STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010102	A. BUILDING: _____ B. WING _____	C 10/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON MANOR CNV & NURSING	2155 WEST PIERCE CHICAGO, IL 60622

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation #2087503/IL127034	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)6) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care b) 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. d) 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These regulations are not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to supervise and monitor a resident, who was previously hospitalized for aspiration pneumonia, to prevent another choking incident. This failure affected one resident (R2) of two residents reviewed for resident injury. R2 choked on a peanut butter sandwich, resulting in R2 becoming unresponsive and later intubated in the hospital due to respiratory failure. Findings include: On 10/13/20, V2 presented the following records of R2: 1. R2's Hospital Records Discharge Summary, dated 9/29/20 written by V10, Hospital Physician, states, "Patient was unresponsive, tachypneic, and oxygen saturation was 50-60 percent (%) on ambient air. Patient was immediately intubated in the ED (Emergency Department) by the ED MD (Medical Doctor) and Peanut Butter in the airway was suctioned out." The hospital record also states that R2's diagnoses at the hospital were: Respiratory Failure, Aspiration Pneumonia, and Hypoxemia. "Plan" states: "Secondary to hypoxemia, respiratory failure, and the patient required intubation essentially on arrival. I used a glide scope video-assisted device with success. He did require large amount of suctioning secondary to the large amount of peanut butter in his airway." V10 also referred to the prior choking episode approximately one year ago on 9/13/2019, when R2 was hospitalized from 9/13/2019 to 9/16/2019, for Aspiration Pneumonia. 2. R2's Care Plan, dated 9/29/2019, states that	S9999		

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S9999	Continued From page 2 R2 has a swallowing problem related to Dysphagia and needs extensive assistance when eating; 3. R2's Nutritional Risk Review, dated 2/27/2020, states that R2 is on Aspiration Precaution, and "needs extensive assistance in eating to ensure adequate PO (oral) intake"; 4. R2's Incident Report, dated 9/12/20, that was sent to the State Agency on 9/13/20 and the investigation by the facility; 5. R2's progress notes which showed R2 was sent to the hospital for Aspiration Pneumonia about a year ago, specifically on 9/13/2019, and now, had this choking incident, for which R2 was intubated. On 10/13/20 at 1:40 PM, V2 (Director of Nursing) stated R2 was in the hospital for over two weeks and is back at the facility. On 10/13/20 at 1:45 PM, V2 stated that R2 had a behavior of grabbing food from another resident and might have grabbed another sandwich, however, no such behavior was documented on R2's care plan either before or after the choking incident. On 10/14/20 at 3:43 PM, V11 (Licensed Practical nurse, LPN) was interviewed regarding R2's choking incident of 9/12/20. V11 stated that during his rounds, he saw R2 holding his neck and coming towards him. He realized that R2 was choking and he did the Heimlich maneuver, and there was no pulse, and 911 was called. V11 stated that V12 (CNA, Certified Nurse Assistant) had given R2 the evening snack which was a sandwich.	S9999		

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S9999	Continued From page 3 Facility's policy on "Aspiration Precautions", dated 1/1/2020, states in #3: Residents that have been assessed to be a risk for aspiration will be monitored on a regular basis. Any further identified aspiration will be relayed to the MD for additional and treatment. (A)	S9999		