

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/04/2012
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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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W0000	<p>This visit was for the investigation of complaint #IN00107684.</p> <p>Complaint #IN00107684: Substantiated. Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149 and W159.</p> <p>Dates of Survey: April 30, May 1, 2, 3 and 4, 2012.</p> <p>Facility Number: 000677 Provider Number: 15G140 AIMS Number: 100234420</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 5/11/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise general operating direction by failing to implement policy/procedure that prohibited neglect of client A (failed to prevent a choking episode which contributed to client A's death).</p> <p>Findings include:</p> <p>Please refer to W104 for 1 of 3 sampled clients (A), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect in regards to a choking episode which contributed to client A's death.</p> <p>Please refer to W122 Condition of Participation: Client Protections for 1 of 3 sampled clients (A), the governing body failed to ensure the rights of all clients to be free of neglect, by failing to address client A's obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food was</p>	W0102	<p><b>Corrective Action: (Specific)</b> The Program Coordinator and the staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans. <b>How others will be identified: (Systemic)</b> All clients who have obsessive behavior regarding food will have a plan in their ISP to prevent the clients from choking. <b>Measures to be put in place:</b> The Program Coordinator and the staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans. <b>Monitoring of Corrective Action:</b> The Program Coordinator and the Nurse will monitor meals weekly on clients who have choking risks due to behavioral issues.</p>	06/03/2012			

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	<p>in mouth and failing to ensure foods eaten were of a modified consistency to prevent choking) which contributed to client A's death.</p> <p>This federal tag relates to complaint #IN00107684.</p> <p>9-3-1(a)</p>				

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the Governing Body failed to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect in regards to a choking episode which contributed to client A's death.</p> <p>Findings include:</p> <p>Review of client A's record on 4/30/12 at 1:37 PM indicated a hospital History and Physical/H &amp; P dated 4/25/12. The H &amp; P indicated client A had been admitted to the local hospital on 4/24/12 via the hospital's emergency room after he "got food lodged in his throat...was unable to get it up, unable to breathe (sic)...collapsed...was brought to the emergency room with pulseless electrical activity...was resuscitated...intubated...sent to the intensive care unit."</p> <p>The H &amp; P indicated the client's diagnoses included, but were not limited to, "Severe anoxic brain damage in unresponsive patient secondary to food bolus lodged in back of patient's throat followed by apnea and cardiac arrest with</p>	W0104	<p><b>Corrective Action: (Specific)</b> The Program Coordinator and staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans. <b>How others will be identified: (Systemic)</b> All clients who have obsessive behavior regarding food will have a plan in their ISP to prevent the clients from choking. <b>Measures to be put in place:</b> The Program Coordinator and staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans.</p> <p><b>Monitoring of Corrective Action:</b> The Program Coordinator and the Nurse will monitor meals weekly on clients who have choking risks due to behavioral issues.</p>	06/03/2012			

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	<p>pulseless electrical activity on arrival to the emergency room... History of syncope (fainting) and bradycardic (slow heartbeat) episodes."</p> <p>The client's record (4/30/12 1:45 PM) indicated client A had a 4/1/12 dining plan which indicated, "Behavioral concerns: [Client A] tends to eat fast, will need reminders to slow down and chew his food. [Client A] has a history of choking related to taking food that does not belong to him. Be sure to offer healthy substitutes....Food Textures: regular diet, give medications in pudding...staff are to cut [client A's] sandwich into bite size pieces...Eating: Eats at the dining room table, family style. Encourage him to cut or chop meal into bite size pieces. Encourage him to chew his food. Encourage him to put his fork down between bites and take a sip of liquids between bites." The record review indicated client A had a nursing care plan dated 4/01/12 which indicated client A's potential for choking and aspiration. The plan indicated "Staff will monitor for signs of choking or aspiration during all food or fluid intake." The plan indicated the risk of nonsupport was "choking, asphyxia, and death."</p> <p>The 4/24/12 EMS/Emergency Medical Services report concerning client A was</p>			

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	<p>reviewed on 5/01/12 at 1:30 PM. The EMS report indicated client A's airway was opened when a "golf ball sized food mass in air way" was removed by suction.</p> <p>The agency's incidents and investigations were reviewed on 5/01/12 at 2:30 PM. The agency's 5/01/12 investigation of the 4/24/12 choking incident summary of evidence indicated the following:</p> <p>"On 4-24-2012 at 4:00 (PM), when consumers arrived home from the Day program, staff [staff #4] threw an uneaten sandwich away from a consumer's lunch that was packed for Day Program. When staff [staff #5] left the kitchen to use the bathroom, [client A] grabbed the sandwich out of the trash. When staff [staff #5] returned to the kitchen, she noticed that [client A] had eaten half of the sandwich. Staff [staff #5] verbally redirected him that he shouldn't eat the sandwich because dinner would be served shortly. [Client A] gave the rest of the sandwich to the staff member where she went and threw it away (sic.). Staff [staff #5] went to the sink to wash her hands but before she could start (sic.), she heard the cracking of a potato chips bag and immediately ran over to the snack cabinet and noticed that [client A] had stuffed a handful of chips into his mouth and was reaching for more. The staff member</p>						

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	<p>prompted him to spit out the food but [client A] refused and kept turning away from her. Staff [staff #5] said that [client A] was coughing and then abruptly stopped so she immediately went behind him and performed the Heimlich maneuver three times but was unsuccessful in freeing the lodged food items. [Client A] then fell forward and became unresponsive. Staff [staff #5] performed a finger sweep which removed all of the chips, but [client A] did not start breathing. Staff immediately called 911. The 911 operator instructed the staff to make a fist and continue thrusts above his belly button in an attempt to dislodge any remaining food. Staff [staff #5] indicated that they performed this maneuver repeatedly until the EMT (Emergency Medical Technicians) arrived and took over the life saving procedures for [client A]. According to the EMS (Emergency Medical Services's) report, when they entered the residence, [client A] was positioned near the rear of the home lying in a supine position with staff straddling him performing abdominal thrusts. CPR (Cardio Pulmonary Resuscitation) was immediately begun, cyanotic (bluish skin color). After compressions, [client A] turned pale pink and started to take in air. [Client A] had no pulse, airway was open, and a golf ball size food mass in his airway. He was suctioned and food was</p>			

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	<p>removed. [Client A] was taken by ambulance to (a local hospital)."</p> <p>Interview with LPN #1 on 4/30/12 at 1:10 PM indicated client A had been admitted to the hospital on 4/24/12 after a choking incident. The interview indicated client A was on a ventilator. LPN #1 indicated client A's family/guardian had made the difficult decision to have him removed from the ventilator on 4/27/12 and he had died shortly there after. LPN #1 indicated client A was on a regular diet with thin liquids but required supervision at mealtime to ensure he ate slowly and took small bites of food. The interview indicated client A's sandwiches were cut into 16 pieces to keep him from over filling his mouth. LPN #1 stated client A had "choked at the workshop 8 or 9 years ago" when he stole a peanut butter sandwich from a co-worker. The interview indicated client A's issues with food were behavioral; he would become obsessed with food, would steal food and eat rapidly if not carefully monitored.</p> <p>This federal tag relates to complaint #IN00107684.</p> <p>9-3-1(a)</p>						

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of neglect, by failing to address client A's obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food was in mouth and failing to ensure foods eaten were of a modified consistency to prevent choking) which contributed to client A's death.</p> <p>Findings include:</p> <p>The facility failed to ensure the rights of all clients to be free of neglect, by failing to address client A's obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food was in mouth and failing to ensure foods eaten were of a modified consistency to prevent choking) which contributed to client A's death.</p> <p>Please refer to W149 for 1 of 3 sampled clients (A), for the facility's failure to implement written policies and procedures which prohibited neglect of</p>	W0122	<p><b>Corrective Action: (Specific)</b> The Program Coordinator and staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans. <b>How others will be identified: (Systemic)</b> All clients who have obsessive behavior regarding food will have a plan in their ISP to prevent the clients from choking\Measures to be put in place: The Program Coordinator and staff will be retrained that each client at the home who has an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. All staff will be retrained on all client dining plans.</p> <p><b>Monitoring of Corrective Action:</b> The Program Coordinator and the Nurse will monitor meals weekly on clients who have choking risks due to behavioral issues</p>	06/03/2012	

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	<p>clients.</p> <p>Please refer to W159 for 1 of 3 sampled clients (A), for the Qualified Developmental Disabilities Professional's failure to revise client A's programs to address his history of choking on food due to his obsessive behavior regarding food (stealing food, taking food from trash, stuffing food into mouth, not chewing, pocketing food in cheeks instead of swallowing, talking while food was in mouth and failing to include appropriate snack foods) in the client's programming so as to prevent choking.</p> <p>This federal tag relates to complaint #IN00107684.</p> <p>9-3-2(a)</p>						

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W0149	<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.</p> <p>Based on record review and interview, for 1 of 1 facility investigations of reportable incidents (client A) reviewed, the facility failed to implement policies and procedures which prohibited staff neglect of clients in regards to a choking incident which contributed to client A's death.</p> <p>Findings include:</p> <p>Review of client A's record on 4/30/12 at 1:37 PM indicated a hospital History and Physical/H &amp; P dated 4/25/12. The H &amp; P indicated client A had been admitted to the local hospital on 4/24/12 via the hospital's emergency room after he "got food lodged in his throat...was unable to get it up, unable to breathe (sic)...collapsed...was brought to the emergency room with pulseless electrical activity...was resuscitated...intubated...sent to the intensive care unit."</p> <p>The H &amp; P indicated the client's diagnoses included, but were not limited to, "Severe anoxic brain damage in unresponsive patient secondary to food bolus lodged in back of patient's throat followed by apnea and cardiac arrest with</p>	W0149	<p><b>Corrective Action: (Specific)</b> All staff will be retrained on the abuse/neglect/exploitation policy. All clients that have an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. The ISP will be monitored by qualified person modification/review, QDDP. All staff will be retrained on all client dining plans. <b>How others will be identified: (Systemic)</b> All staff are trained during initial orientation and annually on the abuse/neglect/exploitation policy. All clients that have an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP.<b>Measures to be put in place:</b> All staff will be retrained on the abuse/neglect/exploitation policy. All clients that have an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking. The ISP will be monitored by qualified person modification/review, QDDP. All staff will be retrained on all client dining plans. <b>Monitoring of</b></p>	06/03/2012			

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	<p>pulseless electrical activity on arrival to the emergency room... History of syncope (fainting) and bradycardic (slow heartbeat) episodes."</p> <p>The physician's neurologic review of client A indicated he was "totally unresponsive" and after coming to the hospital he had a "generalized major motor seizure" which required initiation of the anticonvulsant drug, dilantin. A 4/25/12 electroencephalogram /EEG indicated client A was unresponsive to stimuli and had a "profoundly abnormal comatose EEG."</p> <p>The client's record (4/30/12 1:45 PM) indicated client A had a 4/1/12 dining plan which indicated, "Behavioral concerns: [Client A] tends to eat fast, will need reminders to slow down and chew his food. [Client A] has a history of choking related to taking food that does not belong to him. Be sure to offer healthy substitutes....Food Textures: regular diet, give medications in pudding...staff are to cut [client A's] sandwich into bite size pieces...Eating: Eats at the dining room table, family style. Encourage him to cut or chop meal into bite size pieces. Encourage him to chew his food. Encourage him to put his fork down between bites and take a sip of liquids between bites." The record review</p>		<p><b>Corrective Action:</b> All ISPs will be monitored upon completion by the Director of SGL or the Executive Director to ensure that all clients that have an obsessive behavior regarding food (taking food from trash, stuffing food into mouth, talking while food is in mouth) will have a plan in their ISP to prevent the client from choking.</p>				

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	<p>indicated client A had a nursing care plan dated 4/01/12 which indicated client A's potential for choking and aspiration. The plan indicated "Staff will monitor for signs of choking or aspiration during all food or fluid intake." The plan indicated the risk of nonsupport was "choking, asphyxia, and death."</p> <p>The 4/24/12 EMS/Emergency Medical Services report concerning client A was reviewed on 5/01/12 at 1:30 PM. The EMS report indicated client A's airway was opened when a "golf ball sized food mass in air way" was removed by suction.</p> <p>The agency's incidents and investigations were reviewed on 5/01/12 at 2:30 PM. The agency's 5/01/12 investigation of the 4/24/12 choking incident summary of evidence indicated the following: "On 4-24-2012 at 4:00 (PM), when consumers arrived home from the Day Program, staff [staff #4] threw an uneaten sandwich away from a consumer's lunch that was packed for Day Program. When staff [staff #5] left the kitchen to use the bathroom, [client A] grabbed the sandwich out of the trash. When staff [staff #5] returned to the kitchen, she noticed that [client A] had eaten half of the sandwich. Staff [staff #5] verbally redirected him that he shouldn't eat the sandwich because dinner would be served</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/04/2012
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250		
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	<p>shortly. [Client A] gave the rest of the sandwich to the staff member where she went and threw it away (sic.). Staff [staff #5] went to the sink to wash her hands but before she could start (sic.), she heard the cracking of a potato chips bag and immediately ran over to the snack cabinet and noticed that [client A] had stuffed a handful of chips into his mouth and was reaching for more. The staff member prompted him to spit out the food but [client A] refused and kept turning away from her. Staff [staff #5] said that [client A] was coughing and then abruptly stopped so she immediately went behind him and performed the Heimlich maneuver three times but was unsuccessful in freeing the lodged food items. [Client A] then fell forward and became unresponsive. Staff [staff #5] performed a finger sweep which removed all of the chips, but [client A] did not start breathing. Staff immediately called 911. The 911 operator instructed the staff to make a fist and continue thrusts above his belly button in an attempt to dislodge any remaining food. Staff [staff #5] indicated that they performed this maneuver repeatedly until the EMT (Emergency Medical Technicians) arrived and took over the life saving procedures for [client A]. According to the EMS (Emergency Medical Services's) report, when they entered the residence, [client A] was</p>				

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	<p>positioned near the rear of the home lying in a supine position with staff straddling him performing abdominal thrusts. CPR (Cardio Pulmonary Resuscitation) was immediately begun, cyanotic (bluish skin color). After compressions, [client A] turned pale pink and started to take in air. [Client A] had no pulse, airway was open, and a golf ball size food mass in his airway. He was suctioned and food was removed. [Client A] was taken by ambulance to (a local hospital)."</p> <p>The 5/1/12 investigation contained the following witness statement from staff #5 for the date of 4/24/12:</p> <p>"4:10 PM: When [staff #5] got finished with the bathroom and opened the door she noticed that [client A] was standing in front of the fridge and had a sandwich in his hand and had eaten half of it. She told him that he shouldn't eat the sandwich and he asked why and she told him that it was almost dinner time. She stated that he was chewing and talking with his mouth full. She stated that she thought that [client A] had gotten the sandwich from the trash can that [staff #4] had thrown away. She said that [client A] gave her the other half of the sandwich and she went and stuffed it in the bottom of the trash can. She stated that she then went to try and wash her hands. When she was about to wash her hands she heard the cracking</p>			

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	<p>of the potato chips bag and ran to the snack box and noticed that [client A] had stuffed a handful of chips in his mouth and was reaching for more. She told [client A] to spit out the chips and he refused and kept trying to turn away from her and walked back into the kitchen. She said that she couldn't really understood (sic.) but thought [client A] asked her why he couldn't eat the chips and she told him because they were for lunch. She asked him to spit out the chips and to take a drink of water because he was starting to cough. She stated that [client A] was trying to avoid her because he thought she was going to take the food out of his mouth. She stated that he was coughing the whole time. She then looked at [client A] and noticed that he was starting to turn pale and that is when she realized that he was starting to choke and went behind him and performed the Heimlich maneuver three times. She stated that after she performed the Heimlich he stumbled forward and fell on the porch. She stated that when he fell on the porch that she took his teeth out and scooped out the rest of the food and then went and got the phone and dialed 911."</p> <p>The 5/1/12 investigation contained the following 4/25/12 witness statement from LPN #1 for the date of 4/24/12: "...She stated that [client A] is very OCD</p>			

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
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	<p>(obsessive compulsive disorder) about food and has sat beside (sic.) him during mealtime to monitor him while he is eating. She also stated that [client A] will try and walk to the back of the house and try to sneak food out of fridge or the snack cabinet. She stated that in the last few weeks [client A] has started to get into the trash and take food and take food off the floor. She mentioned that if [client A] walks to the back of the house that a staff member needs to be with him because he will try and steal food."</p> <p>Interview with LPN #1 on 4/30/12 at 1:10 PM indicated client A had been admitted to the hospital on 4/24/12 after a choking incident. The interview indicated client A was on a ventilator. LPN #1 indicated client A's family/guardian had made the difficult decision to have him removed from the ventilator on 4/27/12 and he had died shortly there after. LPN #1 indicated client A was on a regular diet with thin liquids but required supervision at mealtime to ensure he ate slowly and took small bites of food. The interview indicated client A's sandwiches were cut into 16 pieces to keep him from over filling his mouth. LPN #1 stated client A had "choked at the workshop 8 or 9 years ago" when he stole a peanut butter sandwich from a co-worker. The interview indicated client A's issues with</p>						

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	<p>food were behavioral; he would become obsessed with food, would steal food and eat rapidly if not carefully monitored.</p> <p>Interview with staff #5 was conducted on 4/30/12 at 3:07 PM. The interview indicated client D had a sandwich (roast beef with cheese on bun not cut up) he had not eaten at lunch at workshop and had placed the sandwich in the refrigerator. Client A came into the kitchen, as was his custom, inquired about the evening meal menu and looked into the refrigerator. Staff #5 indicated client A had seen the extra sandwich and inquired about it. Staff #5 redirected client A and was needing to use the restroom so client E could use the shower. Staff #5 went to the restroom (adjacent to the kitchen) and when she came out, client A had "less than half" of the roast beef sandwich in his hands. He was asked to show staff #5 if he had food in his mouth, he stated "Why can't I eat that for?" He was talking while he had unswallowed food in his mouth. Staff #5 stated client A would "pocket food" in his mouth and required redirection at mealtime not to talk or pocket food while eating. Client A was directed to go to the living room. Staff #5 turned to check on client D (he was on the back deck smoking area adjacent to the kitchen). She stuffed the remaining sandwich into the</p>			

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	<p>bottom of the trash can and was washing her hands. She heard client A take a bag of tortilla chips from the snack cabinet (cabinet was located near the common doorway of the kitchen/dining room). Staff indicated he had one bite of chips in his mouth and she redirected him and took away the bag of chips. Staff asked client A to get a drink of water. The client was not talking, he was coughing and swallowing repetitively. Staff #5 stated the client was "distressed and panicked." She indicated she spun him around and started abdominal thrusts which did not bring up any food. Client A "passed out" and fell. Staff #5 removed his dental partial plate, and removed chips and sandwich by a finger sweep of his mouth. She called 911 and continued abdominal thrusts until the ambulance arrive and the attendants took over the life saving measures. The interview indicated the attendants suctioned a ball of sandwich out of client A's throat.</p> <p>Staff #4 was interviewed on 4/30/12 at 3:37 PM. Staff #4 indicated client A had seen client D's sandwich, a roast beef sandwich with cheese on a bun. Staff #4 indicated he placed the sandwich into the trash can and left the facility, taking client H with him back to the workshop to administer 4:00 PM medications to clients B, C and F. Staff #4 indicated sandwiches</p>			

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	<p>for client A were made with sliced bread and had to be cut into 16 pieces to prevent choking. The interview indicated client A's food stealing and taking food out of the trash was not a new behavior.</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 10/25/10 Operational Policy and Procedure Manual (revised 01/09/2012) was reviewed on May 2, 2012 at 10:00 AM and on May 4, 2012 at 12:02 PM. The review indicated the agency prohibited neglect of clients. The definitions of neglect was as follows: "F. Neglect--Program Implementation/Intervention Definition: 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Intentional failure to implement a support plan, inappropriate intervention, etc. which may result in jeopardy without qualified person notification/review."</p> <p>This federal tag relates to complaint #IN00107684.</p> <p>9-3-2(a)</p>				

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the Qualified Developmental Disabilities Professional/QDDP failed to integrate, coordinate and monitor client A's programs by failing to ensure revisions to address his history of choking on food due to his obsessive behaviors regarding food (stealing food, taking food from trash, stuffing food into mouth, not chewing, pocketing food in cheeks instead of swallowing, talking while food was in mouth and not including appropriate snack foods) were included in the client's programming so as to prevent choking.</p> <p>Findings include:</p> <p>Review of client A's record on 4/30/12 at 1:37 PM indicated a hospital History and Physical/H &amp; P dated 4/25/12. The H &amp; P indicated client A had been admitted to the local hospital on 4/24/12 via the hospital's emergency room after he "got food lodged in his throat...was unable to get it up, unable to breathe (sic.)...collapsed....was brought to the emergency room with pulseless electrical</p>	W0159	<p><b>Corrective Action (Specific)</b> The Qualified Mental Retardation Professional will be retrained that all clients that have a history of choking on food due to his obsessive behaviors regarding food (stealing food, taking food from trash, stuffing food into mouth, not chewing, pocketing food in cheeks instead of swallowing, talking while food is in mouth and not including appropriate snack foods) are to be included in the client's programming (ISP) so as to prevent choking.<b>How others will be identified:</b> All clients that have a history of choking due to their obsessive behaviors regarding food will have programming in their ISP so as to prevent choking.<b>Measures to be put in place:</b> The Qualified Mental Retardation Professional will be retrained that all clients that have a history of choking on food due to his obsessive behaviors regarding food (stealing food, taking food from trash, stuffing food into mouth, not chewing, pocketing food in cheeks instead of swallowing, talking while food is in mouth and not including appropriate snack foods) are to be included in the client's programming (ISP) so as</p>	06/03/2012			

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	<p>activity...was resuscitated...intubated...sent to the intensive care unit."</p> <p>The H &amp; P indicated the client's diagnoses included, but were not limited to, "Severe anoxic brain damage in unresponsive patient secondary to food bolus lodged in back of patient's throat followed by apnea and cardiac arrest with pulseless electrical activity on arrival to the emergency room...."</p> <p>The client's record (4/30/12 1:45 PM) indicated a nursing note dated 4/26/12 which indicated client A was hospitalized on a ventilator and was non responsive. A 4/27/12 nursing note indicated the client's sister/guardian had him removed from the ventilator and he passed away at 10:35 AM on 4/27/12.</p> <p>The 4/24/12 EMS/Emergency Medical Services report concerning client A was reviewed on 5/01/12 at 1:30 PM. The EMS report indicated client A's airway was opened when a "golf ball sized food mass in air way" was removed by suction.</p> <p>The agency's incidents and investigations were reviewed on 5/01/12 at 2:30 PM. The agency's 5/01/12 investigation of the 4/24/12 choking incident summary of evidence indicated the following:</p>		<p>to prevent choking.<b>Monitoring of corrective action:</b> All ISPs will be monitored upon completion by the Operations Manager for SGL, the Director of SGL, or the Executive Director to ensure that programming is in a client's ISP to prevent choking due to obsessive behaviors</p>				

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	"On 4-24-2012 at 4:00 (PM), when consumers arrived home from the Day Program, staff [staff #4] threw an uneaten sandwich away from a consumer's lunch that was packed for Day Program. When staff [staff #5] left the kitchen to use the bathroom, [client A] grabbed the sandwich out of the trash. When staff [staff #5] returned to the kitchen, she noticed that [client A] had eaten half of the sandwich. Staff [staff #5] verbally redirected him that he shouldn't eat the sandwich because dinner would be served shortly. [Client A] gave the rest of the sandwich to the staff member where she went and threw it away (sic.). Staff [staff #5] went to the sink to wash her hands but before she could start (sic.), she heard the cracking of a potato chips bag and immediately ran over to the snack cabinet and noticed that [client A] had stuffed a handful of chips into his mouth and was reaching for more. The staff member prompted him to spit out the food but [client A] refused and kept turning away from her. Staff [staff #5] said that [client A] was coughing and then abruptly stopped so she immediately went behind him and performed the Heimlich maneuver three times but was unsuccessful in freeing the lodged food items. [Client A] then fell forward and became unresponsive. Staff [staff #5]			

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
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	<p>performed a finger sweep which removed all of the chips, but [client A] did not start breathing. Staff immediately called 911. The 911 operator instructed the staff to make a fist and continue thrusts above his belly button in an attempt to dislodge any remaining food. Staff [staff #5] indicated that they performed this maneuver repeatedly until the EMT (Emergency Medical Technicians) arrived and took over the life saving procedures for [client A]. According to the EMS (Emergency Medical Services's) report, when they entered the residence, [client A] was positioned near the rear of the home lying in a supine position with staff straddling him performing abdominal thrusts. CPR (Cardio Pulmonary Resuscitation) was immediately begun, cyanotic (bluish skin color). After compressions, [client A] turned pale pink and started to take in air. [Client A] had no pulse, airway was open, and a golf ball size food mass in his airway. He was suctioned and food was removed. [Client A] was taken by ambulance to (a local hospital)."</p> <p>The 5/1/12 investigation contained the following witness statement from staff #5 for the date of 4/24/12:</p> <p>"4:10 PM: When [staff #5] got finished with the bathroom and opened the door she noticed that [client A] was standing in front of the fridge and had a sandwich in</p>			

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	<p>his hand and had eaten half of it. She told him that he shouldn't eat the sandwich and he asked why and she told him that it was almost dinner time. She stated that he was chewing and talking with his mouth full. She stated that she thought that [client A] had gotten the sandwich from the trash can that [staff #4] had thrown away. She said that [client A] gave her the other half of the sandwich and she went and stuffed it in the bottom of the trash can. She stated that she then went to try and wash her hands. When she was about to wash her hands she heard the cracking of the potato chips bag and ran to the snack box and noticed that [client A] had stuffed a handful of chips in his mouth and was reaching for more. She told [client A] to spit out the chips and he refused and kept trying to turn away from her and walked back into the kitchen. She said that she couldn't really understood (sic.) but thought [client A] asked her why he couldn't eat the chips and she told him because they were for lunch. She asked him to spit out the chips and to take a drink of water because he was starting to cough. She stated that [client A] was trying to avoid her because he thought she was going to take the food out of his mouth. She stated that he was coughing the whole time. She then looked at [client A] and noticed that he was starting to turn pale and that is when she realized that he</p>			

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NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
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	<p>was starting to choke and went behind him and performed the Heimlich maneuver three times. She stated that after she performed the Heimlich he stumbled forward and fell on the porch. She stated that when he fell on the porch that she took his teeth out and scooped out the rest of the food and then went and got the phone and dialed 911."</p> <p>The 5/1/12 investigation contained the following 4/25/12 witness statement from LPN #1 for the date of 4/24/12: "...She stated that [client A] is very OCD (obsessive compulsive disorder) about food and has sat beside (sic.) him during mealtime to monitor him while he is eating. She also stated that [client A] will try and walk to the back of the house and try to sneak food out of fridge or the snack cabinet. She stated that in the last few weeks [client A] has started to get into the trash and take food and take food off the floor. She mentioned that if [client A] walks to the back of the house that a staff member needs to be with him because he will try and steal food."</p> <p>The client's record review (4/30/12 1:45 PM) indicated an Individual Service Plan/ISP dated 7/27/11 which had a section entitled "Challenging Behaviors: He will obtain food from trash receptacles and will eat it." The record review</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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) COMPLETION DATE
	<p>indicated a Behavior Support Plan/BSP dated 7/27/11 which addressed the targeted behaviors of verbal and physical aggression but food stealing, looking through the trash for food and compulsive behaviors in regards to food were not addressed in the ISP nor the BSP. There was no advice as to how to secure trash containing food that client A may be obsessing about (disposing of trash in secure receptacle, etc.).</p> <p>Client A had a 4/01/12 dining plan which indicated, "Behavioral concerns: [Client A] tends to eat fast, will need reminders to slow down and chew his food. [Client A] has a history of choking related to taking food that does not belong to him. Be sure to offer healthy substitutes...Food Textures: regular diet, give medications in pudding...staff are to cut [client A's] sandwich into bite size pieces...Eating: Eats at the dining room table, family style. Encourage him to cut or chop meal into bite size pieces. Encourage him to chew his food. Encourage him to put his fork down between bites and take a sip of liquids between bites." The dining plan had no list of healthy substitute foods to offer client A when he was obsessing on foods. There was no methodology to address the food obsession.</p> <p>The record review indicated client A had</p>			

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	<p>a nursing care plan dated 4/01/12 which indicated client A's potential for choking and aspiration. The plan indicated "Staff will monitor for signs of choking or aspiration during all food or fluid intake." The plan indicated the risk of nonsupport was "choking, asphyxia, and death." The choking risk plan did not address how staff should monitor the client after he had ingested food inconsistent with his diet recommendations (an uncut, whole sandwich with soft bread and cheese). There was no advice to monitor the client for pocketing food and ensuring his mouth was clear of inappropriate consistency foods in the risk plan. Review of client A's record on 5/1/12 at 4:00 PM indicated a behavior data sheet dated 3/4/12 which documented client A had obtained food from the trash can and/or floor during during meal/snack preparation and staff had provided verbal counseling regarding the behavior. The record review indicated the QDDP had not revised the client's ISP or BSP to add the level of supervision needed to deal with client A's food obsession when he had successfully stolen/ingested foods which constituted a choking risk. The record review failed to indicate the QDDP had added the client's history of past choking episodes.</p> <p>LPN #1 indicated (4/30/12 at 1:10 PM)</p>			

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	<p>client A was on a regular diet with thin liquids but required supervision at mealtime to ensure he ate slowly and took small bites of food. The interview indicated client A's sandwiches were cut into 16 pieces so keep him from over filling his mouth. LPN #1 stated client A had "choked at the workshop 8 or 9 years ago" when he stole a peanut butter sandwich from a co-worker. The interview indicated client A's issues with food were behavioral; he would become obsessed with food, would steal food and eat rapidly if not carefully monitored.</p> <p>Interview with staff #5 was conducted on 4/30/12 at 3:07 PM. The interview indicated client D had a sandwich (roast beef with cheese on bun not cut up) he had not eaten at lunch at workshop and had placed the sandwich in the refrigerator. Client A came into the kitchen, as was his custom, inquired about the evening meal menu and looked into the refrigerator. Staff #5 indicated client A had seen the extra sandwich and inquired about it. Staff #5 redirected client A and was needing to use the restroom so client E could use the shower. Staff #5 went to the restroom(adjacent to the kitchen) and when she came out, client A had "less than half" of the roast beef sandwich in his hands. He was asked to show staff #5 if he had food in his</p>			

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	<p>mouth, he stated "Why can't I eat that for?" He was talking while he had unswallowed food in his mouth. Staff #5 stated client A would "pocket food" in his mouth and required redirection at mealtime not to talk or pocket food while eating. Client A was directed to go to the living room. Staff #5 turned to check on client D (he was on the back deck smoking area adjacent to the kitchen). She stuffed the remaining sandwich into the bottom of the trash can and was washing her hands. She heard client A take a bag of tortilla chips from the snack cabinet (cabinet was located near the common doorway of the kitchen/dining room). Staff indicated he had one bite of chips in his mouth and she redirected him and took away the bag of chips. Staff asked client A to get a drink of water. The client was not talking, he was coughing and swallowing repetitively. Staff #5 stated the client was "distressed and panicked." She indicated she spun him around and started abdominal thrusts which did not bring up any food. Client A "passed out" and fell. Staff #5 removed his dental partial plate, and removed chips and sandwich by a finger weep of his mouth. She called 911 and continued abdominal thrusts until the ambulance arrive and the attendants took over the life saving measures. The interview indicated the attendants suctioned a ball of</p>			

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	<p>sandwich out of client A's throat.</p> <p>Staff #4 was interviewed on 4/30/12 at 3:37 PM. Staff #4 indicated client A had seen client D's sandwich, a roast beef sandwich with cheese on a bun. Staff #4 indicated he placed the sandwich into the trash can and left the facility, taking client H with him back to the workshop to administer 4:00 PM medications to clients B, C and F. Staff #4 indicated sandwiches for client A were made with sliced bread and had to be cut into 16 pieces for prevent choking. The interview indicated client A food stealing and taking food out of the trash was not a new behavior.</p> <p>This federal tag relates to complaint #IN00107684.</p> <p>9-3-3(a)</p>			