FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6001366 08/18/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1545 BARRINGTON ROAD **ALDEN POPLAR CREEK REHAB & HCC HOFFMAN ESTATES, IL 60169** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Statement of Licensure Violations Complaint Investigation 2015184/IL124444 \$9999 Final Observations S9999 Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care Attachment A

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pursuant to subsection (a), general

nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

seven-day-a-week basis:

TITLE

Statement of Licensure Violations

(X6) DATE

100B11

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R1's State of Illinois Certificate of Death Worksheet certified 3/11/20 shows "R1 expired 3/9/20 ... cause of death: asphyxia, due to (or consequence of): choked on food bolus."

R1's Face sheet shows R1 was admitted to the facility on 1/31/20 with diagnoses including: vascular dementia, Parkinson's, and

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001366			A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING			C 08/18/2020		
	PROVIDER OR SUPPLIER	AB & HCC 1545 BAR	DRESS, CITY, S RINGTON R N ESTATES,				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		HOULD BE	(X5) COMPLETE DATE			
\$9999	R1's Minimum Data cognitively impaired R1's Video swallow hospital) shows "pernectar liquids via a caspiration as described R1's Hospital Nurse shows R1 is on a minimum thickened liquids an feeding. R1's Speech Theragon Treatment dated 2/2 choking episode in himechanical soft. Paragon Fluoroscopy Swallow honey thickened liquids appiration/penetration Safety: Reduced attasfety awareness, Flability to make need alayed swallow residence swallow and decrease R1's Speech Theragon 2/26/20 shows "Patiaspiration/choking wilquids/nectar thicker following safe swallow R1's Modified Barium shows "mild-modera"	study (done on 1/29/20 in the netration of thin liquids and cuppenetration and bed." Report Sheet date 1/31/20 echanical soft diet with honey d needed assistance with Evaluation and Plan of 20/20 shows "Patient had nospital and downgraded to attent then completed Video w Study and downgraded to be on Behaviors Impacting ention to task, Decreased foor self-monitoring skills and eds known Patient with ponsedifficulty initiating sed safety awareness." Evy Progress Report dated ent (R1) is at risk for with puree/honey thickened ned liquids when not strictly	\$9999				
	intakestrict ad						

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	1545 RAF		STATE, ZIP CODE				
ALDEN POPLAR CREEK REHAB & HCC 1545 BARRINGTON ROAD HOFFMAN ESTATES, IL 60169							
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S9999	Continued From page 3	S9999					
	diet recommendations: small bites, monitor rate, aspiration precautions, small sips, multiple swallow (2), alternate solid/liquid, supervised feeding."						
	R1's Speech Treatment Encounter Note dated 3/3/20 shows a "repeat Video Fluoroscopy Swallow Study was done with recommendations for mechanical soft/nectar thickened liquids dietEducated patient/wife at lengths regarding results of study, specific strategies of repeat swallows due to pharyngeal residuals, small bites/sips, and recommendations. Discussed results with R1's Registered Nurse V17.						
	R1's Speech Treatment Encounter Note dated 3/6/20 shows "max cues needed for repeat swallow. Instructed patient (R1)/wife in oral motor/pharyngeal/laryngeal exercises. Patient required max cues to follow due to cognitive deficits."						
·	R1's Speech Therapy Progress Report dated 3/6/20 shows "R1 and Caregiver training: development & training in use of compensatory strategies: small bites, small drinks, upright at 90 degrees for all oral intake, double swallow to clear pharyngeal residuals, 1:1 assistance. Educated patient's RN (V17) Supervision for Oral Intake=Close supervision (1:1 assistance with all oral intake for swallow strategies.)"						
	On 8/12/20 at 4:40 PM, V23 Speech Therapist said she was treating R1 due to his diagnosis of dysphagia, dementia, and Parkinson's and his high risk for swallowing problems. V23 stated "R1's biggest problem was that he took large amounts of food at one time and was unable to swallow all of the food in his mouth with the first swallow. R1 needed to be instructed to then take						

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6001366	B. WING		C 08/18/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DESS CITY S	TATE, ZIP CODE		
		1545 BAR	RINGTON RO			
ALDEN	POPLAR CREEK REH	AB & HCC	I ESTATES, I			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETE DATE		
\$9999	a sip of liquid or swithe food, which is vo Parkinson's." V23 sin his mouth R1 cours R1 was able to feed one supervision to rwere small enough, second swallow to V23 said R1 is cogrammer was not go cueing. V23 stated directly, his food tratable with R1." V23 Certified Nursing As Activity Aide/trained closely and to monitand drink, and to talto clear his mouth. communicated R1's regular nurse V17. receiving speech the On 8/11/20 at 1:49 If during the noon metimes while making helping the resident about 80% of the fafinished eating. V26 from the family on the sthe remainder of was making a pean for another resident of R1 when she hear R1 and he was make	allow a second time to clear ery common with said if the food or drink built upuld possibly choke. V23 said himself, but needed one on make sure the bites and sips and he took a drink or a clear the food in his mouth. Intively impaired and his lood so he needed repetitive if no one is watching him y should not be left at the said she trained V25 sistant (CNA) and V26 feeding assistant to watch R1 for the size of the bites of food ke a drink or second swallow V23 said she also swallow strategies with R1's V23 said R1 was still erapy up until his death. PM, V25 CNA said on 3/9/20 all she had fed R1 several rounds in the dining room and is. V25 said R1 had eaten cility food tray and was 5 said there was some food he table in front of R1 as well the facility tray. V25 stated "I ut butter and jelly sandwich and could only see the back and a weird noise. I looked at king a gurgling noise but no	S9999			
	Sometimes R1 feed On 8/11/20 at 1:42 F when she came bac	the nurse." V25 said s himself. PM, V26 Activity Aide said ck from break, V25 had R1 was finished eating and				

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while eating lunch. Heimlich maneuver attempted

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Director said R1 sat in the assisted dining room for meals and due to his cognition and needed

On 8/11/20 at 12:07 PM, V1 Administrator said R1 sat in the small dining room for meals and

cueing at times, but could feed himself.

required staff supervision.

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