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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1220b)3 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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applicable. (Section 3-202.2a of the Act)
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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.1220 Supervision of Nursing 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.
These Requirements are not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure residents with complicated feeding problems were fed by a licensed staff, and to have a charge nurse assessment prior to allowing unlicensed staff feed residents for one of six residents (R8) reviewed for swallowing difficulties in the sample

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of fifteen. These failures resulted in unlicensed staff (E16) feeding R8 and R8 choking on 1/11/16. .

Findings include:

The facility's Resident Attendant policy, no date available, documents: "The facility will use the resident attendant to assist certain residents as assigned in eating and taking fluids...Only those residents who have been evaluated by a nurse or dietitian as appropriate for feeding by resident attendants will be assigned to them; i.e. residents eating in the dining room under supervision and no residents that tend to aspirate or otherwise pose a risk during the feeding process..."

1. R8's Electronic Record, documents that R8 has a diagnosis of Parkinson's disease.

R8's Minimum Data Set (MDS), dated 12/17/15, documents in Section K: Swallowing/Nutritional Status that R8 has coughing or choking during meals or while taking medication, and in Section G: Functional Status that R8 is totally dependent on one assist staff for eating.

The facility's Resident's to be fed list, no date available, documents: "Residents to be fed by Certified staff only-CNA's (Certified Nursing Assistant), LPN (Licensed Practical Nurse), RN (Registered Nurse): R8."

R8's Physician's Orders, dated 1/2016, documents that R8 received an order on 9/2/15 for a regular diet with pureed texture.

R8' Care plan, dated 12/17/15, documents: "R8 does need some assistance with eating as well

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due to R8's advanced Parkinson's disease. R8 has had multiple choking episodes while being fed. R8 had a swallow study done that did show a deficit but the doctor and family still wanted food to be regular consistency. After R8's last choking episode on 9/1/15 doctor did change diet to pureed and family agreed...9/27/15 R8 was diagnosed with aspiration pneumonia after taken to the emergency room after returning from an overnight stay and family became concerned because R8 had several choking episodes...Interventions: Diet as ordered: General pureed; do not feed R8 unless R8 is completely alert; Monitor for signs/symptoms of dysphagia."

R8's Care plan has no documentation specifying which staff members are able to feed R8. On 1/14/16 at 11:30 a.m., E4 (MDS/Care plan Coordinator) confirmed this was not on the care plan.

R8's Nutritional Assessment, dated 7/2/15, documents: "Nutritional Risk Assessment Summary: Difficulty chewing and delayed pharyngeal swallowing phase. Speech therapy working with (R8). Nursing notes that resident coughs some when fed..."

R8's Speech therapy progress and discharge summary, dated 7/24/15, documents: "Impact on burden of care/daily life: at risk for aspiration/pneumonia, malnutrition/dehydration. Precautions: aspiration..."""

R8's Progress noted, dated 8/1/15 at 11:10 a.m., documents: "Activity aide came to get (E8/LPN) stating (R8) was choking. Upon walking in (R8) had a half dollar size piece of food in the back of (R8's) mouth that (R8) was trying to cough out. (R8) taken out of activity and into bathroom and

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(R8) had dislodged it on her own and was spitting it out. The item was a partially chewed up piece of sausage from breakfast."
R8's X-ray video fluoroscopy report, dated 8/5/15, documents the reason for the exam was choking and the results were stasis or pooling with various substances, and there was element of penetration with thin liquids and nectar.
R8's Progress note, dated 8/7/15 at 8:36 a.m., documents: "(R8) became choked at breakfast when (Z1 /R8's husband) was feeding (R8) a regular diet of pancakes and sausage. (R8) was finally able to swallow and clear (R8's) airway. (Z1) then gave (R8) pudding to which (R8) began coughing while swallowing."
R8's Speech therapy progress and discharge summary, dated 8/17/15, documents: "Summary of skilled services provided since start of care: Safe swallow guidelines developed and the staff inservicing completed. Impact on Burden of Care/daily life: at risk for aspiration/choking. Precautions: aspiration..."

R8's Progress note, dated 8/23/15 at 12:13 p.m., documents: "(R8) became choked on prime rib at lunch. Was able to cough and expel food."

R8's Progress note, dated 9/1/15 at 9:32 p.m., documents: "At 5:50 p.m., (E14 LPN) called to dining room by (E17 RN/Paid feeding assistant instructor) and (R8) was noted with eyes open, mouth open unable to speak or expel air. (E14) and (E17) assisted (R8) to feet and (E14) began Heimlich maneuver. After three thrusts (R8) was able to expel air, small amount of food and water. (R8) able to breath at this time and lips noted blue but color returning to lips...Lung sounds noted to be clear and diminished bilateral anterior and posterior. (R8) noted with wet harsh non-productive cough..."

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R8's Physician Progress note, dated 9/2/15 at 3:33 p.m., documents: "Diet changed due to choking episode on 9/1/15."

R8's Nutritional Assessment, dated 9/24/15, documents: "Nutritional Risk Assessment Summary: Difficulty chewing and delayed pharyngeal swallowing phase. Speech therapy working with (R8). Nursing notes that (R8) chokes some when fed prior to the pureed diet..."

R8's Progress note, dated 9/26/15 at 10:08 p.m., documents: "(Z1) took (R8) at 10:00 a.m. this morning. (Z1) called at 4:00 p.m....(Z1) stated that (R8) choked several times and (Z1) was scared it may be the last time...(R8) came back with family at 5:50 p.m...(R8) was unable to eat or drink...The doctor on call was called and (R8) was sent to emergency room for possible aspiration."

R8's Phone order, dated 9/26/15 at 7:37 p.m., documents that R8 received an order to be sent to the emergency room for evaluation and treatment for possible aspiration.

R8's Progress note, dated 9/26/15 at 10:45 p.m., documents: "Nurse from emergency room called to report that (R8) would be returning to the facility with the diagnosis of Pneumonia bacterial right lower lobe and dysphagia from CVA (Cerebrovascular Accident)."

R8's Emergency room physician documentation, dated 9/26/15, documents: "(R8) presents to the emergency room via wheelchair with complaints of possible aspiration..."

R8's Emergency Room physician's orders, dated

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9/26/15, documents an order for aspiration precautions.

R8's Progress note, dated 10/7/15 at 5:35 p.m., documents: "(Z2/R8's daughter) feeding (R8) in dining room. CNA called nurse over stating that (R8) was choking on mashed potatoes. (R8) noted to have large bite of mashed potatoes in mouth. (R8) was able to clear own airway at this time."

R8's Nutrition note, dated 10/8/15 at 4:22 p.m., documents: "(R8) has continued to loose weight and presents with chewing/swallowing difficulty in the form of choking..."

R8's Progress note, dated 11/26/15 at 2:04 p.m., documents: "(R8) was out with family and began choking. Once (R8's) throat was cleared (R8) was struggling with (R8's) breathing. Family brought (R8) back to the facility and (R8) is now breathing fine with no trouble."

R8's Progress note, dated 12/5/15 at 11:55 a.m., documents: "(R8) got choked up on (R8's) lunch, but was able to clear it herself by coughing and deep breathing."

R8's Nutrition Note, dated 12/10/15 at 12:18 p.m., documents: "Regular pureed diet...Continues with occasional choking episodes. Swallow evaluation competed with recommendations for pureed diet..."

On 1/11/16 at 11:50 a.m., R8 was being fed pureed broccoli, mashed potatoes, beef, and applesauce by E16 (Activity Director/feeding assistant).

R8's Progress note, dated 1/11/16 at 1:02 p.m.,

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documents: "(E18 LPN/Licensed Practical Nurse) was called to the dining room at 12:15 p.m. due to (R8) choking on (R8's) lunch. Two nurses were present along with E16(Activity Director/Feeding Assistant). (R8) was taking breaths and working on clearing the material in (R8's) throat...(R8) did get food particles dislodged and is now breathing without difficulty."

On 1/13/16 at 12:10 p.m., R8 was being fed a pureed diet of pudding, applesauce, mashed potatoes with gravy, peas, meatloaf, and gelatin cake by E16. During this feeding, R8 had occasional coughing.

On 1/13/16 at 12:25 p.m., E16 stated, "I am the Activity Director not a CNA. I just completed the feeding classes. Often when (R8) eats (R8) coughs. (R8) has swallowing issues. I was feeding (R8) on 1/11/16 when (R8) had a choking spell. After I fed (R8) a small bite of mashed potatoes (R8) started gagging, and it looked like (R8) might vomit. So I got the nurses and CNAs. I jump in and help residents who need assistance feeding. I can assist any of the residents...I completed the feeding program 12/29/15."

On 1/13/16 at 1:55 p.m., E18 (LPN) stated, "On 1/11/16 (E16) was feeding (R8) when (R8) choked."

On 1/13/16 at 2:10 p.m., E17 (Paid Feeding Assistant Instructor) stated, "The feeding assistants are allowed to feed almost anyone as long as they don't have a swallowing/choking issues or frequent aspirations....At times (R8) can be fed by a paid feeding assistant on certain days but not all days...(E16) was feeding (R8) today. I don't think there was an actual written feeding assessment done."

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On 1/13/16 at 3:55 p.m., E21 (Paid Feeding Assistant) stated, "I have a certificate for paid feeding assistance completed on 8/6/2014. I have fed (R8) who I've fed only one time on 1/8/15..."

On 1/13/16 at 6:20 p.m., Z1 was assisting R8 with drinking a glass of chocolate milk with a straw when R8 began coughing trying to catch R8's breath. Z1 removed R8's drink and pushed R8 forward in R8's high back wheelchair. Z1 began rubbing R8's back and R8 was able to clear the liquids herself.

On 1/13/16 at 6:25 p.m., E17 stated, "I am over the paid feeding assistant program. I have taught two classes in the last year. The paid feeding assistants can feed anyone as long as the nurse taking care of the resident says it is ok. I am not aware of any assessment done by the nurses of which residents are able to be fed safely by a feeding assistant. I put (R8) on the only to be fed by CNA or nurses' list because (R8) has Parkinson's swallowing issues. Paid feeding assistants usually are not allowed to feed (R8). (E16) fed (R8) at lunch 1/13/16...(E16) has taken the feeding class, but is not a CNA. (E16) feeds any resident, including (R8)...The doctor ordered a pureed diet for (R8) due to (R8's) choking."

Z3's (R8's Hospice Doctor) Progress note's, dated 1/14/16, documents: "9/29/15: (R8) has increased dysphagia and is on a pureed diet...10/6/15: (R8) coughs and chokes with bigger intake...12/29/15: (R8) choking and dysphagia...1/12/16: (R8) had single episode of choking..."

On 1/14/16, E18 (LPN) stated, "It is sporadic with (R8)...We watch (R8) for coughing while (R8) is

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eating...I did not do a risk management 1/11/16 with the choking incident. It was reported to the family and hospice. Up until 1/13/16 the feeding assistants could feed anybody. No other interventions to prevent choking have been implemented for (R8)....Paid feeding assistants can feed all other residents. There is no formalized assessment done to determine which residents the paid feeding assistants can feed."

On 1/14/16 at 9:40 a.m., E2 (Director of Nursing) stated, "The paid feeding assistants are not allowed to feed (R8). (R8) is the only resident the paid feed assistants can not feed. (E16) I know was feeding (R8) 1/13/16 and was not suppose to. (E16) should have known (E16) was not suppose to feed (R8). (E16) was told this in the paid feeding assistant class. (E16) was certified on 12/29/15 as a paid feeding assistant...There is no formal assessment done by the nurses, care plan coordinator, or myself of the residents to decide who the paid feeding assistants can feed. It is not on the resident's plan of care if the resident can be fed by the paid feeding assistants. The nurses notify me if the Heimlich was done if choking occurred. The nurses do not do risk management for that...I do not know if this was put on the care plan or new interventions implemented...We do not do actual investigations with the choking incidents, not on paper. When the Heimlich maneuver was performed on (R8) I'm not sure if it was reported to the state agency. I do not feel that is is safe for a paid feeding assistant to feed (R8) because of (R8's) choking episodes."

On 1/14/16 at 9:55 a.m., Z4 (Speech Language Pathologist), stated, "I've seen (R8) quite a bit. (R8) was discharged for speech therapy several months ago...Someone needs to feed (R8) who is

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S9999	Continued From page 10 trained and licensed because (R8) is a choking hazard. (R8) pockets food, inhales food, and (R8's) alertness level varies throughout the day." On 1/14/16 at 10:50 p.m., E 24 (Medical Director) stated, "(R8) choked previously while (R8) was at home prior to admission...(R8) is a very difficult feed. (R8) is especially high risk for choking because of (R8's) diagnosis of a special form of Parkinson's disease. It is Pseudobulbar or swallowing difficulty type of Parkinson's...I think (R8) has a complicated swallowing problem that requires certified or licensed staff to feed (R8)." (A) 300.615 Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) The REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to initiate criminal background checks within 24 hours of admission for	S9999		

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two of two residents (R17 and R18) reviewed for identified offender checks in the sample of 15, and four residents (R19-R22) in the supplemental sample. This failure has the potential to affect all 67 residents in the facility.

Findings include:

The facility's Identified Offender Policy dated 02/2015 documents, "Within 24 hours of admission of a resident, a request for a UCIA (Uniform Conviction Information Act) criminal history background check will be submitted through the Illinois State Police."

The New Resident Admission Logs dated December, 2015, documents R17 was admitted to the facility on 12-18-15, R18 was admitted to the facility on 12-31-15, R19 was admitted to the facility on 12-29-15, R20 was admitted to the facility on 12-24-15, R21 was admitted to the facility on 12-23-15, and R22 was admitted to the facility on 12-23-15.

The Illinois State Police Criminal History Information Response Process Inquiry (CHIRP) dated 12-22-15, documents the facility did not request R17's criminal background check until 12-22-15.

The Illinois State Police CHIRP dated 12-28-15, documents the facility did not request R20, R21, and R22's criminal background checks until 12-28-15.

The Illinois State Police CHIRP dated 1-6-16, documents the facility did not request R18 and R19's criminal background checks until 1-6-16.

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S9999	Continued From page 12 On 1-12-16 at 8:25 a.m., E5 (Director of Social Services) verified that R17, R18, and R19-R22's criminal background checks were not requested within 24 hours of admission, and the date on the Illinois State Police CHIRP was when the background checks were requested from the facility. E5 stated, "Criminal background checks are to be done within 24 hours of admission. I am responsible for requesting them. If I am not scheduled to work when the residents are admitted, then I request the background checks on the day that I return to work. The background checks are not being done within 24 hours of admission." The Centers for Medicaid and Medicare Services (CMS) form 672 , the Resident Census and Condition of Resident's Report dated 1/11/16 and signed by E4 (Minimum Data Set (MDS) Care Plan Coordinator), documents at the time of the survey 67 residents reside in the facility. (AW) 300.670 SECTION 300.670 DISASTER PREPAREDNESS c) c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures The REQUIREMENT was not met as evidence	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009864	A. BUILDING: _____ B. WING _____	01/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY VILLAGE	1200 EAST GRANT STREET MACOMB, IL 61455

(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
S9999	Continued From page 13 by: Based on interview and record review the facility failed to have two Disaster Drills per year and for all shifts in the facility. This has the potential to affect all of the 67 residents residing in the facility at this time. Findings include: A Disaster Drill/Tornado Drill dated 4/01/15 documents one disaster drill was conducted by E27 (Maintenance Director) at 2:30 PM on 4/01/15. The disaster drill from 4/01/15 was the only record of a disaster drill provided for the past year. On 1/13/16 at 11:00 AM E27 (Director of Maintenance) stated the facility does not conduct two disaster drills for all three shifts per year. E27 stated, "I only have the one sign in sheet (for second shift only) for the Disaster Drills. That's all we have." E27 was unable to provide a policy which indicated how many disaster drills would be conducted per year and on each shift. According to the Centers for Medicaid and Medicare Services (CMS) form 672 , the Resident Census and Condition of Resident's Report dated 1/11/16 and signed by E4 (Care Plan Coordinator), documents at the time of the survey 67 residents resided in the facility. (B)	S9999		

Imposed Plan of Correction
NAME OF FACILITY: Wesley Village
DATE January 19, 2016
TYPE OF SURVEY:
Annual

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1220b)3

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Attachment B
Imposed Plan of Correction

Section 300.1220 Supervision of Nursing 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.

This will be accomplished by:

I. Provide education for all departments on facility's policy and procedures for feeding /assistant programs with emphasis on supervision of residents that require assistance for feeding.

II. Director of Nursing or Designee will monitor and maintain current up to date care plans and monitor nurse's aides to ensure residents who require assistance for nutrition unless resident care plan indicates otherwise.

III. Nursing administration will do random observations of residents that require assistance with nutrition to ensure direct care staff is providing supervision as per residents care plan.

IV. Quality Assurance programs implemented to ensure continued compliance with the facilities policies and procedures.

V. Facility Administrator to provide oversight for continued compliance.

Date of completion: Ten days from receipt of the Imposed Plan of Correction

02/23/2016/JP