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
	IL6008478	A. BUILDING: _____ B. WING _____	C 12/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEVENS HOUSE	2182 WINDISH DRIVE GALESBURG, IL 61401

(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
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1060e) 350.1210 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health.	Z9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Z9999	Continued From page 1 Section 350.3240 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) This Requirement is not met as evidenced by: Based on record review and interview the facility failed to ensure policies written to prevent neglect were implemented when they: > Failed to effectively implement an Eating Program for R1 after identifying instances of unsafe eating habits as a priority goal during her annual Individual Service Plan (ISP) meeting > Failed to educate Direct Service Persons (DSP's) on R1's new eating program to ensure it could be evaluated for effectiveness and in measurable terms > Failed to effectively coordinate with R1's day training site regarding her newly implemented Eating Program which was to be conducted across all environments > Discontinued R1's Eating Program after collecting two months of immeasurable documentation These failures affected 1 of 1 individual in the facility who died of cardiac arrest after choking (R1). Findings include: Per a ISP dated 8/31/15, R1 was a 66 year old	Z9999		

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female with diagnoses which include Moderate Intellectual Disability, Obsessive Compulsive Disorder, Seizure Disorder, Possible TIA and Agitation with Verbal Aggression. R1 is her own guardian and signed her ISP on 9/1/15.

A company policy 5.24 titled Investigative Committee defines neglect as, "The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

Records were reviewed of R1's visit to her Neurologist (Z1). On 1/16/15, Z1 had noted, "Pt went home to brothers house for holiday visit and patient sat down to dining room table and was eating off empty plate and telling her brother how good the food was and there was no food. Patient brother concerned. Caregiver states at times patient unable to do things that she normally could do, such as zipping her coat. Patient at times is spoke to and patient sits there with a 'blank stare' and doesn't respond.

Z1's assessment/plan from the 1/16/15 visit reads, "New question of Dementia with hallucination."

Z1's note from 5/21/15 reads, "Patient is here for a follow up (diagnosis Dementia). Patient caregiver states no seizures noted. Patient caregiver states that patient memory has worsened. Patient is found sitting at dining room table eating a meal, but there is no food to eat."

The 5/21/15 visit notes for assessment/plan read, "1. New question of Dementia with hallucination".

A note from a visit to Z1 on 11/19/15 reads, "Patient is here for follow up. Patient caregiver states no seizure noted. Caregiver states

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increase in patient repeating herself."

The 11/19/15 History reads, "Pt here with staff. Pt decline with behaviors like sitting down to eat an imaginary meal. In last 6 months the episodes are more frequent and longer. She will go to the bathroom right next to her bed."

Z1's assessment reads, "1. New question of Dementia with hallucination - still about the same - we held off last visit since these were rare but now this is becoming a common event. Z1 prescribed Donepizil 5mg for R1's dementia.

A Progress Note (P-15) dated 8/16/15 at 5pm was written by E2 and states that R1 "needed prompted to take her mouthful of food out cause she put the entire chunk of chicken in mouth w/out taking bites and did not ask staff to cut for her". The report states this was witnessed by other peers and staff.

The progress note follow up written by E2 on 8/31/15 states, "spoke w/ (with) program manager about it being a concern we can address (at) staffing - (day training facility) - may implement eating program.

E2 was asked during interview on 12/4/15 at 2:21pm if an Eating Program was implemented for R1 at Day Training. E2 stated no, R1's Day Training Program stated she didn't require prompting at Day Training.

During interview with Z2, day training Program Director, on 12/7/15 at 12:32pm, Z2 was asked if she had a current copy of R1's ISP from September 1, 2015 or updated Behavior Programs. Z2 stated no, day training has not received current copies. Z2 provided an email in

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Z9999	Continued From page 4 which she had requested copies of R1's ISP on 11/6/15 and noted she has not received the as of 12/7/15. Review of company policy 6.04 titled Individual Service Plan (ISP) Development under section titled "QIDP action following all ISP staffings" it reads: "B. The QIDP shall implement the ISP immediately following the meeting." "D. The QIDP shall provide a copy of the written ISP to the Day Program." "E. The QIDP shall inform staff of the provisions of the ISP and provide necessary staff training to ensure proper and effective implementation of the ISP." During further review of R1's ISP, on page 3 the following documentation is found, "A choking risk assessment has been completed with no notes to say she is at risk." It also states R1 is on a regular diet. Page 4 of R1's ISP states, "she requires some staff assistance to cut her food with a knife into bite sized pieces...A few occurrences have developed where she has taken too large of bites to chew and swallow efficiently; staff are to monitor her and prompt her as needed and follow her new eating program." Page 11 of R1's ISP reads, "(R1) has needed prompted a few times recently while eating to take smaller bites, and the (Community Support Team) discussed the importance of this with (R1) and how we will start a program to help assist her with safe consumption during all meal/snack	Z9999		

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Z9999	Continued From page 5 times." Page 12 of R1's ISP lists her "Priority Program Goals" as follows: "4. (R1) will increase her safe eating skills by having staff prompt during meal times to remind her to take smaller/manageable bites to prevent choking." A Program Form for R1 dated 9/1/15 which states, "Program Area: Eating" reads as follows, "(R1) requires some staff assistance to cut her food with a knife into bite sized pieces. A few occurrences have developed where she has taken too large of bites to chew and swallow efficiently; staff are to monitor her and prompt her as needed. The Program Form further reads, "Program schedule/duration: Daily at meal times" and, "Suggested Program Carryover: Across all environments". Programming methods and instruction: (R1) requires some staff assistance to cut her food with a knife into bite sized pieces. (R1) will let staff know if she needs help cutting her meat most of the time, so staff should keep an eye on her plate in case her meat needs cut. A few occurrences have developed where she has taken too large of bites of meat to chew and swallow efficiently; staff are to monitor her an prompt her as needed. This happens when (R1) takes more bites before swallowing her first bite. If (R1) is taking bites before swallowing; staff are to prompt her to put her fork down after each bite and chew and swallow all the way before taking another bite."	Z9999		

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The top of the Program Form for Eating has a handwritten note which reads, "d/c'd 11/3/15" and is initialed by E2, Residential Service Director (RSD).

Review of R1's "SN Tracking" sheet for her Eating Program, the following checkmarks are noted in September on 2nd shift: Two checkmarks on 9/4/15, two checkmarks on 9/11/15, one checkmark on 9/17/15, 9//21/15 and 9/27/15.

October documentation for R1's Eating Program Tracking is as follows: Three checkmarks on 10/11/15, one checkmark on 10/15, 10/24/15 and 10/28/15.

E2, RSD, was interviewed on 12/7/15 at 10:30am and asked what the checkmarks on R1's SN Tracking Sheet indicated. E2 stated the checkmarks just indicated she needed some type of prompting. E2 was asked if she was able to track if R1's unsafe behaviors appropriately based off of this tracking sheet. E2 stated no.

E2 was asked if an Incident or Behavior Report was filled out for any of these occurrences where there was a checkmark indicating R1 had an unsafe eating behavior which needed prompted. E2 stated no.

E2 was asked how staff becomes aware when and how to implement a new program for an individual. E2 stated a "GA-9" (company form) is filled out to inform and instruct employees the expectations of the new program. E2 was asked if she would provide this staff education for R1's new Eating Program. E2 stated no, she did not complete a GA-9, she just told staff to watch R1.

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E2 was asked if staff was properly trained on how to implement R1's Eating Program. E2 stated no.

E2 was asked if R1's day training site had received a current copy of her 9/1/15 ISP and programs that are to be run across all settings. E2 stated no.

An email dated 11/3/15 from E2 written to Z2, Day Training Program Manager, reads, "Since the last few instances of needing to prompt (R1) during eating a few months ago, she has not needed prompted nearly as often, so I don't feel she will need to be put on a formal program. In her program grid we had for her staffing we had her put for a formal eating program, but I think an informal program will suffice. What do you think?"

Z2 responded on 11/3/15 as follows, "That is fine with me! If it becomes an issue in the future we can readdress it then."

R1 died after choking on a sandwich at day training on 12/3/15.

E2 was asked during interview on 12/7/15 at 10:30am if R1's Eating Program was discontinued. E2 stated yes, based off of information obtained from the Tracking sheets which indicated she didn't need prompted frequently. Tracking sheets indicate R1 needed prompting for some type of unsafe behavior 7 times in September and 6 times in October. E2 was asked if staff was appropriately trained in how to fill out the tracking sheet. E2 stated no.

A "Report of Death" from E1, Administrator of R1's residential facility reads as follows, "On 12/3/15, (R1) was taken to (a local Emergency Department) due to a reported choking while

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eating her lunch at (day training site). (R1) was unable to regain consciousness and was pronounced dead in the ED."

During interview with Z3, Developmental Technician I at Day Training who performed the Heimlich on R1 while she was choking, on 12/8/15 at 1:11pm, Z3 stated R1's whole sandwich was gone. While he was performing the Heimlich and finger sweeps, he extracted a large amount of the sandwich was was not masticated, coming out in "whole bites" and consisted of ham and bread.

Z3 stated R1 was sitting at a table alone due to earlier behaviors. Z3 stated he had not received training for and Eating Program for R1 nor did Z3 have knowledge of R1 having unsafe eating behaviors.

Z6, Licensed Practical Nurse at Day Training was interviewed on 12/7/15 at 12:20 and asked if R1 was on a program for Eating. Z6 stated no.

Z7 and Z8 both Day Training Developmental Technicians were interviewed on 12/8/15 at 1140 and 1145am and asked if R1 was on an Eating Program. Z7 and Z8 both said no, they had not been advised to monitor R1.

During interview with Z4, Paramedic, on 12/8/15 at 9:20, Z4 advised when he arrived, R1 was being held in a sitting position by staff on the floor. R1 was unconscious with day training staff attempting to do the Heimlich. R1 had no pulse and was not breathing. Z4 extracted a large amount of food from R1's airway which required forceps and consisted of "whole pieces of unchewed ham and bread". Z4 established an airway by entubating R1 and transported her to

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the hospital. From the time of arrival, Z4 stated R1 was lifeless.

Z5, Coroner was interviewed on 12/7/15 at 10:46am. Z5 advised autopsy showed R1's cause of death was that she had aspirated food which led to her cardiac arrest and death.

Per a ISP dated 8/31/15, R1 was a 66 year old female with diagnoses which include Moderate Intellectual Disability, Obsessive Compulsive Disorder, Seizure Disorder, Possible TIA and Agitation with Verbal Aggression. R1 is her own guardian and signed her ISP on 9/1/15.

A Behavior Program Form dated 12/1/14 states R1 has behaviors which include being rude, bossing others, ignoring requests. It further states R1 "has not displayed any incidents of physical aggression in the form of hitting peers."

A "T-Log" dated 12/3/15 at 11:59am was written by Z7, Developmental Technician and reads, "(R1) was incontinent today. Clothes were sent for from her living facility. (R1) appeared confused when it came time to change her clothing. She had difficulty in changing her clothes and required staff assistance. When she arrived to her classroom, she asked staff where she was supposed to sit. Staff told her that she could sit where she had previously sat. She continued to appear confused, but did sit down and continued to play bingo with some assistance from staff."

Z7 was interviewed on 12/7/15 at 1:26pm and asked if R1 was typically confused. Z7 stated no, she is always oriented and independent. She has never been incontinent at day training and is normally able to dress herself and put her own

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Z9999	Continued From page 10 coat on. Three other T logs noted R1's behaviors in the morning hours of 12/3/15 as follows: 1. "(R1) was sitting across from a female peer playing Bingo when she reached over and hit her on the arm. There was no apparent reason for this behavior. " 2. "While clients were preparing lunch and going to the designated place to get their lunch boxes, (R1) reached over and pulled another female peers pants, as to stop her from getting her lunch bag. (R1) was given verbal prompts to not do this and (R1) did let go of her pants." 3. "At the beginning of lunch today, (R1) hit another peer on the arm. There was no apparent reason for this behavior." A "T-Log" dated 12/3/15 at 2:10pm was written by Z3, Developmental Technician I and reads, "(R1) had been behaving abnormally during the morning, appearing confused on several occasions and incapable of using the restroom or changing her clothes. She had also been exhibiting aggressive behaviors towards several peers. Because of this aggressiveness, (R1) was asked if she would like to sit by herself at another table for lunch where it would be quieter for her. She indicated she would (R1) moved to a table away from others in the same room where staff could monitor her." During an interview with Z3 on 12/7/15 at 1:11pm, Z3 stated R1 was typically oriented. Z3 also stated R1 would display verbal behaviors in the past, but never physically hit anyone. Z3 stated R1 had never been incontinent at day training as	Z9999		

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she had been that day. Z3 stated, "That day she was definitely out of it." Z3 further stated R1 had behaviors but they were never that intense or frequent. Z3 was asked if he or any other staff notified nursing of R1's mental status changes. Z3 stated no.

Additionally, Z3 was asked what role he played when R1 choked on 12/3/15. Z3 stated he was first to R1's side and performed the Heimlich. Z3 stated he felt R1 had cleared R1's airway and she sat back down. Z9, Developmental Technician called down and to notify nursing R1 had choked. At this time, R1 appeared to have started choking again as she stood up and her face was dark purple.

Z3 resumed abdominal thrusts and finger sweeps and nursing arrived within approximately 2 minutes. Z6 arrived along with Z10, Supervior of Unit 14 approximately two minutes after being called. Upon approaching R1, Z6 directed somone to call 911. Z10 called 911. Z3 felt 911 was called approximately 2-3 minutes after R1 began to choke the second time.

Day Training provided certification for employees present on 12/3/15 and advised they teach all employees using Red Cross certification.

Red Cross Life saving measures for someone who is choking include first encouraging the individual to cough. If the individual is unable to cough, speak or breath, have someone call 9-1-1 and initiate back blows and abdominal thrusts as necessary.

A policy titled Handling and Reporting Injuries and Illnesses Procedure revised 5/15 reads as follows:

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Z9999	Continued From page 12 "III. A. 1. In an emergency situation, 911 will be called immediately." (A)	Z9999		

Imposed Plan of Correction

Facility Name: Steven's House

Survey Date: December 15, 2015

Incident Report Investigation of 12/3/2015 IL81954

Violation: A

350.620a)
350.1060e)
350.1210
350.3240a)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1060 Training and Habilitation Services

e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.3240 Abuse and Neglect

This will be accomplished by the following:

1. A Committee consisting of QIDP, KCCDD Developmental Tech, and KCCDD Program Manager to review and revise the policies and to develop a program to address eating deficiencies and potential eating risk. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

   A. Recognition of situations that could be interpreted as eating risk and assistance of safe consumption of meals.
   B. Appropriate reporting procedures for staff.
   C. Appropriate training with the QIDP on effective ISP development, Program development, Program coordination with DT site and education of programs implemented to foster consistency of implementation while providing adequate client protection.
   D. Effectively coordinate with the Day Training site regarding newly implemented program which is to be conducted across all environments.
   E. The Administrator will continue to monitor this for compliance through chart review and training records.

2. The facility will conduct MANDATORY in-services for all staff within 10 days that addresses, at a minimum, the following:

   A. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   B. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

3. The following actions shall be taken to prevent re-occurance:

   A. The above In-Service Education will be reviewed with all staff on a regular basis
   B. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.

Completion Date: Twenty days from receipt of the Imposed Plan of Correction.