

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/12/2014
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W000000	<p>This visit was for a post certification revisit to a post certification revisit completed 5/16/14 to the investigation of complaint #IN00145521 completed on 3/21/14.</p> <p>This visit was in conjunction with a post certification revisit to a fundamental recertification and state licensure survey completed on 5/16/14.</p> <p>Complaint #IN00145521: Not corrected.</p> <p>Dates of Survey: August 7, 8, 11, and 12, 2014.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/19/14 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon record review and interview for 3 of 4 sampled clients (clients A, B and C), the governing body failed to provide general policy and operating direction to ensure the facility implemented its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The governing body failed to protect client C from physical assault by client B after a history of physical aggression by client B had been identified and the governing body failed to document a thorough investigation into bruising of unknown origin involving client A.</p> <p>Findings include:</p> <p>1. The governing body failed to provide general policy and operating direction to ensure the facility implemented its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and</p>	W000104	<p>The governing body will exercise general policy, budget, and operating direction over the facility. The operations team will review all plans where client is identified as a choking risk. The current plans to include dining and BSP (as necessary) where client is identified as a choking risk will be reviewed and revised as needed. The QIDP will review plans on a monthly basis. The operations team members will review these plans on a quarterly basis. Client B has a one to one staff. His BSP will be reviewed and revised. Staff members will be retrained. The QIDP will complete observations at least three times weekly. The operations team will complete observations three times a week. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy will be investigated. Operations team members will review and approve all investigations.</p>	09/11/2014

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	<p>choking had been identified. The governing body failed to protect client C from physical assault by client B after a history of physical aggression by client B had been identified and the governing body failed to document a thorough investigation into bruising of unknown origin involving client A. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility documented a thorough investigation into bruising of unknown origin involving client A. Please see W154.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to implement effective corrective action to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. Please see W157.</p> <p>9-3-1(a)</p>			

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (clients A, B and C). The facility neglected to implement policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of gaining food and choking had been identified. The facility failed to protect client C from physical assault by client B after a history of physical aggression by client B had been identified. The facility failed to document a thorough investigation into bruising of unknown origin involving client A.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The facility failed to protect client C from physical assault by client B after a history of physical aggression by client B had been identified and the facility failed to document a thorough investigation into bruising of unknown</p>	W000122	<p>The facility will ensure that specific client protections requirements are met. The operations team will review all plans where client is identified as a choking risk. The current plans to include dining and BSP (as necessary) where client is identified as a choking risk will be reviewed and revised as needed. The QIDP will review plans on a monthly basis. The operations team members will review these plans on a quarterly basis. Client B has a one to one staff. His BSP will be reviewed and revised. Staff members will be retrained. The QIDP will complete observations at least three times weekly. The operations team will complete observations three times a week. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy will be investigated. Operations team members will review and approve all investigations.</p>	09/11/2014

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W000149	<p>origin involving client A. Please see W149.</p> <p>2. The facility failed to document a thorough investigation into bruising of unknown origin involving client A. Please see W154.</p> <p>3. The facility failed to implement effective corrective action to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. Please see W157.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon record review and interview for 3 of 4 sampled clients (clients A, B and C), the facility neglected to implement policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior</p>	W000149	The facility will implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The operations team will review all plans where client is identified as a choking risk. The current plans to include dining and BSP (as necessary) where client is identified as a choking risk will be	09/11/2014

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	<p>of gaining food and choking had been identified. The facility failed to protect client C from physical assault by client B after a history of physical aggression by client B had been identified. The facility failed to document a thorough investigation into bruising of unknown origin involving client A.</p> <p>Findings include:</p> <p>The facility's reportable incidents to BDDS (the Bureau of Developmental Disabilities Services) were reviewed on 8/7/14 at 1:00 PM and included the following:</p> <p>A report dated 7/26/14 indicated client C was found unresponsive on the bathroom floor at "approximately" 12:05 PM after staff heard the sound of someone falling in the bathroom. CPR (cardiopulmonary resuscitation) was immediately started by group home staff and 911 was called. Client C was taken to the ER (emergency room) by EMTs (Emergency Medical Technicians) and client C was pronounced dead at the hospital. "Initial investigation suggests that risk plans were followed."</p> <p>The Manager of Supported Group Living (MSG) was interviewed on 8/7/14 at 12:45 PM and indicated client C's cause</p>		<p>reviewed and revised as needed. The QIDP will review plans on a monthly basis. The operations team members will review these plans on a quarterly basis. Client B has a one to one staff. His BSP will be reviewed and revised. Staff members will be retrained. The QIDP will complete observations at least three times weekly. The operations team will complete observations three times a week. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy. Operations team members will review and approve all investigations.</p>	

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	<p>of death was thought to be aspiration, but the investigation was still in process.</p> <p>The investigation into the incident still in progress was reviewed on 8/7/14 at 1:20 PM. The investigation indicated an autopsy was being conducted because of client C's medical conditions which may have been a factor in his death. The investigation indicated the cause of client C's death was believed to be due to food blockage in the throat. Staff #1 indicated in a statement dated 7/27/14 that she had assisted client C to pull the bedding from his bed at "approximately" 11:00 AM. "At approximately 11:50 AM, I returned to the laundry/kitchen area. (closet) area. When I turned around, [client C] was standing at the refrigerator, holding the handle. He had not opened it. I approached him, checked his hands, nothing in hands. Nothing in mouth. I directed him away from the refrigerator. He walked towards his bedroom/bathroom hallway. He walked into the hallway entrance where bedroom (sic) is and I walked into the living room." Staff #1 indicated client C had attempted to obtain a bag of chips earlier that day. Staff #1 indicated she was in the living room 2-3 minutes before she heard a "thump" and all 3 staff in the home ran to the bathroom/hallway and found client C in the bathroom face up. Staff #1</p>			

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	<p>indicated client C's plan included taking food from him and "we redirect [client C] often from taking food." Staff #1 indicated client C "does not take food to his room. He eats it right away...."</p> <p>The ambulance report as part of the investigation dated 8/1/14 indicated the ambulance was called at 12:09 PM. Upon arrival, client C was "unresponsive" and "appeared to have a slice of pear obstructing his airway; breathing absence; no pulse;...chest has no movement....." The report indicated a slice of pear was removed from client C's airway by the paramedics and he was transported to the hospital.</p> <p>Staff #2 was interviewed on 8/8/14 at 8:30 AM and indicated she had performed CPR on client C after he was found in the restroom. She indicated she had checked his pulse and opened his mouth to check for a blocked airway prior to performing CPR. She indicated there were no objects found in client C's mouth prior to beginning CPR. When asked if client C often took food she stated, "All the time." She indicated client C would usually eat the food he took right away in his bedroom or the bathroom. She indicated he had recently (date unspecified) taken a fish filet she had removed from his hand and "I took a</p>			

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	<p>bag of chips from him earlier that day (7/26/14)."</p> <p>Client C's hospital records were reviewed on 8/8/14 at 11:45 AM and indicated the following:</p> <p>Provider notes dated 7/24/14 indicated client C was treated for a facial injury "nose swelling after altercation...." The notes indicated "There was a dispute with one of the other residing (sic). Members (sic) a group home and he was pushed into a screen door. The screen door broke, and he fell onto a deck...They noticed some bruising over the bridge of his nose and brought him in for evaluation...." The notes indicated tests and evaluation of client C's face and head "shows no acute findings...I do not feel any further emergent work up is needed. The primary encounter diagnosis was Nasal contusion. A diagnosis of Closed head injury was also pertinent to this visit."</p> <p>Provider notes dated 7/26/14 indicated client C was brought to the ER with cardiac arrest. "He lives in a group home. Staff heard him fall to the floor. They found him unresponsive and pulseless. CPR was undertaken until EMS arrival. Upon arrival, the patient was in cardiac arrest...When they went to intubate him,</p>						

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	<p>they found a food bolus that they felt was probably a pear in the back of his airway. This was removed and he was intubated. CPR was continued...."The report indicated client C had a brief return of his pulses after CPR, but they ceased. Upon arrival at the hospital there was no cardiac activity detected and CPR was discontinued. "I spoke with family and they state that he actually had been hit by another resident at the group home 2 or 3 days ago. They thought that his may have accounted for his bruising under his left eye. I talked to them regarding the food bolus found in his posterior oropharynx (throat) prior to EMS intubation. They stated that the patient frequently would sneak into the kitchen and grabbed food that he was not supposed to being (sic)....The patient will be a coroner's case due to the injury he had several days prior. The encounter diagnosis was Cardiopulmonary arrest...."</p> <p>Client C's records were reviewed on 8/8/14 at 1:35 PM. An ISP (Individual Support Plan) dated 11/19/13 indicated client C's diet was modified on 8/26/13 to pureed due to 2 choking episodes. A dining plan dated 3/31/14 indicated he was to receive a pureed diet. "Eating-behaviors/precautions: none." A Safety/Dining objective dated 11/19/13 indicated client C was to alternate sips of</p>			

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	<p>drinks with bites of food with 2 verbal prompts. Methodology indicated client C was to "be supervised anytime he is eating...At this time [client C] has no teeth, has a pureed diet and needs reminders to eat slowly, take small sips and supervised at all meals....[Client C] has taken food off the stove after meals...and taken it to his room to eat. Leftovers should be secured before meal is over and [client C] goes to the kitchen to prevent further choking episodes...." Client C's Behavioral Interventions dated 11/19/13 indicated "Added 7/30/13 <b>STEALING FOOD/STUFFING IN MOUTH-</b> on 7/20/13 [client C] picked up a piece of chicken off of the stove and shoved it into his mouth. He walked to his bedroom and began to choke on it. [Client C] was able to dislodge item with back blows. [Client C] has been known to go through the refrigerator, cabinets, others lunches, and snack items, take an item of food and take it to his bedroom to eat unsupervised. [Client C] has no teeth and should be monitored closely when around any food. <b>Secure all food items</b> -after meals, put food away immediately. Food is not to be left out and/or unattended....Basically [client C] is not to be left unsupervised around food."</p> <p>An undated summary of the investigation still in progress was reviewed on 8/11/14</p>			

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	<p>at 2:20 PM and indicated staff had acted according to agency's emergency response procedure. "While staff was cleaning up the bathroom floor where the incident occurred, a food item resembling a small piece of fruit (size not indicated) was discovered. Staff reported this to the on call supervisor on Sunday, 7/27/14. At this point, the focus of the investigation changed to include the possibility of a choking incident." Recommendations indicated, "In the future, when any consumer has a history of stealing food and is a high risk for choking, the plan will be reviewed and approved by a committee to include, but not limited to the Nurse Manager, Program Manager and the Executive Director."</p> <p>The Clinical Supervisor (CS) was interviewed on 8/11/14 at 2:20 PM and indicated the recommendation was to ensure that in the future administrative staff would now provide oversight to ensure clients' risk plans were adequate to address the risk of choking. Staff had followed client C's risk plan, but he had been able to obtain food and choke and the plan may not have adequately addressed his behaviors.</p> <p>2. During review of Communication Notes on 8/8/14 at 7:50 AM, an entry dated 8/2/14 indicated client A "has a</p>			

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	<p>dark purple bruise 3 cm (centimeter) by 4 1/2 cm.... We are to do a skin assessment until it is healed....."</p> <p>An internal incident report dated 8/1/14 and completed by staff #3 was reviewed on 8/11/14 at 3:14 PM and indicated "while staff was changing [client A] staff seen (sic) a bruise on [client A's] left knee...." Results of investigation indicated the house manager and staff #2 had been interviewed. "[Staff #2] indicated that when he (client A) takes a shower in the east bathroom when he takes off his pants, he could bump his knee on the underside of the counter when he lifts changing his clothes (bruise is consistent with that possibility)." Corrective action indicated "staff should monitor [client A] while in the bathroom changing clothes to prevent [client A] from bumping his knee." There was no evidence of other staff working in the home being interviewed to determine the cause of client A's injuries.</p> <p>The CS was interviewed on 8/11/14 at 3:14 PM and indicated there was no other investigation completed into the incident of the cause of client A's bruising.</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse/Neglect/Exploitation/Mistreatment</p>			

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	t of clients dated 6/2011 was reviewed on 8/7/14 at 3:30 PM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes), then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental Disabilities Service Coordinator...The Director of the Program (SGL or SL) will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators will complete a detailed investigative			

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	<p>case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative." The policy did not indicate the requirement to develop and implement corrective action to address abuse and neglect.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014 and on May 16, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>			
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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview for 1 of 4 sampled clients (client A), the facility failed to document a thorough investigation into bruising of unknown origin.</p> <p>Findings include:</p> <p>During review of Communication Notes on 8/8/14 at 7:50 AM, an entry dated 8/2/14 indicated client A "has a dark purple bruise 3 cm (centimeter) by 4 1/2 cm....We are to do a skin assessment until it is healed....."</p> <p>An internal incident report dated 8/1/14 and completed by staff #3 was reviewed on 8/11/14 at 3:14 PM and indicated "while staff was changing [client A] staff seen (sic) a bruise on [client A's] left knee...." Results of investigation indicated the house manager and staff #2 had been interviewed. "[Staff #2] indicated that when he (client A) takes a shower in the east bathroom when he takes off his pants, he could bump his knee on the underside of the counter when he lifts changing his clothes (bruise is consistent with that possibility)." Corrective action indicated "staff should</p>	W000154	<p>The facility will have evidence that all alleged violations are thoroughly investigated. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy. Operations team members will review and approve all investigations.</p>	09/11/2014

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W000157	<p>monitor [client A] while in the bathroom changing clothes to prevent [client A] from bumping his knee." There was no evidence of other staff working in the home being interviewed to determine the cause of client A's injuries.</p> <p>The Clinical Supervisor (CS) was interviewed on 8/11/14 at 3:14 PM and indicated there was no other investigation completed into the incident of the cause of client A's bruising.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014 and on May 16, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client C) to implement effective corrective action to protect client C from</p>	W000157	The facility will ensure that if an alleged violation is verified, appropriate corrective action will be taken. The operations team will review all plans where client is identified as a choking risk. The	09/11/2014

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	<p>gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to BDDS (Bureau of Developmental Disabilities Services) were reviewed on 8/7/14 at 1:00 PM and included the following:</p> <p>A report dated 7/26/14 indicated client C was found unresponsive on the bathroom floor at "approximately" 12:05 PM after staff heard the sound of someone falling in the bathroom. CPR (cardiopulmonary resuscitation) was immediately started by group home staff and 911 was called. Client C was taken to the ER (emergency room) by EMTs (Emergency Medical Technicians) and client C was pronounced dead at the hospital. "Initial investigation suggests that risk plans were followed."</p> <p>The Manager of Supported Group Living (MSGSL) was interviewed on 8/7/14 at 12:45 PM and indicated client C's cause of death was thought to be aspiration, but the investigation was ongoing.</p> <p>The witness statements of investigation</p>		<p>current plans to include dining and BSP (as necessary) where client is identified as a choking risk will be reviewed and revised as needed. The QIDP will review plans on a monthly basis. The operations team members will audit these plans on a quarterly basis.</p>				

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	<p>into client C's death was reviewed on 8/7/14 at 1:20 PM. The investigation indicated an autopsy was being conducted because of client C's medical conditions which may have been a factor in his death. The investigation indicated the cause of client C's death was believed to be due to food blockage in the throat. Staff #1 indicated in a statement dated 7/27/14 that she had assisted client C to pull the bedding from his bed at "approximately" 11:00 AM. "At approximately 11:50 AM, I returned to the laundry/kitchen area. (closet) area. When I turned around, [client C] was standing at the refrigerator, holding the handle. He had not opened it. I approached him, checked his hands, nothing in hands. Nothing in mouth. I directed him away from the refrigerator. He walked towards his bedroom/bathroom hallway. He walked into the hallway entrance where bedroom (sic) is and I walked into the living room." Staff #1 indicated client C had attempted to obtain a bag of chips earlier that day. Staff #1 indicated she was in the living room 2-3 minutes before she heard a "thump" and all 3 staff in the home ran to the bathroom/hallway and found client C in the bathroom face up. Staff #1 indicated client C's plan included taking food from him and "we redirect [client C] often from taking food." Staff #1</p>			

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	<p>indicated client C "does not take food to his room. He eats it right away...."</p> <p>The ambulance report as part of the investigation dated 8/1/14 indicated the ambulance was called at 12:09 PM. Upon arrival, client C was "unresponsive" and "appeared to have a slice of pear obstructing his airway; breathing absence; no pulse;...chest has no movement....." The report indicated a slice of pear was removed from client C's airway by the paramedics and he was transported to the hospital.</p> <p>Staff #2 was interviewed on 8/8/14 at 8:30 AM and indicated she had performed CPR on client C after he was found in the restroom. She indicated she had checked his pulse and opened his mouth to check for a blocked airway prior to performing CPR. She indicated there were no objects found in client C's mouth prior to beginning CPR. When asked if client C often took food she stated, "All the time." She indicated client C would usually eat the food he took right away in his bedroom or the bathroom. She indicated he had recently (date unspecified) taken a fish filet she had removed from his hand and "I took a bag of chips from him earlier that day (7/26/14)."</p>			

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	<p>Client C's hospital records were reviewed on 8/8/14 at 11:45 AM and indicated the following:</p> <p>Provider notes dated 7/24/14 indicated client C was treated for a facial injury "nose swelling after altercation...." The notes indicated "There was a dispute with one of the other residing (sic). Members (sic) a group home and he was pushed into a screen door. The screen door broke, and he fell onto a deck...They noticed some bruising over the bridge of his nose and brought him in for evaluation...." The notes indicated tests and evaluation of client C's face and head "shows no acute findings...I do not feel any further emergent work up is needed. The primary encounter diagnosis was Nasal contusion. A diagnosis of Closed head injury was also pertinent to this visit."</p> <p>Provider notes dated 7/26/14 indicated client C was brought to the ER with cardiac arrest. "He lives in a group home. Staff heard him fall to the floor. They found him unresponsive and pulseless. CPR was undertaken until EMS arrival. Upon arrival, the patient was in cardiac arrest...When they went to intubate him, they found a food bolus that they felt was probably a pear in the back of his airway. This was removed and he was intubated.</p>			

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	<p>CPR was continued...."The report indicated client C had a brief return of his pulses after CPR, but they ceased. Upon arrival at the hospital there was no cardiac activity detected and CPR was discontinued. "I spoke with family and they state that he actually had been hit by another resident at the group home 2 or 3 days ago. They thought that his may have accounted for his bruising under his left eye. I talked to them regarding the food bolus found in his posterior oropharynx (throat) prior to EMS intubation. They stated that the patient frequently would sneak into the kitchen and grabbed food that he was not supposed to being (sic)....The patient will be a coroner's case due to the injury he had several days prior. The encounter diagnosis was Cardiopulmonary arrest...."</p> <p>Client C's records were reviewed on 8/8/14 at 1:35 PM. An ISP (Individual Support Plan) dated 11/19/13 indicated client C's diet was modified on 8/26/13 to pureed due to 2 choking episodes. A dining plan dated 3/31/14 indicated he was to receive a pureed diet.</p> <p>"Eating-behaviors/precautions: none." A Safety/Dining objective dated 11/19/13 indicated client C was to alternate sips of drinks with bites of food with 2 verbal prompts. Methodology indicated client C was to "be supervised anytime he is</p>			

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	<p>eating...At this time [client C] has no teeth, has a pureed diet and needs reminders to eat slowly, take small sips and supervised at all meals....[Client C] has taken food off the stove after meals...and taken it to his room to eat. Leftovers should be secured before meal is over and [client C] goes to the kitchen to prevent further choking episodes...." Client C's Behavioral Interventions dated 11/19/13 indicated "Added 7/30/13</p> <p><b>STEALING FOOD/STUFFING IN MOUTH-</b> on 7/20/13 [client C] picked up a piece of chicken off of the stove and shoved it into his mouth. He walked to his bedroom and began to choke on it. [Client C] was able to dislodge item with back blows. [Client C] has been known to go through the refrigerator, cabinets, others lunches, and snack items, take an item of food and take it to his bedroom to eat unsupervised. [Client C] has no teeth and should be monitored closely when around any food. <b>Secure all food items</b> -after meals, put food away immediately. Food is not to be left out and/or unattended....Basically [client C] is not to be left unsupervised around food."</p> <p>An undated summary of the investigation still in progress was reviewed on 8/11/14 at 2:20 PM and indicated staff had acted according to the agency's emergency response procedure. "While staff was</p>			
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	<p>cleaning up the bathroom floor where the incident occurred, a food item resembling a small piece of fruit (size not indicated) was discovered. Staff reported this to the on call supervisor on Sunday, 7/27/14. At this point, the focus of the investigation changed to include the possibility of a choking incident." Recommendations indicated, "In the future, when any consumer has a history of stealing food and is a high risk for choking, the plan will be reviewed and approved by a committee to include, but not limited to the Nurse Manager, Program Manager and the Executive Director."</p> <p>The Clinical Supervisor (CS) was interviewed on 8/11/14 at 2:20 PM and indicated the recommendation was to ensure that in the future administrative staff would now provide oversight to ensure clients' risk plans were adequate to address the risk of choking. Staff had followed client C's risk plan, but he had been able to obtain food and choke and the plan may not have adequately addressed his behaviors.</p> <p>9-3-2(a)</p>			