Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010052	A. BUILDING: ______ B. WING ______	C 02/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER HOUSE	1125 NORTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048

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S 000	Initial Comments Facility Reported Incident of 2-6-18/IL100316	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)6) 300.1220)b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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 300.1220 Supervision of Nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to provide necessary care and services by not ensuring recommended swallowing precautions were implemented for a resident who is at risk for aspiration. This failure resulted in R1 choking on meat in R1's room and expiring on February 6, 2018.

This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3.

The findings include:

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The facility's Final Incident Investigation Report dated February 13, 2018 shows on February 6, 2018 R1 experienced a choking episode. R1 was eating in his room with his roommate. R1 was alert and oriented, on a general diet and had no swallowing precautions. Nursing staff was alerted that resident was having a choking episode and responded and performed the Heimlich maneuver. Upon the third thrust a food particle was expelled. R1 then lost consciousness and CPR (Cardio Pulmonary Resuscitation) was initiated and 911 called. CPR continued by paramedics as R1 was transferred out of the facility. Per the local hospital R1 expired.

The Physician Order Sheets (POS) dated through February 2018 shows R1 has diagnoses including Cerebral Palsy (neurologic disorder) and muscle weakness. POS shows R1 is on a low concentrated sweet diet.

The Minimum Data Set assessment dated October 26, 2017 shows R1 requires setup during meals and has no swallowing disorders.

R1's Speech Evaluation by V12 (Speech Therapist) dated December 14, 2016 shows R1 at risk for Aspiration related to physical impairments and functional deficits. The same report showed R1 demonstrates Mild Oral Phargenal Dysphagia (a condition that weakens your throat muscles, making it difficult to move food from your mouth into your throat and into your esophagus when swallowing. You may choke, gag or cough when you try to swallow. Neurologic disorders can cause this disorder). R1 is recommended to have occasional supervision, sit upright, and eat slow during meals. V12 identifies R1 has behaviors impacting safety including impulsiveness and complaints of

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odynophagia (painful swallowing). The facility did not provide evidence of a later speech screening or evaluation for R1 after December 14, 2016.

R1's Speech Evaluation report dated December 14, 2016 showed it was faxed to V15 (Physician) on December 19, 2016. The same report showed it was signed by V15 on December 19, 2016 and faxed back to the facility on December 20, 2016. (The POS dated through February showed the swallowing recommendations were not on the POS.)

R1's menu card dated February 6, 2018 shows for the dinner meal he was served included BBQ Pork, rice, stewed tomatoes, and a fruit cup.

The nurse's notes for February 2018 showed R1 took his medications with applesauce.

R1's Care Plan dated through April 2018 shows R1 has self care deficit related to cerebral palsy, fatigue, impaired balance, limited mobility. R1 requires extensive assist with most activities of daily living. Feeds self after set up. R1's care plan interventions were last revised on October 31, 2016. R1's care plan does not include R1 is at risk for aspiration or include V12's recommendations for R1 to have supervision and cueing to eat slowly during meals.

R1's Care Plan dated August 2017 shows his preference's include choosing his own clothing, choosing his bedtime, having snacks available, taking a shower, caring for personal belongings, using phone in private, and having a place to lock up items. R1's care plan does not show a preference that R1 prefers to eat in his room.

On February 22, 2018 at 4:00 PM, V16

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(Physician) said he "was not surprised (R1) choked." R1 had a diagnosis of Cerebral Palsy (CP) a neurological disorder that affects their swallowing abilities. Their swallowing abilities are progressive as they age. V16 said he would expect staff to follow the speech recommendations.

On February 15, 2018 at 11:00 AM, V4 (resigned CNA) said she was R1's CNA on February 6, 2018. R1 was served BBQ pork. V4 said she opened R1's milk and cut up his pork and left the room. V4 said R1 always ate his meals in his room, but she did not know why. V4 said she did not cue or observe R1 during meals. V4 said she heard a yell on February 6, 2018 and went to R1's room. V3 (RN) was performing the Heimlich maneuver. V4 said, "R1 looked at me with eyes 'to help me.'" V4 said she performed the Heimlich maneuver too. V4 said V3 continued with the Heimlich maneuver and a piece of meat was expelled. V4 said "it didn't seem like it all came out;" R1 was still "choking." V3 told her to call 911. V4 said she called 911 and did not return to R1's room.

On February 14, 2018 at 10:00 AM, V3 (RN) said she was R1's nurse on February 6, 2018. V3 said R1 was eating dinner in his room. She heard R5 (R1's roommate) scream "R1's choking." V3 said at 5:48 PM she entered R1's room it was obvious he was "choking." R1 was sitting in R1's wheelchair with his hands gripped to the wheelchair arms gasping for air. V5 said V5 performed the Heimlich maneuver on R1 with the third thrust a piece of pork was expelled. V5 said R1 was still choking after the piece of pork was expelled. V5 said V4 (Certified Nursing Assistant) performed the Heimlich maneuver on R1, but was unsuccessful. V3 said R1 would always eat in his

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room, was not a risk for aspiration, and did not have any swallowing problems. V3 said she was not sure why R1 would eat in his room. V3 said maybe because he had some dexterity issues related to his Cerebral Palsy.

On February 15, 2018 at 1:05 PM, V14 (Visitor) said on February 6, 2018 she was visiting her mom at the facility during dinner. V14 said she heard someone screaming and she saw V3 (Registered Nurse-RN) running down the hall. V14 said she entered R1's room and V3 was performing the Heimlich maneuver on R1. R1 was "not breathing" and looking "lifeless."

On February 14, 2018 at 11:20 AM, R5 (R1's roommate) said he had been R1's roommate for about 3 weeks. R1 would eat in the room during meals. R5 said on February 6, 2018 during the dinner meal R1 started choking. R5 said he yelled out for staff. Staff came performed the Heimlich maneuver and a piece of meat came out. Staff performed CPR on the floor then the paramedics arrived.

On February 14, 2018 at 9:15 AM, V7 (CNA) said R1 would eat in his room. R1 needed help cutting up his food.

On February 14, 2018 at 8:55 AM, V8 (CNA) said R1 would eat in his room. R1 was impulsive; staff had to remind him to use his call light for assistance. R1 did not follow direction well. R1 had to be reminded repeatedly not to get up without assistance. V8 said she had not observed R1 during meals.

On February 14, 2018 at 9:00 AM, V9 (CNA) said R1 was alert but needed frequent reminders not to get up by himself. Staff would have to remind

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R1 all the time. R1 needed staff to cut up his food. V9 said she did not supervise R1 or cue him during meals. V9 said she did have to remind R1 to slow down when drinking liquids. V9 said R1 had a poor appetite. "I guess he did have problems swallowing. Maybe that's why R1 did not eat much." V9 said she was not sure why R1 ate in his room; she thought maybe because he was a messy eater.

On February 14, 2018 at 1:10 PM, V13 (Speech Therapist) said she did not perform R1's speech evaluation on December 2016. V13 said she had not assessed R1 yet for any swallowing problems. V13 said she started in August 2017 and had not screened R1 for any swallowing problems. V13 was asked what "occasional supervision" means recommended by V12 (former speech therapist). V13 said "occasional supervision" is not a routine recommendation, residents either need supervision or not. V13 confirmed the speech evaluation recommended cueing and eat slowly. V13 said maybe R1 was impulsive. She said she would expect staff to remind R1 to eat slowly during each meal. V13 said the same report showed R1 had a diagnosis of Mild Oral Pharyngeal Dysphagia and "maybe it took him longer to chew," putting him at risk for aspiration. R1 was at risk for Aspiration with swallowing precautions including supervision, sit upright, cueing to eat slow during meals and lots of care giver education. V13 said these should be in R1's care plan.

The EMS report on February 6, 2018 showed the call was dispatched at 5:50 PM. On the way to the call dispatch was notified R1 was now having CPR. On arrival to the scene at 6:02 PM, R1 was on the floor, non responsive and blue. R1 was transported to the local hospital.

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S9999	Continued From page 7 The Hospital Records dated February 6, 2018 showed at 6:27 PM, a large foreign body 5x4 cm (centimeters) of undigested food was removed from R1's trachea by the physician. The same report showed R1 was pronounced dead at 6:35 PM. The facility's Aspiration Precautions Policy dated August 2015 states, "Aspiration precautions are determined by the Speech Therapist and Provider....Speech therapy will determine the aspiration precautions that are necessary for the guest, in collaboration with the provider...Notify Provider with swallowing concerns..." (A)	S9999		