be chopped/cut up into small pieces. E5 was asked if all the mechanical soft diets were served in this manner(whole beef burrito) that evening meal on 7/13/16. E5 stated that they were. E5 was asked if he was aware that R10's recommendation from his speech evaluation is to alternate solids and liquids, and that staff should assist R10 as needed. E5 stated that he was not aware of this recommendation. E5 was asked if this information is on a meal card for staff to be aware. E5 stated that they do not have that on his meal card, and his card is no longer here, because of his passing. E5 was asked to describe what alternating between solids and liquids means to him. E5 stated it means that R10 should take one bite of his food, and then take one sip of liquid, and continue to eat in this manner until he is finished. E5 clarified that they never knew about this recommendation, and therefore, never encouraged R10 to eat this way. E5 continued, stating that R10 was an independent eater; he could feed himself. E4 prepared the food the wrong way. E5 stated he received a phone call that night at home from E7(Direct Care staff supervisor) , asking if the meal was served in the appropriate manner, and he told E7 that the burrito needed to be cut up. E5 stated that he then spoke to E4 about it. E5

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stated that the burrito needs to be cut up, because it can stick to the roof of his mouth. E5 stated that he has seen R10 eat before, and he was a very fast eater, and staff should tell him to slow down. E5 stated that he showed E4 how the burrito needed to be served, and that currently he is not allowing E4 to cook. E5 stated that R10's food was not served as it should be, and this choking incident could have been prevented. E5 continued that right now E4 is only working with him, until he decides when she can be safe to cook again.

E6(Cook) was interviewed on 7/29/16 at 9:50 am. E6 stated that she is the morning cook, and works from 3 am to 11 am. E6 explained that they as cooks know what can and cannot be served by looking at the spread sheet. E6 stated that the spread sheet for that day stated that two beef tacos should be served for the general diets. E6 stated that under the box for mechanical soft, there is an X. E6 stated that the X indicates it is not ok to serve to anyone who is on a mechanical soft diet. E6 stated that when she serves a breakfast burrito, she cuts the burrito up. E6 stated that if she would ever have to work in the evening, and they were to serve beef burritos, they too would need to be cut up. E6 stated that only the general diet can have a whole burrito. E6 stated that the mangos need to be diced, and instead of the rice, they should have potatoes, mashed. For beans, they should receive carrots or green beans. E6 stated that she has always been told to follow the spread sheet. E6 then left the interview. Five minutes later, at 10:05 am, E6 came back into the room, and stated that she needed to clarify what she just had told me. E6 stated that R10 could have the beef burrito, but it still needed to be cut up. R10 could have rice

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MEADOWS	**3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008**

(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
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because it is soft, and the beans are refried, so they are more juicy, so they are ok, because they are on the burrito. E6 stated that she knows for sure the burrito needs to be cut up.

During an interview with E4 on 7/29/16 at 10:10 am, E4 verified that she was the cook who prepared the meal the evening R10 choked on his beef burrito. E4 stated that the way she prepared the beef burrito was appropriate. E4 stated that it was very soft, and she followed the menu. E4 stated that because it was soft, she thought it was ok to give it whole. E4 stated that after R10 choked on his burrito, E7 told her that if they served beef burritos again in the future, they need to be cut up. E4 was asked if she is still not cooking, and working only with E5. E4 stated that she is cooking, and that E5 never told her that she couldn't cook. E4 was asked if she realized that R10 choked on the beef burrito. E4 stated she was not sure if he choked. E4 stated she really wasn't sure what happened with R10. E4 confirmed that she cooked the weekend after R10 choked the previous Wednesday, on the 13th of July. E5 was asked to join the interview at this point, because the information that E4 was sharing was conflicting with the information that E5 had shared the previous day. E5 was asked for clarification. E5 stated that when he was interviewed the day prior, he was very nervous, and what he said was not true about the beef burrito needing to be cut up. E5 stated that it was soft, so it did not need to be cut up. His only issue was with the mangos, but when he felt them, they were ok too, because they were soft. E5 was asked why E4 was cooking, when the day prior he stated she was not allowed to cook. E5 asked E4 if she was cooking; E4 verified that she was cooking, and then E5 stated, "So I guess that

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is not true either, I didn't take her off cooking." E5 was asked if he went through any training after this incident. E5 stated that E1 and E7 asked him questions, but he did not go through any formal training, or classes, and he didn't sign anything.

During an interview with E7(Direct Care Staff Supervisor) on 7/29/16 at 9:30 am, E7 was asked if she was present the evening R10 choked on the beef burrito on 7/13/16. E7 confirmed that she was, and that initially her first concern was to make sure R10 received the care he needed. E7 stated once R10 left for the ER via ambulance, she then called E1 and E2(Residential Services Director) to let them know what happened. E7 stated E1 instructed her to have E4 make up a plate that was exactly like what was served to R10. E7 stated she asked E4 to prepare this plate of food. E7 stated that she then contacted E5, and told him to check the menu to verify if R10 received the correct food, and preparation. E7 stated that the spread sheet did not indicate that the burrito needed to be cut up, so the preparation was acceptable. E7 stated that since this has happened, she thinks that Z1(Speech Therapist) is working on all mechanical soft diet burritos needing to be cut up. E7 clarified that E5 never said the burrito was served incorrectly to her.

During an interview with Z1 on 7/28/16 at 1:50pm, Z1 confirmed that he was the speech therapist that performed R10's dysphasia evaluations. Z1 stated that R10 never had a video fluoroscopy. Z1 stated that R10's diet is a mechanical altered diet, and confirmed that he wrote the recommendation to alternate solids with liquids, and provide staff assistance as needed.

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{W 154}	Continued From page 14 During an interview with E3(Qualified Intellectual Disability Professional) on 8/2/16 at 2:00pm, E3 was asked if he was the QIDP for R10. E3 confirmed that he was. E3 was asked if he was aware that R10 had a recommendation from Z1 to have solids alternated with liquids. E3 stated that he was not aware. E3 reviewed R10's dysphagia evaluation. E3 was asked to explain the process of how recommendations from the speech therapist are communicated, so all staff can be aware. E3 stated that whenever a diet gets changed, he would get an updated sheet. E3 was asked why R10 had an evaluation completed back in January of 2014, then July of 2015, and then most current, February of 2016. E3 stated he does not know why, but usually they perform a dysphasia evaluation related to some concern or issue. E3 stated anyone can raise a concern, its really whoever notes or observes a swallowing problem. E3 explained that they have social service meetings, and E7, E2, E1, the director of nurses and the QIDP's all attend. It is usually on a bi-weekly basis. Information such as a diet change or recommendation should be shared during this meeting. E3 confirmed that he does not have any information in his notes about R10 needing to alternate between solids and liquids when he eats. E3 stated that E2 will receive a copy of the speech therapy evaluation once it has been completed. This information is then shared with the dietician and the physician(E10), and then eventually dietary. From there it is added on the dietary list. E3 was asked why this information never made it to the dietary list. E3 stated he is not sure, but his guess is it would have to come from nursing, because when the evaluation is completed, it goes to nursing.	{W 154}		

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{W 154}	Continued From page 15 During an interview with E11(Licensed Practical Nurse) on 7/28/16, via the telephone, E11 was asked if she was aware that R10 needed to alternate between solids and liquids. E11 stated that when speech therapy recommends something, we carry it out. The recommendations are placed on the Physician Order Sheet(POS), and then the direct care staff should be made aware, so they can watch to make sure he is alternating. E11 stated she does not know why this information is not known by staff, or herself. E11 was asked if a mechanical soft diet is ok to receive a whole burrito. E11 stated that she thinks as long as the burrito is soft enough, it should be ok. E11 stated that bread should be cut up. E11 stated it really is not her area, it is dietary's responsibility, and does not always see the food when it is served, as usually she is passing medications. E11 stated that there is a piece of paper that is placed on each table at meal time, and it has the clients' diets and precautions, as well as special directions printed on it. E11 stated that is where the recommendation should be located for staff to be aware. E11 was asked if they received any special training after this choking incident. E11 stated that they had a CPR refresher in-service, but they did not receive any in-service on how diets/meals should be served. The Diet List All Residents By Table form dated 7/11/16, was reviewed. This diet list was from table 2, second seating, which was the seating and table R10 was a part of. R10's diet states, Diabetic, Mechanical soft, skim milk, Great shake plus at 3pm, and No family dining. There is no mention of alternating solids and liquids, or to provide staff assistance as needed. R10's Physician Order Sheet, signed by E10(Physician),	{W 154}		

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{W 154}	Continued From page 16 dated 7/5/16 through 8/3/16, was reviewed. R10's diet order reads mechanical soft, diabetic, no family dining, great shake daily with skim milk. There is no mention of alternating between solids and liquids, or to provide staff assistance as needed. R10's Individual Support Plan dated 12/3/15 was reviewed. Under Nutritional, it states R10 is on a Diabetic Mechanical soft diet with skim milk and a Greatshake plus. There is no mention that R10 had a prior history of choking back in 2014, when his diet was intially changed to Mechanical soft. There is no mention of the recommendation to alternate between solids and liquids. During an interview with E2 on 8/2/16 at 12:00pm, E2 was asked if she had a chance to interview the dietician while performing her investigation. E2 stated that she knows that they communicated with their dietician(Z3), but she thinks it was via email. E2 then presented this surveyor with an email correspondence, which was initiated on 7/16/16, between E2, E1, and Z3. This correspondence notes that Z3 was asked to review all the menus including the spread sheets to ensure that the mechanical soft diets are appropriate. Z3's response on 7/18/16 stated that she would need a copy of the spread sheets. Her concern about the texture of the mechanical soft diets is an issue for the speech therapist. Z3 responded that she cannot speak to the proper consistency of a diet, because that is out of the realm of what she would know with what her license covers. Once she reviewed the spread sheets which were sent on 7/18/16, Z3 responded on 7/19/16, that nutritionally the diets look fine, but as far as consistency goes, she again deferred to the speech therapist.	{W 154}		

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{W 154}	Continued From page 17 During a follow up interview with E2 on 8/2/16 at 12:20pm, E2 was asked why R10 had the three dysphasia evaluations; Jan of 2014, July of 2015 and February of 2016. E2 stated that the original evaluation was because of the choking episode that R10 had while at the rehab facility, after his hospital stay. E2 was asked if she knows what R10 choked on while at the rehab facility, but E2 stated she does not know the particulars of his choking episode. E2 explained that the other two evaluations are probably because they were trying to complete swallow evaluations annually, and they were not completed exactly a year apart. E2 was asked the process of how a recommendation and or diet change from the speech therapist gets communicated to all staff involved in R10's care. E2 stated that she will find out how this information is communicated. E2 was informed that the recommendation to alternate between solids and liquids is not on his Physician Order Sheet or on the diet list for R10. During an interview with E10(Physician) on 8/3/16 at 10:15am, E10 confirmed he was R10's physician. E10 was shown the picture of recreated food that R10 received on 7/13/16, which was the day he choked on his beef burrito. E10 was then asked if this was the appropriate way to serve his meal; whole beef burrito, diced mango and rice. E10 stated that it was not appropriate., E10 stated that for someone who is on a mechanical soft diet, such as R10 was, the beef burrito cannot be served whole, but rather, it needs to be cut once down the middle, and then across as well, ensuring that it is cut into at least 6 bite size pieces. E10 stated this is how all mechanical soft diet burritos should be served. E10 confirmed that recommendations from the dysphasia evaluation need to be followed.	{W 154}		

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{W 154}	Continued From page 18 During a subsequent interview with E6(Cook) on 8/3/16, E6 was again asked to clarify if burritos should be served whole or cut up for clients who are on a mechanical soft diet. E6 once again confirmed that when she serves breakfast burritos, they are cut up, so if she would ever serve a beef burrito; it should also be cut up. E6 stated that if one type of burrito needed to be cut up, all burritos need to be cut up. E6 stated it is too large to serve to a client on a mechanical soft diet. During a subsequent interview with E5 on 8/3/16 at 10:20am, E5 was asked why E6 stated both a breakfast burrito and a beef burrito needed to be cut up for any client on a mechanical soft diet, yet on his interview from 7/29/16, he clarified and stated a beef burrito does not need to be cut up for a mechanical soft diet. E5 stated that because a breakfast burrito has sausage in it, and it is crumbled, it needs to be cut up. A beef burrito does not. E5 stated that since this incident has occurred with R10, he was told that all burritos need to be cut up. E5 was asked who told him this information, and E5 stated he was not sure, but he thinks it was E7. E5 was asked what he did with information. E5 stated that he verbally told all of his kitchen staff. E5 stated that he is sure a memo went out, but there was no formal in-service. E5 continued, saying that in addition to burritos being cut up, they are now required to cut up all breads, and sandwiches too for mechanical soft diets. During an interview with E2 at 11:45am on 8/3/16, E2 was asked if she ever interviewed the physician during her investigation process. E2 stated she did not think that was necessary, and	{W 154}		

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{W 154}	Continued From page 19 never interviewed E10. E2 was made aware that E10 stated that he would expect a beef burrito to be cut into bite size pieces for any client who was on a mechanical soft diet. E2 was not aware that E10 would expect the burritos to be cut up into pieces. E2 was asked if she ever interviewed the speech therapist, Z1. E2 stated she reached out to Z1 to re do swallow evaluations for any client on a mechanical soft diet, but confirmed that she does not have a formal interview with him. E2 stated when Z1 performs an evaluation, the diet and recommendations are turned over to nursing, so they can be reviewed with E10. Once approved, the diets are written on the physician order sheet. The changes are then written on a change of diet card, brought to the kitchen, and the kitchen then changes the order. E2 was made aware that the physician order sheet does not have the recommendation to alternate solids with liquids. E2 stated she is not sure why this information was not transferred to the POS. E2 was also made aware that E5 stated a memo was presented to him, and that now, as a facility, all burritos, breads and sandwiches for mechanical soft diets are to be cut up. E5 stated that the memo came from upper management. E2 stated that she is not aware of any memo regarding cutting up beef burritos, or breads and sandwiches for mechanical diets, but she will double check to make sure she is not miss speaking. A follow up interview with E2 on this same date at 12:20pm was conducted, and E2 confirmed that there was no memo sent out regarding the above information. E2 confirmed that there have been no changes for mechanical soft diets, and burritos and sandwiches are not being cut up into bite size pieces. The facility failed to determine that E10(physician)	{W 154}		

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{W 154}	Continued From page 20 would expect that a soft flour burrito for a mechanical soft diet should be cut up. The facility never interviewed the physician, to inquire what his expectation was on the preparation of a mechanical soft burrito. The facility failed to determine that some cooks prepare burritos cut up, while other cooks think it is fine to serve a mechanical soft burrito whole. The facility failed to determine that recommendations from their speech therapist to alternate solids and liquids was never transcribed to the Physician Order Sheet, and therefore never placed on the diet list. The QIDP was not aware of this recommendation, nor were nursing or the dietary staff. The facility failed to formally interview the speech therapist, but rather, asked him to re-evaluate all clients who are on mechanically altered diets. The facility also is not aware that E5 stated that a memo which was initiated from upper management has now determined that all burritos, bread and sandwiches, need to be served cut up for mechanical soft diets. E2, once informed of the above, stated that there is no such memo, and that they are not cutting up their burritos or sandwiches for mechanical soft diets,(despite the fact that E10 would expect burritos for mechanical soft diets to be cut up).	{W 154}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: REPEAT Based on record review, observation, and interview, the facility failed to ensure nursing	{W 331}		

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{W 331}	Continued From page 21 services communicated recommendations from a dysphasia evaluation for 1 of 1 client in the sample who choked on a burrito which was served whole, requiring emergency medical services, and later expired after life saving measures were removed(R10). Findings include: The Accident\Incident Report for R10 dated and timed 7/13/16 at 1625(4:25pm) was reviewed. It states that R10 was choking, so the nurse(E11) was called to R10's table to help. First aid was started right away, then CPR(Cardiopulmonary Resuscitation). The report reads that R10 was on a diabetic mechanical soft diet with thin liquids. The investigation was performed by both E1(Administrator) and E2(Residential Services Director), but authored by E2. During the facility's investigation, E2's report indicates that R10 was served a soft taco that was a flour tortilla with ground meat inside. Because the taco was very soft, it did not need to be cut up for any individual who was on a mechanical soft diet. The meal also consisted of a serving of rice, and a serving of diced/cut up mangos. The rice did not need to be mechanically altered, and the mango pieces did not need to be altered other than being diced/cut up as they were already served. The facility investigation stated that each item was very soft in texture, and easily would slice when a finger was pressed into the food. The investigation notes that R10's most recent dysphasia evaluation from 2/20/16 recommends to continue R10's current diet(diabetic mechanical soft), alternate liquids and semi-solids, and staff to assist with meals as needed.	{W 331}		

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{W 331}	Continued From page 22 R10's Dysphasia Evaluations were reviewed. R10's original evaluation from 1/25/14 notes that R10 had a choking episode while in the hospital/rehab, and his diet was changed from diabetic pureed to diabetic mechanical soft. Per review of nursing notes from the facility dated 1/26/14, the entry states that R10 had a bedside dysphasia evaluation performed on 1/25/14 due to a choking episode while at a rehab facility, with the clinical impression of mild oral dysphasia characterized by a edentulous short choppy bite pattern and minimal residual remaining after the swallow. Recommendations are to change diet from pureed to mechanical soft, alternate liquids and semi solids, and encourage to eat slowly. A second Dysphasia Evaluation dated 7/22/15 was reviewed. It states to remain on his diabetic mechanical soft diet for his mild dysphasia characterized by decreased mastication skills secondary to edentulous and minimal residual remaining on his liquid surface after the swallow. Recommendations continue to alternate liquids and semi-solids, with staff to assist with meals as needed. The last Dysphasia Evaluation present in R10's chart is dated 2/20/16. Diet is to continue as diabetic mechanical soft, with alternating of liquids and semi-solids, and staff to assist as needed with meals. The video camera footage from the dining meal involving R10's choking episode(7/13/16) was observed. R10 was observed in the dining room, sitting in his wheel chair at the dining table. E8(Certified Nursing Assistant) was the staff member assigned to R10's table during this meal. R10 is observed eating his entire flour burrito without alternating a drink of liquid with his taco as recommended and ordered by his physician. After R10 had consumed his entire burrito, it is	{W 331}		

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then that R10 is observed reaching for his water, and E8 assists R10 in reaching it. E8 does not offer any other assistance during the meal, until it is observed that R10 is choking, and the Heimlich maneuver and CPR are instituted.

During an interview with E8 on 7/28/16 at 2:30pm, E8 was asked if she could describe what happened on 7/13/16, when R10 choked on his soft burrito. E8 stated that she was the staff member assigned to R10's table. E8 stated that she has R10's table every day she works. E8 stated that R10 ate his entire beef burrito, and when he was finished eating it, he started to cough. E8 stated that R10 pointed to his water, and she helped him reach it. E8 stated he drank the whole cup of water, and then he stopped coughing. He had no exchange of air. E8 was asked if she was trained on R10's diet, and what his recommendations are while eating. E8 stated that when she was trained she was told that R10 is very functional, and was an independent eater. If R10 needed a drink he could help himself. E8 stated that the only reason she assisted R10, was because he was reaching for his cup of water, and she assisted by bringing the cup within his reach. E8 was asked if she was aware that R10 should alternate between eating a bite of food, and drinking a cup of water. E8 stated that she is not aware of this recommendation, and never prompted R10 take a drink of water after eating a bite of food.

E5(PM Cook Supervisor) was interviewed on 7/28/16 at 1:50pm. E5 was asked if he was aware that R10's recommendation from his speech evaluation is to alternate solids and liquids, and that staff should assist R10 as needed. E5 stated that he was not aware of this

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	14G026	A. BUILDING _____ B. WING _____	R 08/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS	3250 SOUTH PLUM GROVE ROAD ROLLING MEADOWS, IL 60008

(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
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recommendation. E5 was asked if this information is on a meal card for staff to be aware. E5 stated that they do not have that on his meal card, and his card is no longer here, because of his passing. E5 was asked to describe what alternating between solids and liquids means to him. E5 stated it means that R10 should take one bite of his food, and then take one sip of liquid, and continue to eat in this manner until he is finished. E5 clarified that they never knew about this recommendation, and therefore, never encouraged R10 to eat this way.

During an interview with Z1 on 7/28/16 at 1:50pm, Z1 confirmed that he was the speech therapist that performed R10's dysphasia evaluations. Z1 stated that R10 never had a video fluoroscopy. Z1 stated that R10's diet is a mechanical altered diet, and confirmed that he wrote the recommendation to alternate solids with liquids, and provide staff assistance as needed.

During an interview with E3(Qualified Intellectual Disability Professional) on 8/2/16 at 2:00pm, E3 was asked if he was the QIDP for R10. E3 confirmed that he was. E3 was asked if he was aware that R10 had a recommendation from Z1 to have solids alternated with liquids. E3 stated that he was not aware. E3 reviewed R10's dysphasia evaluation. E3 was asked to explain the process of how recommendations from the speech therapist are communicated, so all staff can be aware. E3 stated that whenever a diet gets changed, he would get an updated sheet. E3 explained that they have social service meetings, and E7, E2, E1, the director of nurses and the QIDP's all attend. It is usually on a bi-weekly basis. Information such as a diet change or recommendation should be shared

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during this meeting. E3 confirmed that he does not have any information in his notes about R10 needing to alternate between solids and liquids when he eats. E3 stated that E2 will receive a copy of the speech therapy evaluation once it has been completed. This information is then shared with the dietician and the physician(E10), and then eventually dietary. From there it is added on the dietary list. E3 was asked why this information never made it to the dietary list. E3 stated he is not sure, but his guess is it would have to come from nursing, because when the evaluation is completed, it goes to nursing.

During an interview with E11(Licensed Practical Nurse) on 7/28/16, via the telephone, E11 was asked if she was aware that R10 needed to alternate between solids and liquids. E11 stated that when speech therapy recommends something, we carry it out. The recommendations are placed on the Physician Order Sheet(POS), and then the direct care staff should be made aware, so they can watch to make sure he is alternating. E11 stated she does not know why this information is not known by staff, or herself.

The Diet List All Residents By Table form dated 7/11/16, was reviewed. This diet list was from table 2, second seating, which was the seating and table R10 was a part of. R10's diet states, Diabetic, Mechanical soft, skim milk, Great shake plus at 3pm, and No family dining. There is no mention of alternating solids and liquids, or to provide staff assistance as needed. R10's Physician Order Sheet, signed by E10(Physician), dated 7/5/16 through 8/3/16, was reviewed. R10's diet order reads mechanical soft, diabetic, no family dining, great shake daily with skim milk.

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{W 331}	Continued From page 26 There is no mention of alternating between solids and liquids, or to provide staff assistance as needed. R10's Individual Support Plan dated 12/3/15 was reviewed. Under Nutritional, it states R10 is on a Diabetic Mechanical soft diet with skim milk and a Greatshake plus. There is no mention that R10 had a prior history of choking back in 2014, when his diet was intially changed to Mechanical soft. There is no mention of the recommendation to alternate between solids and liquids. During an interview with E2 on 8/2/16 at 12:00pm, E2 was asked if she had a chance to interview the dietician while performing her investigation. E2 stated that she knows that they communicated with their dietician(Z3), but she thinks it was via email. E2 then presented this surveyor with an email correspondence, which was initiated on 7/16/16, between E2, E1, and Z3. This correspondence notes that Z3 was asked to review all the menus including the spread sheets to ensure that the mechanical soft diets are appropriate. Z3's response on 7/18/16 stated that she would need a copy of the spread sheets. Her concern about the texture of the mechanical soft diets is an issue for the speech therapist. Z3 responded that she cannot speak to the proper consistency of a diet, because that is out of the realm of what she would know with what her license covers. Once she reviewed the spread sheets which were sent on 7/18/16, Z3 responded on 7/19/16, that nutritionally the diets look fine, but as far as consistency goes, she again deferred to the speech therapist. During a follow up interview with E2 on 8/2/16 at 12:20pm, E2 was asked the process of how a recommendation and or diet change from the	{W 331}		

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{W 331}	Continued From page 27 speech therapist gets communicated to all staff involved in R10's care. E2 stated that she will find out how this information is communicated. E2 was informed that the recommendation to alternate between solids and liquids is not on his Physician Order Sheet or on the diet list for R10. During a follow up interview with E2 at 11:45am on 8/3/16, E2 stated when Z1 performs an evaluation, the diet and recommendations are turned over to nursing, so they can be reviewed with E10(Physician). Once approved, the diets are written on the physician order sheet. The changes are then written on a change of diet card, brought to the kitchen, and the kitchen then changes the order. E2 was made aware that the physician order sheet does not have the recommendation to alternate solids with liquids. E2 stated she is not sure why this information was not transferred to the POS.	{W 331}		