Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OFCORNECTION	IDENTIFICATION NOTIFICA	A. BUILDING:		COMPLETED	
		IL6014666	B. WING		C 03/30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
DUNHAN	I REHAB & HEALTHO	CARE 850 DUNI				
- OOTTI A		ST CHAR	LES, IL 601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE	
S 000	Initial Comments		S 000			
	Complaint investiga	ation # 2171872/IL00131944.		8		
S9999	Final Observations		S9999		9	
	Statement of Licens	sure Violations:				
	300.610a) 300.1210b) 300.1210d)2)6) 300.1220b)2)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory confursing and othe policies shall complime written policies the facility and shall	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
ħ	b)The facility shall p and services to atta	General Requirements for nal Care provide the necessary care hin or maintain the highest I, mental, and psychological		Attachment A		
	well-being of the re-	sident, in accordance with nprehensive resident care		Statement of Licensure Violations		
Illinois Depar	rtment of Public Health		1	1		

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

TITLE

(X6) DATE

03/30/2021

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 A. BUILDING: _ C

IL6014666

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

NAME OF		DRESS, CITY, ST	TATE, ZIP CODE			
DUNHAM REHAB & HEALTHCARE 850 DUNHAM RD ST CHARLES, IL 60174						
(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 1 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: 2)All treatments and procedures shall be administered as ordered by the physician. 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.	S9999				
	Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were not met evidenced					
linois Denar	by: Based on interview, and record review, the facility failed to supervise a resident (R1), who had a medical condition of dysphagia (difficulty tment of Public Health	^				

E0BL11

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6014666	B. WING	C 03/30/20		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DUNHAN	REHAB & HEALTHO	ARE 850 DUNI- ST CHAR	IAM RD LES, IL 6017	74		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE COMPLETE	
S9999	Continued From pa	ge 2	S9999			
	swallowing foods or failure, R1 had chok sandwich and ultimate aspiration on 1/31/2 follow physician ord modified diet to a remedical condition or swallowing foods or This applies to 1 of safety related to aspirate to 1 of safety related to 2 of safety related	liquids). As a result of this ked while eating a roast beef ately expired due to food 2021. Also, facility failed to der regarding a prescribed esident (R1) who had a f dysphagia (difficulty liquids). 4 residents (R1) reviewed for biration risk.				
linois Depar		Order Sheet) for the month owed the following orders for				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6014666 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD **DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 3 S9999 R1: -on 1/22/2021, diet was downgraded to a mechanical soft diet and nectar thick liquid. -on the readmission order dated 1/27/2021 were: 1) Mechanical diet and nectar thick liquid 2) Full Code status 3) Physical and occupational therapy 4) Speech therapy for dysphagia management and diet tolerance The Nursing Admission Summary dated 1/27/2021 showed that R1 was alert, oriented to person, and place. The summary also revealed that R1 was a Full Code status. The summary also showed that R1 had "dementia in which he forgets to eat and drink." As indicated on this summary, R1 was on aspiration precautions and that he required supervision when eating. The facility's incident report dated 1/31/2021 showed that R1 was served Italian Beef sandwich for lunch by V6 and V7 (CNAs) on 1/31/2021. After V6 and V7 had opened the wrapper of the Italian beef sandwich for R1 to use his hands to eat, both V6 and V7 had left R1, unsupervised while eating beef sandwich, and french fries that was served to him. V6 and V7 proceeded to pass lunch trays to the rest of the residents in the nursing unit. After V6 and V7 was done passing lunch trays, they passed by R1's room and saw R1 slumped over, skin was pale, and R1 was not responsive, not breathing and no pulse beat. V4 and V5 (Nurses) were summoned immediately and initiated CPR (Cardiopulmonary Resuscitation) and another CNA had called 911 emergency life service. Paramedics worked on R1 and tried to revive him to no avail. R1 expired and pronounced dead at 1:21 P.M. on 1/31/2021. The nurse's progress notes dated 1/31/2021

PRINTED: 05/27/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6014666 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD **DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 4 showed the following events prior to R1's demise: -11:45 A,M. - Entered by Activity Staff: "(R1's) daughter, and granddaughter came around 11:45. The granddaughter brought the food to the front desk. I then took it and delivered it. I left it on his table out of his reach because he was sleeping. I don't know what was in the bag." - 1145 A.M. - Portillo's bag dropped off to facility and front desk delivers food to resident's room and food is placed on bedside table - 1230 - "(V6) passed by residents room and noticed he was slumped over, pale skin color, and immediately yelled out to V5 (Nurse) for help, (V5) runs to V4 (RN) for help. - 1232- (V4) and (V5) initiate CPR (Cardio Pulmonary Resuscitation) and (V4) swipes softened substance out of (R1's) throat, CNA called 911, (V7) went to get oxygen tank, (V6) went to get crash cart. - 1240- EMS arrives at facility and takes over CPR with Police officers waiting by the main door entrance. - 1:30 P.M., (V5) calls (R1's) POA (Power of Attorney) daughter. - 1:40 P.M., (R1's) daughter arrives at facility. states to (V4) "if he choked eating an Italian beef,

then he died happy" please tell the coroner "I do not want an autopsy to be done to him, please

- 3:00 P.M. - Coroner came to facility and took

- 3:00 P.M. - funeral home came to pick up (R1)"

don't let them do that to him"

pictures and did evaluation.

PRINTED: 05/27/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C IL.6014666 B. WING 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 DUNHAM RD DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 During the survey, interviews were held with the following staff who were involved with the care regarding R1's dysphagia treatment and aspiration/swallowing precautions: 1) On 3/26/2021 at 11:30 A.M., interview with V1 (Former Administrator, in charged at the facility at time of R1's choking incident). V1 stated that R1 was on "mechanical soft diet and anyone prescribed with altered/modified diet requires some form of supervision. My CNAs left (R1) room after they set up the Italian Beef from Portillo's that (R1's) family had brought for him. My CNAs then left (R1's) room with the Italian Beef sandwich was within R1's reach without supervision. My CNAs proceeded to pass lunch trays to other residents in the nursing unit. My Activity staff was the one who brought the Italian beef bought from Portillos by (R1's) family for (R1's) lunch. During lunch time on 1/31/2021, R1 was found unresponsive, with the Italian beef sandwich loosely on (R1's) hand. CPR initiated timely, paramedics took over, however, was not able to revive (R1). The (2) CNAs and the Activity were no longer being employed at the facility after this choking incident." 2) On 3/27/2021 at 1:59 A.M., interview with V8 (Activity Aide), stated that R1's daughter had brought a bag of Portillos sandwich to the facility for R1's lunch around 11:45 A.M. on 1/31/2021. V8 also added that this is nothing new since R1's family had always brought Portillos food for R1. V8 added that she delivered the Portillos sandwich bag to R1's room and placed it on the bedside table where R1 cannot reach. V8 also added that she had informed V6 and V7 that she had placed the Portllos sandwich and placed it on R1's bedside table.

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A. BUILDING:			
0,					(c
		IL6014666	B. WING			30/2021
NAME OF I	PROVIDER OR SUPPLIER	eteet an	DDECC CITY	STATE, ZIP CODE		
IVANE OF F	-ROVIDER OR SOFFLIER	850 DUNH		STATE, ZIP CODE		
DUNHAN	REHAB & HEALTHO	ARE "	LES, IL 601	7.4		
	CHARADY CTA		iv.	i		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 6	S9999			Ť-
\$9999	(ĆNA), stated that thave elevated R1's lying in bed in preparation of the variation of variation of the variation of variation	2:05 P.M., interview with V7 ogether with V6, both of them head of bed while R1 was aration for lunch on 1/31/2021. R1 was sleepy and weak. V7 ned the sandwich bag that ught. V7 added that it was a st Beef sandwich, 2 precut ring approximately 4-5 inches marine bread and in it were	S9999			
	the sandwich withou	ndwich wrapper, left R1 eating ut supervision and her and V7 unch trays to other residents.				

PRINTED: 05/27/2021

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6014666 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD **DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOUL DIBE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 7 S9999 V6 added that R1 was on mechanical soft diet and honey thick liquid but no one told her that R1 needs to be supervised. V6 also stated that her employment from the facility was terminated because she did not follow the facility's policy but does not know what kind of policy but was in regards to R1's choking. 5) On 3/27/2021 at 3:10 P.M. interview with V4 (Registered Nurse) stated that on 1/31/2021 around 12:30 P.M., V6 and V7 velled for help because R1 was found unresponsive. V4 added that she and V5 immediately went to R1's room. V4 found R1 lying in bed, unresponsive, not breathing and no pulse. V4 also stated that R1 was loosely holding a precut Italian beef sandwich in his right hand. V4 added that there was a bite or two from the sandwich. V4 also added that she swiped R1's mouth and was able to remove some amount of mushy type off white/light brown color that "most definitely resemble part of the chewy and hard French bread and the sliced roast beef." V4 added that R1 was on a mechanical soft diet and on aspiration risk and needed supervision for eating. V4 added that CPR was initiated immediately. paramedics called and took over R1's care. Despite of paramedics' effort, R1 had expired at the facility as V4 continued to state. V4 also added that she called R1's daughter, came to facility while paramedics were still working on R1. V4 also added that when R1 was pronounced dead, R1's daughter had stated "at least he died happy eating his favorite food." 6) On 3/30/2021 at 9:15 A.M, interview with V5

Illinois Department of Public Health

(Licensed Practical Nurse) stated that she was aware that R1 was on mechanical soft diet, and on aspiration precaution and should have been supervised when eating. V5 also added that she

PRINTED: 05/27/2021 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6014666 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD **DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 8 S9999 was not informed that R1 was served with the Italian roast beef sandwich, because if she would have known, she would have not let R1 eat it since definitely R1 will choke. V5 also added that " even a person with no swallowing difficulty have problems swallowing french bread that was chewy and tough and sliced beef, that though was thinly sliced, they were long." V5 stated that CPR was immediately initiated, paramedics took over but R1 expired at the facility despite efforts were made to revive him V5 also added that R1's daughter was at the facility when paramedics were working on R1. V5 also stated that R1's daughter had stated that "at least he died happy eating his favorite food." 7) On 3/27/2021 at 5:45 P.M., interview with V9 (R1's Attending Physician) stated that she deferred all plan of care regarding swallowing difficulty management and diet tolerance to the speech therapist. V9 also added that she refused to sign the death certificate since R1 was pronounced dead by the paramedics. 8) On 3/28/2021 at 10:30 A.M., interview with V10 (Speech Therapist) stated that he had provided a speech therapy treatment to R1 prior to hospitalization on 1/22/2021 because R1 had swallowing difficulty. V10 also added that he downgraded R1's diet on 1/22/2021 to a mechanical soft, was placed on aspiration precaution due to risk of aspiration. V10 also added that he assessed, evaluated and provided plan of treatment regarding R1's dysphagia/swallowing difficulty on 1/29/2021 when R1 had returned back to the facility from the hospital on 1/27/2021. V10 also added that R1 was placed on a mechanical soft diet, placed aspiration precaution and "needed direct supervision to provide verbal cues to (R1) for

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: C B. WING IL6014666 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 DUNHAM RD DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 9 S9999 safety swallowing techniques like taking a small bite/ swallow, clear throat alternate with honey thick liquid. (R1) will not be able to do this on his own because (R1) lack safety awareness. I told the plan of care regarding safety swallowing precaution to staff and (V5). I did not informed (R1's) family because I did not get a chance and before given a chance (R1) had already choke from the Italian roast beef. (R1) should not have been given that Italian roast beef, it was not the right diet consistency for him and will he definitely choke from it especially no staff was there to supervise and give verbal cues for safety swallowing. I wrote on my documentation distant supervision because in the real, perfect world. they cannot provide that to him because the CNAs were doing other task, but indeed (R1) needed to be directly supervise. His food should be ground meat like the ground meat that was use to mix with a spaghetti sauce. " The Speech Therapy Assessment and Evaluation dated 1/29/2021 made by V10 showed that R1 was assessed as follows: "Short Term Goals: 1. (R1) will safely swallow mechanical soft and nectar thick fluids using alternation of liquids/solids, hard throat clear/re-swallow. effortful swallow, no straws, and general swallow techniques/precautions with 80% of attempts and 20% verbal cues in order to decrease signs and symptoms of oral and or pharyngeal dysphagia. 2. (R1) will complete oral motor exercises given skilled instruction and 35 %. Verbal cues in order improve mastication of solids and to improve lingual ROM (Range of Motion) and strength.

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
IL6014666		B. WING		C 03/30/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD ST CHARLES, IL 60174						
(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	Long Term Goals: 1. (R1) will safely so nectar thick liquids liquids/solids, hard effortful swallow, not techniques/precaut with occasional versigns and symptom dysphagia. Patient Goals: (R1) management and depotential for Achiev good rehab potential swallow 1 step directoregivers/staff, pair and able to make nearticipation: Patier establishing POT (Fee The speech assesses	wallow mechanical soft and using alternation of throat clear/re-swallow, o straw and general swallow ions with 90% of attempts and bal cues in order to decrease is of oral and or pharyngeal goals on dysphagia liet tolerance. In Goals: (R1) demonstrates al as evidenced ability to ctions, supportive rticipation in passive activity eeds known.	S9999			
	dated 5/19/1999 with showed that "Mechan meat ground and of consistency." The facility's Guidel Precautions were: "Residents who reconnected by the short of care to refer t	quire swallowing/aspiration have the following carried out: valuation lect targeted precautions as peech; may include but not			æ. U	

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/27/2021 **FORM APPROVED**

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C IL6014666 B. WING 03/30/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD **DUNHAM REHAB & HEALTHCARE** ST CHARLES, IL 60174 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 11 S9999 S9999 - Head of bed (HOB) elevation - Increased 1:1 supervision" The death certificate showed R1 had expired on 1/31/2021 at 1:21 P.M. with immediate cause of death as "aspiration of food bolus." The death certificate also showed that significant factors that cause the death were: dysphagia and CVA." " AA "