Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6010433	B. WING		04/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			MAR DRIVE			
SPARTA	TERRACE	SPARTA,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETE	
7,000	COMMENTO		7,000			
2 000	COMMENTS		Z 000			
	Annual Certification	Survey-Full				
	Inspection of Care					
	ANNUAL CERTIFIC	CATION SURVEY-EXTENDED				
Z 9999	FINDINGS		Z9999			
	Statement of Licens 350.620a) 350.1040b)1) 350.1210b) 350.1230)b)3) 350.1230d)3) 350.1840b)e) 350.3220f) 350.3240a)	sure Violation:		£		
	Section 350.620 Re	sident Care Policies	×			
	procedures governifacility which shall be involvement of the a shall be available to public. These written	have written policies and ng all services provided by the e formulated with the administrator. The policies the staff, residents and the n policies shall be followed in and shall be reviewed at		0 % %		
	Audiology Services b) Speech path	Speech Pathology and nology and audiology services ity shall include the following:	88			
		nd evaluation of residents ech and hearing functions.	23.	Attachment A Statement of Licensure Violations		
Mineia Dance	tment of Public Health				1	

STATE FORM

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

6899

P2VT11

TITLE

(X6) DATE

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	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
3		IL6010433	B. WING		04/0	9/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SPARTA	TERRACE	1501 MEL	MAR DRIVE				
SPANIA		SPARTA,	L 62286				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 1	Z9999				
	Section 350.1210 F	lealth 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 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming.						
			5				
				5.			
	d) Direct care but are not limited to	personnel shall be trained in, o, the following:					
	3) First aid in tillness.	he presence of accident or		5 <i>a</i>	İ		
	Section 350.1840 [Diet Orders			V		
	medical record, for whether the residen	write a diet order, in the each resident indicating at is to have a general or a e diet shall be served as					
	physician as part of clinical condition, to	t means a diet ordered by the a treatment for a disease or eliminate or decrease certain iet (e.g., sodium) or to				!	

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6010433 04/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1501 MELMAR DRIVE** SPARTA TERRACE **SPARTA, IL 62286** 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 TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) Z9999 Continued From page 2 Z9999 increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet). Section 350.3220 Medical Care All medical treatment and procedures shall f) be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely nursing interventions and medical treatment for 2 individuals in the sample, (R1, R2) who have a history of choking, when the facility failed to: 1. Ensure a speech-language pathologist assessment was completed per physician's orders for 1 individual in the sample, (R1) who has had 2 additional choking episodes since referral was initially ordered. 2. Ensure a follow up appointment with a physician after a choking episode resulting in an emergency room visit to determine if preventative modifications or further evaluation of current diet

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		U	
		IL6010433	B. WING		04/09/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SPARTA	TERRACE	1501 MEL SPARTA, I	MAR DRIVE IL 62286			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
Z 9999	Continued From pa	ge 3	Z9999			
	orders are warranted for 1 individuals in the sample, (R2).					
		n regarding choking episodes he sample, (R1, R2).				
		ing and safeguards were in episodes for 2 individuals in 2).				
		the potential to affect 13 at the facility, R1-R13.				
	The facility's policy titled, "Nursing Services," dated July/2014, documents in part, "Travel: 3. Delivery of instructions for procedures, medication changes, etc. as needed. Additional Documentation: 5. Update POS (Physician's Order Sheet)/MAR (Medication Administration Record) simultaneously when orders changed."			U.		
€ 2	dated 10/23/2019, of "Procedure: 9. Notifing resident's guardian condition. Facility with the determine if preventions."	titled, "Airway Obstructions," documents in part: fy the physician and the of the incident and current ill follow up with the physician entative modifications or f current diet orders are	79			
	dated 3/2021, documents of Intellectual diagnoses of Depre Schizophrenia, Con Syndrome, and Dial of R1's POS documents of R1's POS d	OS (Physician Order Sheet) ments R1 functions in the Mild al Disabilities with additional ssion, Suicidal Ideation, stipation, Irritable Bowel betes Mellitus. Further review lents R1's diet as, "LCS (Low he does not drink regular soda		11	53o	

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED	
1,112,123,			A. BUILDING:				
		IL6010433	B. WING		04/0	9/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SPARTA	TERRACE	1501 MEL SPARTA,	MAR DRIVE IL 62286				
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Z9999	Continued From pa	ige 4	Z9999	Ę.			
	Review of R1's ST Discharge Summa	(Speech Therapy) Progress & ry dated 2/16/20, documents liagnosis of Dysphagia,				=	
	8/19/20, document	ident/incident report dated s in part, "Resident sent to ER) for choking episode."					
	documents R1 was	pital records dated 8/19/20, evaluated for a choking n a diagnosis of Esophageal					
<	physician orders we (Speech-Language instruct in use of st served instead of g Put utensils down tood/liquid bites, de	this hospital record documents are written as follows, "SLP and Pathologist) Services to rategies, smaller portion size a liven entire meal at one time. Detween bites, alternate acrease distractions when a liven meal."				5	
3	documents in part, EXAMINATION: dy material in a dilated stricture, tumor, ac process was very dof dry food and req dilators, Balloon dil IMPRESSION: Larmid-esophagus, papushed into the stonormal EGD. Poter cannot be diagnose	uodenoscopy) dated 8/18/20 "REASON FOR sphagia with retained food d esophagus, rule out distal halasia. ESOPHAGUS: this lifficult due to the large amount uired the aid of Savary ators and Roth-net. ge food impaction at intially removed and partially mach otherwise essentially intial motility disturbances ed endoscopically."				3.	
		spital records documents R1 another choking incident on					

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	EETED
		IL6010433	B. WING		04/0	9/2021
		MAR DRIVE	STATE, ZIP CODE			
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Z9999	2/4/21 and docume history of choking e feeding. EMS (Eme states that patient h States that patient h States that patient h States that patient h R1's Annual Nursing documents in part, episodes-request m (2/16/20) Remind m (2/16/20) Remind m consumption, no tall between bites. Mon eating/drinking at m Review of R1's Died documents in part, plan." Review of R1's Died documents in part, appropriate, meets Further review of R no indication that the choking incident on On 3/23/21 at 3:13 room table for the splate with ground m collard greens with regular utensils conspoon. On 3/24/2021 at 7:4 medication room ar breakfast plate at the divided dish with pabowl of cereal. The pieces and the potal	ints in part, "Patient has a pisodes due to vigorous self orgency Medical Service) has a hx (history) of aspiration. In and emesis episode x1." If Assessment dated 11/19/20 "Regarding frequent choking nost recent swallow eval. It during eating, take drinks with the eals. Ground meats." It itian Memo dated 10/8/20 "At this time no change in diet it itian Memo dated 1/29/21 "Current diet appears assessed needs." It is Dietitian Memo's, there is ne dietitian was aware of the	Z9999			

(X2) MULTIPLE CONSTRUCTION

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: IL6010433 B. WING 04/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 MELMAR DRIVE SPARTA TERRACE **SPARTA, IL 62286** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) Z9999 Continued From page 6 Z9999 amounts of pancakes quickly, without taking any drinks, and began to choke. R1's eves became very wide eyed, her mouth was opened wide and a very faint noise was heard. R1 was unable to cough out the pancakes. E7/DSP, alone in the dining area, had his back turned to assist with another individua's wheeled walker, but did turn around towards R1 and stated, "(R1) you ate too fast, spit it out." R1 began to vomit and was able to clear her airway at that time. Interview with E3/RN (Registered Nurse) on 3/24/21 at 10:10 AM, when asked if the diet recommendations for R1 from her hospital visit on 8/19/20 should be on her current POS? E3 stated, "It should be on there. Yes, I can see how that would be an issue." In the same interview, when asked if the dietitian was notified of the choking incidents that occurred on 8/19/20 and 2/4/21 for R1? E3 stated, "I have no proof the dietitian was notified." Interview on 3/24/21 at 12:28 PM with E3/RN. when asked to explain what should happen after a choking event with a client, E3 stated, "Staff call me and describe if the person threw up and don't show signs of breathing difficulty and cleared the airway, staff should monitor for signs and symptoms of aspiration and pneumonia, shortness of breath, coughing, low Sp02 (oxygen saturation), blue tinged lips, blue fingernail beds. Then they would report abnormal findings to me. If resident choked and show signs of respiratory distress and wasn't able to clear the airway, they should perform the Heimlich maneuver and call 911. Upon discharge from the emergency room or hospital or after a choking incident, a follow-up appointment is set up with the PCP (Primary Care Provider) for orders and recommendations for

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speech, language, pathology and MBS (Modified

PRINTED: 06/17/2021 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6010433 04/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 MELMAR DRIVE **SPARTA TERRACE SPARTA, IL 62286** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Z9999 Continued From page 7 Z9999 Barium Swallow) study or diet modifications. Staff trained to continue to watch for choking episodes and signs of respiratory distress. Dietary is notified. Interview with E3/RN on 3/24/21 at 12:20 PM, when asked if there is staff signatures for training regarding choking episodes that occurred on 8/19/20 and 2/4/21 for R1? E3 stated, "No, I can't find them." Interview with E1/Administrator on 3/24/21 at 3:11 PM, when asked if R1 was referred to SLP on 8/19/20 per the physician's orders? E1 stated, "I have no proof of that." On 3/24/2021 at 3:00 PM, Z1 Registered Dietitian stated, "I just took over consulting with this facility in January 2021, If there was a choking episode I would expect to be notified of it. I would ensure that diets be temporarily downgraded, no large food, I would refer to a speech language evaluation with a swallowing study and take the recommendations of those assessments. I was not notified of the choking episode for R1 on February 4th 2021." 2. R2's ISP, dated 10/8/2020, documents R2 functions in the Severe Range of Individuals with Intellectual Disabilities, R2's ISP further documents: "Diet: Double protein at meals, Low Concentrated Sweets (LCS), No Added Salt (NAS), and skim milk." R2's ISP also documents

Illinois Department of Public Health

R2 has no teeth.

Review of R2's ST Plan of Care (Evaluation Only) dated 10/7/17, documents in part, "Functional Deficits: swallowing, swallow status. Prior Level: minimal impairment (10-25% impairment; risk of trace aspiration, diet may need modified due to

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6010433	B. WING		04/0	9/2021
		MAR DRIVE	STATE, ZIP CODE			
(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 APPROF	D BE	(X5) COMPLETE DATE
Z9999	medical/dental statu There is no evidence were completed for modified diet due to since 10/7/17. R2's Accident/Incide documents: "Reside room) for choking e with Abx (antibiotic) PCP (Primary Care R2's General Instru- Room, dated 6/23/2 for visiting (Local He evaluated today for Bronchitis. (Aspirati week. Your cat scar except for possible Review of R2's Diet documents in part, ' Further review of R2 indication that the d choking incident on R2's Accident/Incide documents: "Reside room) for choking e with Abx (antibiotic) PCP (Primary Care The RN-Trainer Not 6/23/2020, docume ER visit for choking 500 Milligrams (MG at 7 AM x 6 days for	te that further evaluations R2's potential need for a her medical and dental status ent Report, dated 6/23/2020, ent sent to ER (emergency pisode." Update: "Sent home and Flagyl. To follow up with Physician)." ctions from the Emergency 2020, documents: "Thank you pspital), you have been the following conditions, on). See your doctor in 1 n of your lungs was normal mild infection." itian Memo dated 7/30/20 'Noted is tolerating diet plan." 2's Dietitian Memo, there is no ietitian was aware of the 6/23/20. ent Report, dated 6/23/2020, ent sent to ER (emergency pisode." Update: "Sent home and Flagyl. To follow up with	Z9999			

(X2) MULTIPLE CONSTRUCTION

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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: IL6010433 B. WING 04/09/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 MELMAR DRIVE **SPARTA TERRACE SPARTA, IL 62286** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Z9999 Continued From page 9 Z9999 AM. 2 PM, and 9 PM x 7 days for antibiotic use. RN Instructions: Give meds with plenty of water. watch for signs and symptoms of aspiration pneumonia: Increase coughing, shortness of breath, chest pain, fatigue, bluish tinge color to lips, change in oxygen saturation level. Check spo2 (Oxygen levels) every 2 hours x 24 hours then three times daily to continue. Notify RN trainer if level below 95%. Continue checking vitals per Covid protocol. Notify RN trainer if temp greater than 99.0, pulse above 90 or lower than 50, respirations greater than 22 or less than 14, blood pressure top # above 150 or lower than 100, bottom # higher 90 or less than 60." The RN-Trainer Notification does not include any safe guards related to prevention of further choking episodes regarding R2's rate of consumption during her meals or making any alterations to her diet. On 3/23/2021 at 11:45 AM, R2 was served a regular can of sugar filled soft drink, two pieces of pizza,1 pepperoni and 1 sausage on a plate. A bowl of diced peaches and utensils were also provided, however R2 proceeded to eat the pizza, using her hands, consuming large pieces of pizza at a time. On 3/24/2021 at 7:20 AM, E2 Residential Service Director stated, "On 6/23/2020 at lunch, R2 became choked, I heard it from the office, the DSP said she was eating too fast, I did the Heimlich and food dislodged. I contacted the nurse and we sent her out to the emergency room." E2 further stated, "(R2) had a follow up appointment with her Primary Physician on 7/9/2020, however the appointment was canceled by us for some reason and R2 never had a follow up appointment for the choking incident on

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: __ B. WING 04/09/2021 IL.6010433 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1501 MELMAR DRIVE **SPARTA TERRACE** SPARTA, IL 62286 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Z9999 Z9999 Continued From page 10 6/23/2020." Interview with E3/RN on 3/24/21 at 10:10 AM. when asked if the dietitian was notified of the choking incidents that occurred on 6/23/20 for R2? E3 stated, "I have no proof the dietitian was notified." Interview on 3/24/21 at 12:28 PM with E3/RN, when asked to explain what should happen after a choking event with a client, E3 stated in part. "Dietary is notified." On 3/24/2021 at 9:10 AM, E3 Registered Nurse-Trainer stated, "I sent over staff training on 6/23/2020 related to R2's choking incident and the new orders for the medications ordered during the Emergency Room visit. "The staff should be mechanically alternating foods for the residents if they are unable to cut the food up themselves." Interview with E3/RN on 3/24/21 at 12:20 PM. when asked if there is staff signatures for training regarding choking episodes that occurred on 6/23/20 for R2? E3 stated, "No, I can't find them." On 3/24/2021 at 3:00 PM, Z1 Registered Dietitian stated, "I just took over consulting with this facility in January 2021, If there was a choking episode I would expect to be notified of it. I would ensure that diets be temporarily downgraded, no large food. I would refer to a speech language evaluation with a swallowing study and take the recommendations of those assessments."

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