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	IL6005789	A. BUILDING: _____ B. WING _____	C 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARIAN CTR FOR ADULT RESIDENTS	6300 NORTH RIDGE AVENUE CHICAGO, IL 60660

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Z 000	COMMENTS COMPLAINT INVESTIGATION: 2586650/IL196492 FACILITY REPORTED INCIDENTS (FRI) OF: FRI OF 7/10/25/IL196476 FRI OF 7/01/25/IL196042	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.620a) 350.1210b) 350.1220k) 350.1840b)2) 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 b) The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services	Z9999		

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Z9999	Continued From page 1 k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures. Section 350.1840 Diet Orders b) Physicians shall write a diet order for each resident indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate the task of writing a diet order to the dietitian. 2) The diet shall be served as ordered. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting Act. These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to: 1) Implement the required assistance with meals and appropriate interventions for 1 of 1 resident (R1), who showed signs and symptoms of choking on a food item. As a result of these failures, R1 had a choking incident that resulted in R1's death. 2) Failed to follow ordered meal plan for 1 of 1 resident R6 who showed signs and symptoms of choking on a food item. As result of this failure R6 required emergency room evaluation.	Z9999		

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Z9999	Continued From page 2 Findings include: 1) R1's Individual Support Plan (ISP) dated 06/20/2025 indicates R1 is a 40-year-old man diagnosed with severe developmental delay, seizure disorder, and behavior disorder. R1 benefits from minimal to maximal assistance with other Activities of Daily Living (ADL's) depending on the task. R1's 07/2025 Diet Order: General, Diet Texture: Regular, Liquid Consistency: Thin R1's Mealtime Plan dated 5/15/25. Lists the following: -R1 should be seated as upright as possible with 1:1 assistance at meals and prompting slow rate. -R1 should be provided small amounts of liquid throughout his meal. -R1 to Continue soft and bite-sized solids with thin liquids. -R1's device should be turned over to limit distractions. Nurses progress note dated 07/10/25 at 6:05pm indicates that, Nurse report was called at 5:44 PM, Nurses (E4, E20, E29) were in the apartment 5:45 PM to respond to the report. Resident was found in the den unresponsive, sitting in the chair, not breathing, no pulse and no reflex. Resident was pale and cyanotic, mottling of the extremities and the lips were blue. Nurses got the Resident on the floor and started performing Cardiopulmonary Resuscitation (CPR), 911 was called and Automated External Defibrillator (AED) was obtained. Emergency Medical Services (EMS) took over about 5:50 PM. Do Not Resuscitate (DNR) paperwork was provided to EMS. EMS called the provider and called time of death at 6:03 pm.	Z9999		

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Z9999	Continued From page 3 Undated Notification of Death indicates that, R1was eating dinner in R1's apartment between 5:30 and 5:40 PM on 7/10/2025. R1 was sitting in a chair in the den in an upright position with R1's food on the table next to R1. E15 Direct Support Person (DSP) was sitting with R1 in the den. E15 (DSP) had prepared a peanut butter and jelly sandwich that was cut into 8 pieces. E15 (DSP) described R1 as eating very quickly like R1 always does, while E15 (DSP) verbally prompted R1 to slow down. As R1 neared finishing eating the sandwich, R1 began pulling at R1's clothing, and soon R1 began wheezing. E15 (DSP) was unable to perform adequate back blows or get R1 up from the chair to perform the Heimlich maneuver. The chair was positioned in a corner of the room. E15 (DSP) called facility internal emergency number (3010) for an immediate nursing response right after R1 began wheezing. E10 (DSP) was in the apartment and came to the den as soon as (3010) had been called. E10 also mentioned hitting R1 on the back but was not able to do adequate back blows given the position of the chair in the room. E10 and E15 tried to get R1 up to do the Heimlich maneuver, but E10 and E15 were unable to do so. E4 Registered Nurse (RN) responded within a minute or minute and a half after the "nurse report" was called at approximately 5:45pm or 5:46pm. R1 was found unresponsive, not breathing, and did not have a pulse. E4 and E20 (RN) brought R1 to the floor and started CPR. 911 was called and the AED was retrieved. EMS took over at 5:50pm. When DNR paperwork was provided, CPR was stopped, and time of death was noted to be 6:03pm. Facility's phone log and E30 (Receptionist) statement of phone calls made from R1's	Z9999		

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apartment on 7/10/25 indicate that "Nurse Report" (3010) was called twice at 5:43pm and 5:44pm. E30 (Receptionist) at that time, stated that the first call was at 5:43pm, a male voice saying "R1, R1, R1 name repeatedly". E30 did not hang up, hoping someone would come to the phone. E30 stated that the voice saying "R1 name" was in the background, R1's name was not being spoken directly to E30. E30 tried to get E15's attention, but E15 must not have been able to hear E30. E30 stayed on the line, but eventually the E15 hung up. (3010) was called a second time very soon after, and this time the male voice on the other end stated, "Nurse report, R1's apartment, R1". E30 first overhead paged the "Nurse Report" at 5:44pm. E30 then paged "Nurse Report" over the walkie talkie, and through the text app on the phones at 5:47pm. 911 was called at 5:46pm from R1's apartment. Nurse report text came through phones at 5:47pm.

Emergency Medical Services (EMS) Care Report for R1 dated on 7/10/25 at 5:50pm indicates that (EMS) crew were in the facility returning to quarters after the initial call attending to another choking individual. (EMS) was directed downstairs by staff to a patient (R1) who was laying supine on the floor. Staff were crying, screaming, and attempting CPR. Staff acquired an AED and had it placed on the patient (R1) as (EMS) were arriving on the scene with (EMS) equipment. EMS allowed the AED to finish its analysis cycle before switching to EMS monitor. EMS continued CPR because staff were confused about if R1 had a DNR. EMS attempted to clear R1's airway of liquid debris while continuing compressions. R1 had profuse vomit in R1's mouth and on R1's shirt on arrival. R1 was mottled in R1's hands and cyanotic in R1's

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Z9999	Continued From page 5 face. R1's Death Certificate dated on 07/11/2025 listed: -Date of Death 07/10/2025 -Cause of Death: (a) Asphyxiation (body is deprived of oxygen, leading to unconsciousness or death). (b) choking on food bolus. On July 28th, 2025, at 4:48 p.m., E10, (Direct Support Person) DSP stated that he (E10) worked in R1's apartment on July 10th, 2025. Dinner starts at 5:00 pm. R1 came out of R1's room a few times, wanting help with R1's IPad (portable computer). R1 walked back and forth to R1's bedroom. E10 was cleaning up after dinner at 5:30pm. E10 was assigned to do laundry after dinner and started preparing for laundry. E15 (DSP) came to the kitchen and prepared a peanut butter and jelly sandwich for R1. R1 usually eats whenever R1 is ready and not with other peers. E10 could hear R1 and E15 in the den but could not hear what E15 and R1 were saying. E10 was not sure when E15 and R1 went to the den and E10 was not aware that R1 was eating in the den. E10 was in the kitchen preparing to do laundry when E10 saw E15 running to get the phone at the phone station. E15 grabbed the phone and E15 went back to the den. E15 did not ask for help with R1. E10 followed E15 to the den because E10 thought that R1 was having a seizure and E15 might need help. Typically, R1 shakes during seizure activity. R1 was not shaking, R1 was sitting in the chair, and it appeared that R1 was choking. R1 was turning purple and there was food in R1's mouth. E10 could not do back blows but was trying to hit R1's back. E10 and E15 tried to get R1 out of the chair to perform Heimlich maneuver but could not manage to do so. E15 then told E10 to go and get	Z9999		

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the supervisor. E10 went to the supervisor's office but the supervisor was not there, E10 ran back to the apartment. E4 and E29 Registered (RN)Nurse were entering R1's apartment at the time and started doing CPR to R1.

On July 28th, 2025, at 6:00 p.m., E4 Registered Nurse (RN) stated E4 arrived in R1's apartment just over a minute from when the Nurse report was called, R1 was slumped over in a chair in the den. R1 was not breathing and R1 had no pulse, R1 was purple, lips pale white, and R1's skin seemed mottled. There was fluid on the floor which appeared to be R1's urine. E15 was with R1 in den sitting by the table next to R1. E15 should have performed the Heimlich Maneuver to R1 and ask E10 to call 911. E15 and E10 should have called 911 after the first Heimlich attempt was unsuccessful. E4 began compressions while R1 was in the chair as soon as E4 arrived to R1's apartment. E20 (RN) arrived seconds later, E20 and E4 put R1 on the floor from the chair and continued compressions. 911 was called (although still in building from other 911 call), E4 and E20 stopped doing CPR when EMS arrived, which was around 5:50pm. EMS continued CPR until R1's DNR paperwork was retrieved.

On 8/04/25 at 09:03 am, E29 Registered Nurse (RN) stated that it was the 2nd Nurse report of the evening. E29 showed up in R1's apartment with E4. E20 was 30 seconds behind us. E4 and E29 were in the apartment at the same time. E29 came in the living room door, turned left and saw E15 in the control station going through the cabinets. E4 headed past the control station and screamed R1's name. E29 was 5-10 seconds behind E4. R1 was in the den in a chair, seated and slumped over. E4 was giving R1 compressions/sternal rub when E29 told E4 to

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lower R1 to the floor and to continue compressions. R1 did not have color on the lips and face. R1's lips were blue, probably one of the most textbook things E29 have seen. R1 had no pulse, was not breathing. E29 did not know if 911 was called. E20 and E29 did not really have relief from the chest compressions. No staff was with R1 in the den.

On July 30th, 2025, at 3:03 p.m., E20 Registered Nurse (RN) stated that R1 was not responsive, not breathing, and had no pulse. R1 skin was blue and grayish. E20 helped to pull R1 to the ground and perform CPR. There was a lot of clear liquid on the floor, which might have been R1's urine. E20 was also trying to get the EMS to come from upstairs because they were still in the building.

On July 30th, 2025, at 3:03 p.m., E9 (Nursing Supervisor) stated that E15 is trained to initiate abdominal thrusts and giving back blows. E15 failed to initiate the Heimlich Maneuver and back blows as well simultaneously calling for the other staff that were working in the apartment to call 911 immediately then call "Nurse Report." (3010). R1's meal plan is in a binder in R1's apartment, the meal plans should have R1's information, like the size of the food, types of foods, and drinks. R1 typically eats in the dining room and is monitored 1:1 during meals to provide either physical or verbal prompts for pacing as well as like take a drink in between bites or every couple bites. R1's meal plan 5/15/25 indicates to provide small amounts of liquid throughout R1's meal. E15 failed to provide R1 with small amount of liquid throughout R1's meal as recommended, which contributed to R1 choking to death.

On July 30th, 2025, at 11:04 a.m., E16 Nurse

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Practitioner (NP) stated that R1 was found in the den choking. It is not typical for R1 to eat in the den. R1 has some behavioral issues that sometimes R1 would start eating like at the table and then R1 would get up and try to get to the den to watch R1's IPad (portable computer) or whatever reason to get into the den. When R1 was turning blue, that means R1's airway was obstructed. E15 staff should have acted accordingly and start the Heimlich maneuver and ask someone to call 911 immediately and then call Nurse Report (3010). If R1 turns blue and pulseless, E15 should have started CPR.

On July 31st, 2025, at 11:14 a.m., E19 On the Job Trainer (OJT) stated that DSP training occurs every year, as well as CPR and includes emergency situations and specific protocols for 911 and 3010 calls, which are reviewed throughout the training process. Staff have opportunities to revisit topics they are uncomfortable with and receive additional training or shadowing. Staff are trained in cases of immediate life-threatening emergencies (e.g., blue lips, unresponsiveness), staff should call 911 first, then 3010 to alert the facility. After calling 911, staff must call 3010 to inform the facility of the emergency and the location for emergency responders.

On July 30th, 2025, at 10:17 am, E1 (Assistant Vice President) stated that Both E10 and E15 were present in the den after 3010 was called. R1's chair was up against a wall. Attempt to pull out R1's chair to do back blows failed. Back blows are most effective when you can stand somebody up and bend them over and then hit their back, but there wasn't movement of R1's chair. R1 was dead weight. Back blows and Heimlich maneuver were not able to be given.

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Facility's Cardiopulmonary Resuscitation (CPR) and First Aid certificates indicates E15 (DSP) was current in E15's CPR/First Aid at the time of the 07/10/25 choking incident for R1. E15 received training on 1/10/2024. The training certificates indicated the training was valid for 18 months.

Facility's internal Investigation Report dated on 7/21/2025, under additional conclusions, indicates that the findings were substantiated for neglect. E15 chose to not adhere to R1's Mealtime plan. During the interview with E15 on 7/15/25, E15 indicated that E15 usually gives R1 something to drink when R1 was done eating, which does not comply with R1's mealtime plan. R1's most recent Mealtime Plan, dated 5/15/25, indicates that R1 should be provided small amounts of liquid throughout R1's meal. This was again confirmed during E15's interview on 7/16/25 at which time E15 indicated that he did not give R1 something to drink because R1 drinks fast and always wants more. E15 would not have provided R1 with more drinks because E15 was in the den. E15's Discharge Notice dated 7/21/2025, indicates Nature of Violation as failure to follow R1's Mealtime Plan. E15 was discharged from the facility as of 07/21/2025.

2) Facility's Incident dated on 7/1/2025 indicate that R6 choked on a piece of meat (brisket) during dinner. 3010 was called and the Heimlich maneuver was performed. It was later discovered that the meat R6 was choking on was not fully cut to the recommended consistency that is safe for R6. R6 must have soft, and bite sized food (dime sized) and the meat given was not dime sized. Upon investigation, it was concluded that the bite R6 had taken was bigger than dime sized, R6 was taken to the hospital for further evaluation.

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R6 returned from the hospital on 7/1/25 at 10:55 PM.

R6's Individual Support Plan (ISP) dated 07/20/2025 indicates R6 is a 68-year-old female diagnosed with seizure disorder, severe intellectual disability. R6 requires supervision and some assistance for thoroughness and accuracy with Activities of Daily Living (ADL) such as toileting, grooming and eating.

R6's 07/2025 Diet Order: General diet, Texture: Regular, Liquid Consistency: Thin.
Mealtime Plan Dated 01/21/2025 list the following:
-Cut food as necessary.
-R6 should NOT be offered foods with small seeds (i.e., strawberries, raspberries, blueberries, fig newtons, etc.).
-Encourage fluids.

On July 28th, 2025, at 4:37 p.m., E9 (Supervisor) stated that E9 was in E9's office when "Nurse Report"3010 was called due to R6 choking episode. Heimlich maneuver was successful on R6, and a big piece of meat dislodged from R6's throat. The meat that dislodged from R6's throat was bigger than dime sized as recommended in R6's meal plan. Staff failed to cut R6's meat according to R6's meal plan recommendation.

Facility's Policy for Reporting Abuse/Neglect Allegation dated 7/20/25, v.4 includes:
VI. Definitions "Neglect" An employee's, agencies, or facility's failure to provide adequate medical care, personal care, or maintenance, and that, as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition

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or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death.

Facility's Policy for Emergencies - Calls to 3010.
Revision Date: 10/2015.
Purpose: Define situations when 3010 should be called.
Policy: Staff should call 911 for life threatening emergencies.
All telephones on campus will call 911 Emergency. When you call 911 from a Misericordia phone, there will be a good 5 seconds of "dead time". Do not hang up, do not redial. Wait for a response from the 911 operator and state your emergency. The address of your location should be posted on the phone. It is not necessary to dial "9" before dialing 911. After calling 911, staff should call 3010 and inform reception of the emergency and alert them that an emergency vehicle will be arriving. Security or other staff members will direct the ambulance to your location. Stay with the resident.

Facility document included in the On-the-Job Training Packet (OJT packet used for training new employees) titled Finding Reporting Procedure dated March 2023, Page 67 includes:
Reactive: what to do when an incident occurs
...any life-threatening injury: individual falls and is not getting up, falls and is bleeding, seizure lasting more than 2 minutes, diabetic shocks, choking, etc. Immediately call 911 and then call 3010 (Nurse Report).
(A)