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 |
|---|---|---|---|
| | IL6013940 | A. BUILDING: _____ B. WING _____ | C 03/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MADISON TERRACE | 95 NORTH MAIN WOOD RIVER, IL 62095 |

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| Z 000 | COMMENTS<br><br>Incident Report Investigation of 2/21/16/IL83556 | Z 000 | | |
| Z9999 | FINDINGS<br><br>Statement of Licensure Violations<br><br>350.620a)<br>350.1210<br>350.1210b)<br>350.3240a)<br><br>Section 350.620 Resident Care Policies<br>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.<br><br>Section 350.1210 Health Services<br>The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:<br>b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.<br>Section 350.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These requirements were not met as evidenced by:<br>Based on interview and record review, the facility | Z9999 | Attachment A<br>Statement of Licensure Violations | |

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failed to ensure the safety of 1 of 1 individuals (R1) who choked on multiple pieces of bread and expired as evidence by the facility's failure to:

To have sufficient staff scheduled to have sufficient staff scheduled to provide adequate care, monitoring, and supervision for 4 residents (R1, R2, R3 and R4) with profound IID who reside in the facility.

To ensure competent staffing and programming for R1 who; required his food and drink to be prepared to honey consistency, was known to have a history of aspiration, and had recently demonstrated food stealing behavior/s.

To thoroughly investigate a choking incident for 1 of 1 individual (R1) which occurred on 2/21/16 and resulted in R1 gaining unsupervised access to bread and choking; emergency personnel being called to intervene and transport R1 to the hospital. R1 was put on a ventilator and expired on 2/29/16.

Findings Include:
The facility's initial incident report of 2/22/16 documents on 2/21/16: R1 choked on a piece of bread; R1was taken to the emergency room at approximately 11am.; and R1 was admitted to the hospital for observation.

R1's Individual Service Plan (ISP) of 7/29/15 documents R1 is a 47 year old ambulatory non-verbal male who functions in the Profound Range of Individuals with Intellectual Disabilities (IID). R1 has additional diagnoses of Down's Syndrome, Swallowing Difficulties, and a History of Aspiration. R1 is to have his food and drink prepared to honey consistency.

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On 2/29/16 at 10:15 an interview was conducted with E2, Qualified Intellectual Disabilities Professional (QIDP). E2 verified there are 4 male individuals who reside in this facility and function in the profound range of Intellectual Disabilities. R3 and R4 utilize a wheelchair for mobility and needs assistance by staff to transfer to/from the toilet.
R2 has a history of seizures and requires stand by (1-on-1) assist with ambulation due to history of falling. The recommendation by R2's Interdiscplinary Team (IDT), was that R2 have someone with him 1-on-1 due to R2 getting up at random and falling. The facility was in the process of fading out R2's 1-on-1 supervision." E2 stated "the 1-on-1 stand by staff for R2 had been utilized as a second staff." E2 verified the facility failed to schedule an additional staff along with R2's 1-on-1 to meet the needs of the other individuals.

E2 stated; "R1 does have a behavior of stealing food at the table from other residents. The facility informally was having R1 eat before the other individuals to prevent food stealing and decrease the chance of aspiration."
E2 also stated: " In the last 2-3 months, R1 was attempting to take food off the kitchen counter and needed to be monitored closely by staff." The facility was unable to produce any evidence that R1's behavior of stealing food had been addressed.

R1's 8/1/15 eating program documents R1 had a maintenance program to ensure that staff were monitoring R1's eating to ensure that R1 ate at slower pace, but did not include details about R1 stealing from others.

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On 2/29/16 an interview was conducted with E3, Direct Support Person (DSP). E3 stated that " I (E3) was scheduled on 2/21/16 from 7:30am-3:30pm. The midnight staff leaves at 9:00am ... I (E3) was the only staff until 12:00pm with the 4 individuals. The second staff (E4) is scheduled from 12:00pm-8:00pm.."
E3 stated: "around 10:00am, I (E3) had taken R3 down the hall to assist him in transferring to the toilet. R2 was using the bathroom in the front of the hall. R4 was in his bedroom watching a movie and R1 was sitting in the living room."
E3 heard the kitchen door open and knew that R1 was in the kitchen. E3 stated "it was approximately 5 minutes before I (E3) was able to check on R1. R1 was coming out of the kitchen holding a bread bag that was on the counter ... there were 5 pieces of bread in the bag after breakfast."
E3 took the bread bag out of R1's hand and R1 returned to the living room. E3 noticed a piece of bread in his mouth and swept R1's mouth.
R1 walk back to his bedroom and E3 followed a few minutes later. R1 was discovered to be lying on his side with his head off the bed and pieces of bread on the floor. R1 was unresponsive. E3 called 911 and immediately started CPR. E3 stated during thrust R1 coughed up some more bread. EMT personnel appeared within 10 minutes and took over.
E3 called E2, QIDP and few minutes later E4, House Manager appeared at the facility.

On 2/29/16 an interview with E4 was conducted. E4 stated "I (E4) received an upsetting call from E2 around 10:40am on 2/21/16. I (E4) was informed there was an emergency at the facility concerning R1." E4 stated: "I (E4) live within a few miles from facility and when I (E4) arrived all 3 individuals were in the living room and E3 was

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upset in the office." E4 proceeded down to R1's room. E4 was told by the EMT that R1 had a pulse and was shown a bolus of bread the size of a doughnut hole that had been removed from R1's mouth. R1 was transferred to the local emergency room by ambulance.

The 2/21/16 hospital admission records document R1's admitting diagnosis was respiratory arrest. R1 was placed on a ventilator and expired on 2/29/16 at 6:05pm.

The January, 2016 and February, 2016 facility staff schedules document: Six different days in January (8th, 16th, 23rd, 30th & 31st), 2016 when there was only 1 staff scheduled for 2 hours; and three days in February (6th, 20th & 21st), 2016 when there was only 1 staff is scheduled for 3 hours.

On 2/29/16 at 10:15 an interview was conducted with E2, Qualified Intellectual Disabilities Professional (QIDP). E2 stated "the second staff had been utilized as a 1:1 for R2. R2 has a history of falling and a recommendation by the IDT was that R2 have someone with him 1-on-1 due to R2 getting up at random and falling. The facility was in the process of fading out R2's 1-on-1 supervision." E2 verified the facility failed to schedule an addition staff along with R2's 1:1 to meet the needs of the other individuals

The Facility's Neglect Policy (dated 12/15), documents the definition of Neglect as: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

On 2/29/16 at 10:30am an interview was conducted with E2, QIDP. E2 stated: "the Safety

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| Z9999 | Continued From page 5<br><br>Committee met on 2/22/16 and completed a summary of the incident from 2/21/16."<br><br>The 2/22/16 Summary of Incident documents: "On 2/21/16, E3 (Direct Support Person) took an individual to the bathroom. E3 heard R1 go into the kitchen. R1 is on a pureed diet. E3 came out of the bathroom and found R1 holding a bag of bread with his mouth full. E3 followed R1 to the chair in the living room and attempted to remove the bread out of his mouth. R1 then went to his room. E3 followed R1 shortly after and when she entered R1 was unresponsive. E3 called 911 and immediately started CPR. When paramedics arrived R1 was taken to the ER."<br><br>The Safety Committee concluded with:<br>A) In-service given to staff on keeping food off the counters in the kitchen so R1 does not try to eat any food and<br>B) Having 2 staff working on the weekends to hopefully prevent another incident of choking.<br><br>On 2/29/16 at 2:00pm, an interview was conducted with E1, Administrator. E1 stated: "The facility did not complete a thorough investigation to include interview statements from all staff (staff that were called in to assist after 911 responded) and ensure appropriate actions were taken by the facility."<br><br>(A) | Z9999 | | |

**IMPOSED PLAN OF CORRECTION**
NAME OF FACILITY: Madison Terrace-14G333
DATE AND TYPE OF SURVEY: 3/3/16, IRI of 2/21/16/IL83556

**Licensure Violations:**
350.620a)
350.1210
350.1210b)
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 350.1210 Health Services**
The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following:

b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent.

**Section 350.3240 Abuse and Neglect**
a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.*

## This will be accomplished by:

I. The facility will review policy and procedures on all nursing services including: adequate staffing, safety, supervision, abuse and neglect per resident individualized service plans and make policies available to all staff, residents and public, at a minimum the following:
   A. Recognition of situations that could lead to resident injury and/or death or mental anguish.
   B. Appropriate staff and supervision based on resident individual service plan
   C. Appropriate and thorough investigations and follow-ups of accident hazards, inadequate assistance and supervision.
   D. The facility's responsibilities to prevent further potential abuse and or neglect while the investigation is in progress.

II. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:
   A. How to identify and report allegations or suspicions of abuse or neglect and implement facility policies on nursing services.
   B. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
   C. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
   D. 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.

I. The following actions will be taken to prevent re-occurrence.
   A. The above In-Service Education will be reviewed with all staff on a regular basis.
   B. Supervisory staff will ensure that the State Regulations regarding nursing and health services (reporting and follow-up) are followed.
   C. Supervisory staff will ensure there is sufficient staff to carry out established resident care procedures, safety and supervision for all residents.

III. Documentation of in-service training, assessments and related follow up actions will be maintained by the facility.



Attachment B
Imposed Plan of Correction

IV. The Administrator, the facility representative will monitor Items I through III to ensure compliance with this Imposed Plan of Correction.

Completion Date: Ten days from receipt of the Imposed Plan of Corrections.

Attachment B
Imposed Plan of Correction