

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G212	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
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W000000	<p>This visit was for the investigation of complaint #IN00134375. This visit resulted in an immediate jeopardy.</p> <p>Complaint #IN00134375: Substantiated. Federal and state deficiencies related to the allegation are cited at W102, W104, W120, W122, W149, W157 and W159.</p> <p>Dates of Survey: August 13, 14, 15, 16, 19, 20, 21, and 22, 2013.</p> <p>Facility number: 000738 Provider number: 15G212 AIM number: 100243260</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 8/28/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000102	<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, observation and interview for 3 of 3 sampled clients (clients A, B and D), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>Findings include:</p> <p>1. Please see W122. The governing body failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B and D). The governing body failed to provide oversight and direction to implement its policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B</p>	W000102	The facility will ensure that specific governing body and management requirements are met. The governing body will provide oversight and direction to implement its polices and procedures to prevent neglect in regards to developing and implementing sufficient supervision to protect clients from choking after a risk of choking has been identified. The facility's governing body will ensure outside services are provided training and plans are implemented to prevent choking after a risk of choking has been identified. The Supported Group Living Manager and/or Quality will complete workshop observations at least two times a month that will ensure the client's individual rights are protected. The QIDP will complete weekly observations at the workshop including lunch observations and will document all observations. The Supported Group Living Manager and/or Quality will complete monthly audits of this home to ensure compliance with interventions for consumers. (See W104, W122, W120)	09/21/2013			

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	<p>and D from choking after a risk of choking had been identified.</p> <p>2. Please see W104. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>3. Please see W120. The facility's governing body failed for 3 of 3 sampled clients (clients A, B and D) to exercise general policy, and operating direction over the facility to ensure outside services were provided training and implemented plans to prevent choking resulting in death for client A, and for clients B and D after a risk of choking had been identified.</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-1(a)</p>			

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review, observation and interview for 3 of 3 sampled clients (clients A, B and D), the governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>Findings include:</p> <p>1. The governing body failed for 3 of 3 sampled clients (clients A, B and D) to provide oversight and direction to ensure outside services implemented plans to prevent choking resulting in death for client A, and for clients B and D after a risk of choking had been identified, and for 2 of 4 sampled clients (clients B, D) and 3 additional clients (clients E, F, and G), the facility failed to ensure the clients' individual rights were protected when outside services implemented blanket restrictions on peanut butter and secured their lunches without unimpeded access.</p>	W000104	<p>The governing body will exercise general policy, budget and operating direction over the facility. The governing body will ensure outside services implement plans to prevent choking after a risk of choke has been identified. The QIDP was given corrective disciplinary action for not communicating client D's dining plan to the workshop and for not thoroughly reviewing and addressing client B's incident at the workshop. The QIDP has received training to ensure that ISP/BSP will include supervision needs to prevent gorging and non compliant food behaviors. The QIDP will ensure that outside services will be provided training to implement plans to prevent choking for clients at risk for choking. The facility has discussed with the outside services the blanket restrictions on peanut butter. Clients who choose to take peanut butter and/or peanut butter products in their lunches, consistent with their dining plan, may do so. The QIDP will observe lunch at the workshop at least one time per week and document. The Supported Group Living Manager and/or Quality will complete workshop observations at least two times a month that</p>	09/21/2013			

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	<p>Please see W120.</p> <p>2. The governing body failed to provide oversight and direction to ensure its policy and procedures were implemented to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified. Please see W149.</p> <p>3. The governing body failed to provide oversight and direction to ensure development and implementation of sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified. Please see W157.</p> <p>4. The governing body failed to provide oversight and direction for 3 of 3 sampled clients (clients A, B and D) to ensure the QIDP (Qualified Intellectual Disabilities Professional) developed client A's plan to include her supervision needs to prevent gorging and non-compliant food behavior, failed to immediately develop a plan to address client B's choking risk after an incident of choking occurred, and failed</p>		will ensure the clients' individual rights are protected.				

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	<p>to ensure outside services were provided training to implement plans to prevent choking for clients B and D after a risk of choking had been identified. Please see W159.</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-1(a)</p>			

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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based upon record review, interview and observation, the facility failed for 3 of 3 sampled clients (clients A, B and D) to ensure outside services implemented plans to prevent choking resulting in death for client A, and for clients B and D after a risk of choking had been identified, and for 2 of 3 sampled clients (clients B, D) and 3 additional clients (clients E, F, and G), the facility failed to ensure the clients' individual rights were protected when outside services implemented blanket restrictions on peanut butter and secured their lunches without unimpeded access.</p> <p>Findings included:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/13/13 at 3:45 PM and included the following:</p> <p>1. A BDDS report dated 8/6/13 indicated client A was found choking at 8:30 AM, was given the Heimlich maneuver and CPR without success in expelling the food from her throat. Day service nursing</p>	W000120	The facility will assure that outside services meet the needs of each client. The facility will ensure outside services implement plans to prevent choking after a risk of choking has been identified. The facility will ensure client individual rights are protected when outside services implement blanket restrictions on peanut butter and secure their lunches without unimpeded access. The facility has discussed the blanket restrictions on peanut butter with the outside services. Clients who choose to take peanut butter and/or peanut butter products in their lunches, and these items are consistent with their dining plan, may do so. Keyed locks have been purchased for clients B, D, E, F, and G. Clients who are not able to utilize a key have training objectives to address the need. The clients will have unimpeded access to their lockers/lunches. Outside services have been trained on client B and D's risk and dining plans. The QIDP will observe lunch at the workshop at least one time per week and document these observations. Any client who has a BSP that includes stealing food or any other non-compliant food behavior will have the level of	09/21/2013			

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	<p>staff who had administered CPR noted "a large amount of peanut butter" was expelled and client A had shallow respirations. Her respirations ceased again, and CPR was resumed until EMS (emergency medical services) arrived. Client A was transported to the hospital via EMS who arrived "within 5 minutes." The report indicated client A "had a choking risk plan in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowly, using the plate to plate method (one spoon of food at a time). She is currently prescribed a pureed diet due to her high risk for choking. Additional staff is to monitor her at all times with food and fluid intake due to high risk for choking. [Client A] has a behavior support plan which includes...targeted behaviors of stealing, non-compliance, and gorging." The report indicated client A had arrived at the workshop at "approximately" 7:45 AM. "[Client A's] group home staff had checked [client A] prior to leaving to be sure she had not stolen or hid any food in her pockets. Finding none, ResCare staff left. At approximately 8:15 AM, [workshop staff #1] and staff #10 from [group home] had spoken to [client A]...." Other unidentified staff had observed client A talking about her birthday and had seen client A sit at a work station,</p>		<p>supervision needed by the workshop staff and will be trained by the QIDP. The QIDP will complete weekly observations at the workshop and document these observations. The Supported Group Living Manager and/or Quality will complete workshop observations at least two times a month that ensure the clients' individual rights are protected.</p>	

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	<p>though she had not engaged in a work activity. The report indicated client A "typically greets other consumers and staff upon their arrival to the day program." The report indicated client I arrived at the workshop at 8:25 AM and proceeded to her work station. The staff from client I's group home "accompanied [client I] to the workshop, ...made eye contact with [workshop staff #1] and left. During the course of the investigation, it was verified that [client I] had a peanut butter sandwich in her lunch and her sandwich was missing from her lunch box. The next time [client A] was observed was at 8:30 AM when she came into the work services area from the ladies room and appeared to be in distress." A follow up report dated 8/14/13 was reviewed on 8/16/13 at 10:30 AM and indicated client A passed away at the Intensive Care Unit on 8/14/13 after the choking incident on 8/6/13. The report indicated client A did not regain consciousness and was placed on a ventilator. After an EEG revealed there was no brain activity, client A's guardians made the decision to take her off the ventilator.</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 8/13/13 at 3:45 PM. She indicated the investigation into client A's choking was</p>			

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	<p>ongoing and being conducted by day services staff. She indicated the group home staff and workshop staff were going to meet the following day regarding the incident and corrective action to prevent future incidents.</p> <p>An investigation completed by the PMSGL dated 8/7/13 regarding the incident of choking by client A was reviewed on 8/13/13 at 4:00 PM. It indicated staff #6 had taken client A to workshop and secured her lunch in her locker, and checked to ensure client A did not have anything she was not supposed to have and left her at the workshop area. Staff #10 indicated she had arrived "a little late" with the clients from client I's group home due to a consumer who had been incontinent prior to leaving for the workshop. She indicated client I walked to the workshop and "put away their own belongings, including their lunches into their lockers." The investigation did not indicate if client I or staff had secured client I's locker. She indicated she had left the workshop after she gave workshop staff (unidentified) a communication book.</p> <p>The PMSGL was interviewed again on 8/13/13 at 4:14 PM. She indicated workshop staff were aware of client A's history of taking and gorging on food and</p>			

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	<p>that her food was to be of pureed consistency. She was unaware of the procedures at the workshop for securing food.</p> <p>The interim PD of the workshop was interviewed on 8/14/13 at 11:45 AM. She indicated the plan to secure food had been in place prior to the incident of choking by client A. She indicated workshop staff were to ensure lunches were locked in client lockers in the morning upon arrival. She indicated the workshop started at 8:00 AM and client I arrived late at 8:25 AM. She indicated group home staff made eye contact with workshop staff, but no staff saw client I put her lunch in her locker. She indicated staff had noticed the peanut butter sandwich was missing from client I's lunchbox after the incident and a new procedure was put into place to lock the lockers in the evening so clients would not be able to put their lunches in the lockers without staff assistance or monitoring. She indicated group home staff will now walk clients into the area, talk to workshop staff to notify them of clients' arrival and ensure client lunches are secured before leaving the workshop.</p> <p>The workshop QDDP (Qualified Developmental Disabilities Professional) was interviewed on 8/14/13 at 12:30 PM. She indicated client A had arrived at 7:45</p>			

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	<p>AM and had a routine of greeting staff and clients. Client A had been talking about her birthday prior to the incident. Workshop staff had last observed client A in the workshop area between 8:15 AM and 8:25 AM. The next time she was observed, she was in distress. She indicated client I had arrived at 8:25 AM and client A was found choking at 8:30 AM. She stated there was a procedure in place prior to the incident that workshop staff were to ensure client lunches were locked, but "since she (client I) came late, staff hadn't gotten over to ensure it (her lunch) was locked." She indicated workshop staff #5 often ensured client lunches are locked, but it was not an assigned role. She indicated workshop staff had realized client I's sandwich was gone after client A was taken to the hospital. She indicated the workshop had sent out a memo to all clients and providers they would not allow peanut butter to be brought into the workshop due to the risk of choking it presented to clients at risk for choking. She indicated the group home staff would now be working together with the workshop staff to ensure lunches are secured before group home staff leave the workshop area.</p> <p>The investigation (undated) into the incident of client A's choking was</p>			

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	<p>reviewed on 8/14/13 at 12:45 PM. It indicated in part, "At approximately 8:15 AM, [client A] spoke to ResCare staff about her birthday at the workshop. At 8:25 AM, [client I] arrived from another ResCare group home arrived and sat at her work station, the staff delivered the communication book and made eye contact with day services staff and left." According to ResCare staff (unidentified) the individual who transported client I to day services "was filling in for the regular staff that was on vacation and did not lock [client I's] locker when her lunch was placed in it. [Day services] had a system in place whereby staff would check lockers to be sure lunches and belongings were secured. On this day, they had not had a chance to check [client I's] locker before this incident happened...[Day services] staff did not observe [client A] steal the sandwich, therefore was unable to redirect her, or provide any type of oversight when she was eating the sandwich, per her choking plan."</p> <p>The investigation indicated client A has a history of stealing other's food off their plates and also getting food out of the trash and eating it. "[Client A] has been observed to watch staff carefully and other consumers to see what they put in the trash. When staff turns their head, she would swiftly grab the food and shove it</p>			

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	<p>in her mouth within just a second. When this behavior occurs, she is prompted to spit the food out. At times she would comply, other times she would continue chewing and swallow the food. At the time of the incident, [client A] had a choking risk in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowing, using the plate to plate method. She was currently prescribed a pureed diet due to her high risk for choking. [Client A] has a behavior support plan which includes targeted behaviors of stealing, non-compliance, and gorging. Staff working at the day program on the day of the incident all were able to describe the interventions from [client A's] choking plan and were aware of her targeted behaviors of stealing and gorging food."</p> <p>The investigation indicated the services janitor would be responsible to clean the break room after lunch "to ensure trash containers, and floor and table are cleared of any food items...."</p> <p>Included in the investigation were client A's records as follows: A 6/1/13 Gastritis (stomach upset) and risk of choke and Nutritional Supports which indicated, "[client A] will receive diet as ordered by physician, staff will be in constant attendance during meals and will assist</p>			

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	<p>consumer with healthy food choices, encourage [client A] to eat slowly, using plate to plate method, staff will monitor [client A] for signs and symptoms of increased swallow difficulties, staff will monitor [client A] at all times with food and fluid intake due to high risk for choking, staff will encourage [client A] to have slow intake of food and fluid, staff will be trained in when to notify the nurse and when to call 911...." There were no guidelines to indicate client A's supervision needs to prevent her from ingesting items she shouldn't have.</p> <p>Included in the investigation were the following: A choking/dysphagia assessment dated 6/24/13 indicated client A is at risk for choking and a choking plan is to be completed. Client A's Behavior Support Plan dated 6/27/11 included in the investigation packet indicated the targeted behaviors included stealing and gorging. A section of the plan for non-compliance behavior for food items indicated client A will often refuse to give up a food item that she has stolen, or safely ingest a food item she had purchased. "This puts her at increased risk for choking as the food item is most likely not modified for the texture she needs for safe eating." Interventions included redirection, and supervision of staff while client A was eating the item</p>			

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	<p>and providing water to drink. A section on gorging indicated "[client A] has been known to take large amounts of food such as entire packages of cheese, lunchmeat and other food items. She will try to stuff things in her mouth before she is caught or will attempt to hide items and come back and eat them later. [Client A] has had gorging issues since childhood. Interventions included redirection, block and asking her to expel." There were no guidelines in the plan to indicate client A's supervision needs to prevent her gorging or non-compliant food behavior.</p> <p>An ISP (Individual Support Plan) objective dated 6/27/11 indicated client A would put only one spoonful of food in her mouth, and the methodology indicated staff would provide direct plate to plate assistance and prompt her to take sips of liquid between bites. Group home staff were responsible for implementing the objective.</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. She indicated she was aware client A's food was to be pureed, and client A would take food, and had two risk plans for choking. She indicated client A was to be supervised while eating and had a plate to plate method during dining. She was not aware of a formal intervention in her plan</p>			

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	<p>regarding her supervision needs while not dining, but indicated it was common practice of workshop staff to know the whereabouts of clients at all times. She stated client A was "very quick" when she obtained food others threw away and staff would follow her around during lunch time to ensure she did not obtain food from the trash or from other clients. She indicated she was unaware client A had left the workshop area until she saw her in distress after leaving the restroom at 8:30 AM. Workshop staff #1 indicated she had initiated the Heimlich maneuver when she noticed client A was choking after alerting staff and 911 had been called by other staff after client A went limp.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated client A had two risk plans to address her choking, and she had assisted with giving the Heimlich maneuver to client A after she choked. She indicated client A's plan indicated staff were to watch for client A's stealing of food.</p> <p>Client A's records were reviewed at the facility's administrative offices on 8/14/13 at 3:11 PM. A 5/13/13 dining plan indicated a Heart Health diet with pureed texture. Eating Behaviors/Precautions indicate "HIGH RISK FOR CHOKING. Takes large bites, eats too fast, doesn't</p>			

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	<p>chew thoroughly. Takes more than recommended portions, gorges throughout the day, talks, screams with food in her mouth. Difficulty swallowing." The plan did not indicate instructions to staff to address her identified behaviors. A Social History update dated 6/24/13 indicated in part, "All of [client A's] behavioral rates saw decreases in the last year except for non-compliance with food items, which remained the same." The 6/24/13 Lifestyle Plan indicated client A "requires 24 hour supervision and care, with supervision needed every 15 minutes in the home and eyesight supervision when in the community." A dining objective dated 6/24/13 indicated client A was to take a drink between bites. A BSP dated 6/24/13 included the interventions for non-compliant food behavior and gorging as indicated in her 6/27/11 plan at the workshop. There were no guidelines in client A's record to indicate client A's supervision needs at the workshop except during dining.</p> <p>The PMSGL, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. When asked what had been in place to prevent client A from choking while at day services, the QIDP indicated she had included interventions for staff to take when she obtained food</p>			

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	<p>she wasn't to have including offering water to prevent choking. She indicated client A was to have eyesight supervision while in the community and every 15 minute checks while at the group home, but there were no guidelines in her plan to indicate her supervision level needs while at workshop.</p> <p>2. A BDDS report dated 8/7/13 indicated client B was eating a piece of bread during break time at day services. Client B began coughing and staff encouraged her to continue to cough. When staff observed that she was no longer able to cough on her own they began the Heimlich maneuver and the bread was able to come up out of her throat. "QDDP (Qualified Developmental Disabilities Professional) of ResCare was notified and per their policy [client B] was taken to [hospital] for evaluation. Evaluation was negative for any signs or symptoms of aspiration. [Client B] does not currently have a choking risk plan, however staff noted that they had encouraged her to take small bites and chew thoroughly prior to [client B] choking on the bread. Treating physician at Emergency room stated no injury was noted."</p> <p>The PMSGI was interviewed again on 8/13/13 at 4:14 PM. She stated the incident of client B choking was being</p>			

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	<p>investigated and it was thought the incident may have been an "emotional reaction" by client B and "over-reaction by workshop staff."</p> <p>Observations were completed at the group home on 8/13/13 from 4:55 PM to 5:30 PM. Client D ate her dinner sitting at the dining room table. Staff #1 sat beside her placing one teaspoonful of food on her plate at a time. Client D's onion rings, chicken nuggets were ground and mixed vegetables were soft.</p> <p>Client B's record was reviewed at the group home on 8/13/13 at 4:01 PM. A dining plan dated 5/13/13 indicated client B was to receive a Heart Health diet with regular texture and had Behaviors/Precautions of takes large bites, eats too fast, alternate between solids and liquids. There were no instructions to staff as to how address client B's behaviors noted on the plan.</p> <p>Client D's record was reviewed in the group home on 8/13/13 at 5:21 PM. A dining plan dated 5/13/13 indicated client D was to receive a Heart Health diet, regular texture with toast cut into bite sized pieces, monitor portion size. Eating Behaviors/Precautions included, takes large bites, talks with mouth full of food, eats quickly, guzzles her drinks, stuffs</p>			

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	<p>solids, alternate between solids and liquids. There were no instructions to have staff use a plate to plate method or other instructions for staff to address her behaviors noted on the plan.</p> <p>Staff #2 was interviewed on 8/13/13 at 5:00 PM. She stated client D recently was placed on a mechanical soft diet as a "precaution" due to too large of a bite size and "watery eyes" (when eating).</p> <p>Observations were completed at the workshop on 8/14/13 from 11:10 AM to 12:25 PM. Client D heated her mixed vegetables up in the microwave and ate them without assistance from staff. Client B ate her mixed vegetables at a table seated with clients D and F and without prompts from staff to chew her food thoroughly or to put her utensil down between bites. Workshop staff #1, #2, #3 and the QDDP from the workshop walked past the clients eating, but did not provide constant and direct supervision. At the conclusion of her meal, client B drank 5 large gulps of her water bottle without intervention from staff.</p> <p>The interim Program Director (PD) was interviewed on 8/14/13 at 12:20 PM. When asked if client D had a dining plan, she stated, "No I don't think so. She's a safe eater."</p>			

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	<p>Client B's records were reviewed at the workshop on 8/14/13 at 2:15 PM. A Risk Plan dated 7/1/13 did not include a risk for choking. Client B's ISP (Individual Support Plan) dated 6/1/13 indicated a dining objective to put her fork/spoon down between bites. "Staff will train with [client B] on the importance of chewing her food completely and swallowing before putting another bite in her mouth, in order to prevent choking. Throughout the meal, staff will prompt [client B] to lay her eating utensil down between bites. Staff should sit near [client B] to provide continuous training. The goal is to be trained all meals and snacks, with data collected during the morning and evening meals. "</p> <p>The interim PM at the workshop was interviewed again on 8/14/13 at 1:20 PM regarding client B's choking incident. She indicated client B had choked on bread. Client B had been asked by the PM if she choked on purpose and client B stated, "I wanted to go to the hospital." She indicated staff thought client B was pretending to choke at first and then she did choke. When asked what plans were in place to prevent future incidents of choking for client B, the PM indicated staff were watching her more closely, but no formal interventions had been put into</p>			

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	<p>place. She stated, "They haven't changed anything as far as I know."</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. She indicated client B did not have a plan for dining, but that she ate rapidly and stated, "She's done (eating lunch) in two minutes." and "We have to constantly tell her to slow down. She put a whole piece of bread in her mouth that day." She indicated staff had reminded client B to slow down and take small bites. Workshop staff #1 indicated she had spoken to the nurse about reviewing the needs of all clients for dining plans, but there was nothing specific in place for client B regarding dining.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated she had prompted client B to slow down before she choked. She indicated client B's rapid rate of eating was common.</p> <p>Client D's records were reviewed at the workshop on 8/14/13 at 2:25 PM. A Risk Plan dated 12/1/11 indicated client D was to receive a heart healthy diet with toast cut into bite sized pieces. An 11/21/12 ISP objective indicated client D "will independently use her napkin...." There were no additional instructions for staff to assist client D with dining.</p>			

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	<p>The PMSGL, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. The QIDP indicated the incident of choking with client B on 8/7/13 had been reported as choking with struggle. She indicated she was unaware of an investigation into the incident and no interventions had been made by the QIDP to address client B's risk of choking to prevent future episodes. She indicated staff sit next to client B at home to encourage client B to cut up her food into bite sized pieces. She indicated client D had recently been switched to a mechanical soft diet with plate to plate as needed by staff to address unsafe eating practices of large bites and not drinking between bites. She indicted the intervention for client D was not communicated to workshop, and they should have been notified. She indicated the intervention for staff to sit with client B during meals had not been communicated to workshop staff.</p> <p>Client B's records at the facility's office were reviewed on 8/14/13 at 4:01 PM. A dining objective indicated she was to put her fork/spoon down between bites. Methodology indicated staff should remind client B to "chew her food completely and thoroughly before putting another bite in her mouth in order to</p>			
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	<p>prevent her from choking. Throughout the meal, staff will prompt [client B] to lay her eating utensil down between bites. Staff should sit near [client B] during the meal to provide continuous training. The goal is to be trained at all meals and snacks, with data collected during the morning and evening meals." There was no other evidence of a dining plan in client B's records at the day service workshop.</p> <p>Client D's records were reviewed on 8/14/13 at 4:31 PM at the facility's administrative offices. An ISP (Individual Support Plan) objective dated 11/21/12 indicated client D "will independently use her napkin." There was nothing in the dining objective to indicate additional staff interventions to assist client D with dining. There was no other evidence of a dining plan in client D's records at the day service workshop.</p> <p>The QIDP was interviewed on 8/14/13 at 4:05 PM and indicated she was unsure if the dining plans or precautions were available to workshop staff except in their dining objectives. She indicated the definition of "near" for client D was to sit right next to her during meals.</p> <p>A revised risk plan for choking dated 8/9/13 for client B was reviewed on</p>			

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	<p>8/14/13 at 4:25 PM. It indicated staff would "monitor" for signs and symptoms of increased swallowing difficulties, and would "monitor " at all times with food and fluid intake due to high risk of choking. Staff will encourage slow intake and fluid. There were no instructions as to what type of monitoring or staff supervision were needed to address her high risk of choking.</p> <p>A Risk Assessment for Choking dated 8/7/13 for client B was reviewed on 8/14/13 at 4:26 PM and indicated client B had a previous history of Heimlich use, a swallow study was requested and rate and size, and rapid spooning were noted.</p> <p>The QIDP was interviewed on 8/14/13 at 5:30 PM. She indicated she had not trained workshop staff on the revised plan for client B.</p> <p>The QDDP for the workshop was interviewed on 8/15/13 at 8:30 AM and indicated there were no other plans for clients B and D available at the workshop.</p> <p>The interim workshop Program Director was interviewed on 8/15/13 at 1:30 PM. She indicated workshop staff were trained on clients' ISP objectives including dining objectives, but did not document their progress. She indicated workshop staff</p>			

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	<p>were to implement the objectives contained in the ISP.</p> <p>3. Observations were completed at the workshop on 8/14/13 from 11:10 AM to 12:25 PM. Client I showed the surveyor her locker with a combination lock securing the contents of a vinyl bag at 11:11 AM. At 12:00 PM, clients B and F got their lunches from their locked lockers after workshop staff #4 opened the combination locks for them. Client D got her lunch from her locker after using a key to open the lock on the door. Client B obtained her lunch from a locked locker after workshop staff #5 opened the combination lock securing her locker for her. Client F waited for workshop staff #5 to open her locker secured by a combination lock. Workshop client J was asked to step aside so staff #5 could see the numbers to open her locker. Clients B, F and J did not receive training by staff #5 to open their lockers.</p> <p>The workshop QDDP (Qualified Developmental Disabilities Professional) was interviewed on 8/14/13 at 12:30 PM. She indicated the workshop had sent out a memo to all clients and providers they would not allow peanut butter to be brought into the workshop due to the risk of choking it presented to clients at risk for choking. She indicated the group</p>			

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	<p>home staff would now be working together with the workshop staff to ensure lunches are secured before group home staff leave the workshop area.</p> <p>The interim PD of the workshop was interviewed again on 8/14/13 at 11:45 AM. She indicated the plan to secure food had been in place prior to the incident of choking by client A. She indicated workshop staff were to ensure lunches were locked in client lockers in the morning upon arrival, and indicated a new procedure was put into place to lock the lockers in the evening so clients would not be able to put their lunches in the lockers without staff assistance or monitoring. She indicated group home staff will now walk clients into the area, talk to workshop staff to notify them of clients' arrival and ensure client lunches are secured before leaving the workshop.</p> <p>Client F's updated Dining Plan dated 8/5/13 was reviewed on 8/20/13 at 3:55 PM. Client F was to receive a Heart Healthy diet, mechanical soft in texture with chopped 1/2 " (inch) pieces, ground or shredded meat. Interventions for choking indicated, "Choking: Must call 911 immediately!!!! Start life saving procedures." There was no evidence in client F's plan to indicate she was unable to safely eat peanut butter.</p>			

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	<p>Client E's updated Dining Plan dated 8/5/13 was reviewed on 8/20/13 at 3:56 PM. Client E was to receive a Heart Healthy diet, with regular texture. Interventions for choking indicated, "Choking: Must call 911 immediately!!!! Start life saving procedures." There was no evidence in client E's plan to indicate she was unable to safely eat peanut butter.</p> <p>Client D's updated Dining Plan dated 8/5/13 was reviewed on 8/20/13 at 3:57 PM. Client D was to receive a Heart Healthy diet, "all foods to be cut into 1/2 x 1/2" x 1/2. Plate to Plate Dining Program d/t rapid eating, all meals to be monitored; staff to sit next to/across from [client D] and place food onto [client D's] plate one bite at a time to encourage her to slow down during meals...." Interventions for choking indicated, "Choking: Must call 911 immediately!!!! Start life saving procedures." There was no evidence in client D's plan to indicate she was unable to safely eat peanut butter.</p> <p>Client B's updated dining plan dated 8/5/13 was reviewed on 8/20/13 at 3:58 PM. The plan indicated a Heart Healthy diet, regular texture with sandwiches and bread cut into fourths. Interventions for choking indicated, "Choking: Must call 911 immediately!!!! Start life saving</p>			

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	<p>procedures." There was no evidence in client B's plan to indicate she was unable to safely eat peanut butter.</p> <p>Client G's updated dining plan dated 8/5/13 was reviewed on 8/20/13 at 3:59 PM. The plan indicated a Heart Healthy diet with regular texture. "Staff must be in line of sight of [client G] at all times." Interventions for choking indicated, "Choking: Must call 911 immediately!!!! Start life saving procedures." There was no evidence in client G's plan to indicate she was unable to safely eat peanut butter.</p> <p>Client G's 1/13/13 Key Assessment was reviewed on 8/20/13 at 3:50 PM. The assessment indicated client G was able to unlock a lock using a key, but was unable to maintain the whereabouts of a key.</p> <p>Client B's undated key assessment was reviewed on 8/20/13 at 3:51 PM. It indicated client B was able to unlock a lock using a key, but was unable to maintain the whereabouts of a key.</p> <p>Client E's 2/13 Key Assessment was reviewed on 8/20/13 at 3:52 PM. The assessment indicated client E was not able to open a lock using a key.</p> <p>Client F's 12/12 Key Assessment was reviewed on 8/20/13 at 3:54 PM. It</p>			

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	<p>indicated client F was unable to independently use a key to open her locker.</p> <p>The QDDP at day service/workshop was interviewed on 8/14/13 at 12:30 PM. She indicated the day service/workshop had sent out a memo to clients, their families and providers there was no more peanut butter to be brought to into the day services. She indicated they had not initiated due process in regards to the restriction as it was applicable only to the day service/workshop setting.</p> <p>This federal tag relates to complaint #IN00134375.</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.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B and D). The facility failed to implement its policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 8/6/13. The Immediate Jeopardy was identified on 8/14/13. The Quality Assurance Manager, Quality Assurance Coordinator, Program Manager of Supported Group Living (PMSGSL) and QIDP (Qualified Intellectual Disabilities Professional) were notified of the Immediate Jeopardy on 8/14/13 at 5:30 PM.</p> <p>The facility submitted a plan of action to remove the immediate jeopardy on 8/15/13. The undated abatement/plan of correction indicated "All staff at the day</p>	W000122	<p>The facility will ensure that specific client protections requirements are met. The facility will implement its policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident and implement plans to protect clients from choking after a risk of choke has been identified. Any client who has a BSP that includes stealing food or any other non-compliant food behavior will have the level of supervision needed by the workshop staff and will be trained by the QIDP. The QIDP was given a corrective disciplinary action as related to the lack of communication with day services/workshop regarding dining plans and dietary interventions. All dining plans and risk plans associated with dietary were reviewed by the team and modified as needed. The dining and risk plans for clients B and D were reviewed and revised by their IDT. Workshop staff has been trained on these plans along with E, F, and G dining and risk plans. The QIDP will observe lunch at the workshop at least one time per week and document those observations. The Supported Group Living Manager and/or Quality will complete</p>	09/21/2013			

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	<p>service/workshop received training on all dining plans for all individuals who attend the program. Training was also completed on 8/15/13. Meal observations were completed in the home on [street name] Dr. to ensure all staff are adequately trained and following dining plans and modified diet orders. The QIDP has received corrective disciplinary action as related to the lack of communication with day services/workshop regarding dining plans and dietary interventions. All dining plans and risk plans associated with dietary were reviewed by the Team and modified as needed. The following specific in service for the employees assigned to the home located on [group home street name] Dr. is scheduled for 8/15/13 at 2:00 PM to ensure all staff are adequately trained with regard to dining plans, risk plans and dietary interventions. A follow up training is scheduled with the day service/workshop regarding these revised plans (dining, risk and dietary intervention). This training is scheduled for 8/15/13 at 3:30 PM. The agency will continue to provide administrative observation/oversight during each meal until the Immediate Jeopardy is removed. Once removed, the observations will continue no less than weekly to ensure all staff are adequately trained and all plans are followed. Observations will continue at the day service/workshop during meals</p>		<p>workshop observations at least two times a month that ensure the clients' individual rights are protected.</p>				

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	<p>and morning transition times daily until the Immediate Jeopardy is removed. Once removed the observations at day service/workshop will be completed no less than weekly. These observations will be documented on the Active Hab (Habilitation) Observation form."</p> <p>Observations were completed at the workshop on 8/15/13 from 4:31 PM to 5:05 PM. Workshop staff #1, #2, #3, #4, and #6 had just completed training on the dining plans for clients B, C, D, E, F and G. All client lockers were locked with the exception of client D's. The janitor indicated he cleaned the lunch room after meals at noon by wiping the tables, sweeping the floor and emptying the trash and also emptied the trash between lunch periods for workshop clients.</p> <p>Workshop staff #1, #2, #3, #4 and #6 were interviewed on 8/15/13 at 4:43 PM and indicated they had just received training regarding client B, C, D, E, F and G's dining plans. Workshop staff #1 indicated all lockers were to be locked by the time clients left for the day.</p> <p>Training records dated 8/15/13 were reviewed on 8/15/13 at 4:45 PM and indicated workshop staff #1, #2, #3, #4, #5, #6, and #7 had been trained on revised/updated dining plans/risk plans,</p>			

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	<p>meal tracking sheets, modified diet definitions, dining log book, and a Training Verification Safe Eating document (undated). The Training Verification Safe Eating document indicated "All diet orders, dietary restrictions, or precautions related to feeding techniques and diet must be followed at all times...Always monitor closely all individuals during meal times. Never leave anyone unattended during meals. Meal tracking procedure is to be completed at every meal."</p> <p>The dining log book was reviewed on 8/15/13 at 4:45 PM and included the following dining plans:</p> <p>For client B: "Monitor portion size and discourage second helpings...Eating-behaviors/precautions: Takes large bites, eats too fast, alternate between solids and liquids...Meal Monitoring; Staff must have [client B] in line of sight during all meals...Adaptive Equipment: Plate Guard..." The plan indicated client B was to receive a regular diet, "cut sandwiches/bread into 1/4" (inch) x 1/4 "x 1/4...."</p> <p>For client D: "Food/fluid texture: CUT UP Food Consistency; ALL FOODS to be cut into 1/2" x 1/2" x 1/2"...Eating behaviors/precautions: Plate to Plate</p>			

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	<p>Dining Program d/t (due to) rapid eating, all meals to be monitored; staff to sit next to [client D] and place food onto [client D's] plate one bite at a time to encourage her to slow down during meals. Adaptive Equipment: Plate guard...."</p> <p>The dining plans indicated "All meals must be monitored and record any triggers on meal tracking form. If a consumer has 3 "triggers" in a 7 day period, a nurse must be notified."</p> <p>Day Program Observations dated 8/15/13 were reviewed on 8/19/13 at 1:15 PM and indicated observations by the Quality Assurance Manager on 8/15/13 from 7:45 AM until 10:00 AM and indicated "observed arrival of individuals. All items secured in lockers." A Day Program Observation dated 8/15/13 by the QIDP indicated an observation was completed from 11:55 AM until 12:35 PM. She indicated staff were implementing client B and D's objectives.</p> <p>Staff #1, #2, and #3 were interviewed at 5:30 PM and indicated they had been trained on dining plans for clients B, C, D, E, F and G.</p> <p>Observations were completed at the day service on 8/16/13 from 11:58 AM to 12:15 PM. Client D ate her meal with</p>			

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	<p>staff #2 in direct line of sight placing one bite of canned peaches cut into 1/2" pieces one piece at a time on her plate. Client F had completed her meal, but sat at the table. Client B had finished her meal per staff #2. All client lockers were secured by combination or keyed locks.</p> <p>Observations were completed at the day services on 8/19/13 from 11:35 AM until 12:15 PM. Client B was in direct line of sight of staff while eating her meal of bean dip, canned fruit with pudding, and carrots and used a plate guard. She was reminded by staff #1 to use her napkin, to take one bite, then a drink of liquid. Client D was in direct line of sight by staff #1 and offered one bite of her lunch consisting of bean dip, canned fruit with pudding and carrots cut into 1/2 " pieces. Client D used a plate guard and was reminded to swallow her food before taking another bite or swallowing liquid, and was reminded to use a napkin.</p> <p>The Program Manager was interviewed on 8/16/13 at 12:15 PM and indicated group home staff observations from 8/15/13 to 8/19/13 have indicated all lockers have been secured as per corrective actions and day service/workshop staff had implemented client goals.</p>			

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	<p>Staff #1 was interviewed on 8/19/13 at 11:45 AM and stated, "This is the longest time [client B] has taken to eat."</p> <p>The Program Manager and the Quality Assurance Coordinator were notified of the removal of the Immediate Jeopardy on 8/19/13 at 2:00 PM. Even though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at the Condition level because the facility needed to demonstrate ongoing implementation of the corrective actions to protect clients B and D from the potential of choking.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedures to to prevent neglect in regards to monitoring/supervision and implementation of plans of clients A, B, and D to prevent them from choking after a risk of choking had been identified. Please see W149. 2. The facility failed to develop and ensure implementation of sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified. Please see 			

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	<p>W157.</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-2(a)</p>				

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W000149	<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 upon observation, record review, and interview for 3 of 3 sampled clients (clients A, B and D), the facility failed to implement its policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/13/13 at 3:45 PM and included the following:</p> <p>1. A BDDS report dated 8/6/13 indicated "At approximately 8:30 AM, [client A] entered the [day services] workshop coming from the ladies restroom and [workshop staff #1] noticed that [client A] was choking... [workshop staff #1] immediately alerted other staff in the area that [client A] was choking. At the same time [workshop staff #1] began</p>	W000149	The facility will implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will implement its policy and procedures to prevent neglect in regards to developing and implementing sufficient supervision to prevent a choking incident and protect clients from choking after a risk of choking has been identified. Any client who has a BSP that includes stealing food or any other non-compliant behavior will have the level of supervision needed by the workshop staff and will be trained by the QIDP. The QIDP was given a corrective disciplinary action as related to the lack of communication with day services/workshop regarding dining plans and dietary interventions. The QIDP has received training to ensure that ISP/BSP will include supervision needs to prevent gorging and non compliant food behaviors. All dining plans and risk plans associated with dietary were reviewed by the team and modified as needed. The dining and risk plans for clients B and D were reviewed and revised by their IDT. Workshop staff has been trained on these plans along with E, F, and G dining and risk	09/21/2013

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	<p>performing the Heimlich maneuver. No food was expelled after several thrusts. Staff noticed that [client A] became limp. At that time another staff [workshop staff #3] called 911 to report the incident." The report indicated client A was placed on the floor where workshop staff #1 and workshop staff #2 gave abdominal thrusts and finger sweeps in an effort to clear her airway which were unsuccessful. The Program Coordinator lifted client A off the floor and attempted the Heimlich maneuver. No food was expelled and she was placed back on the floor at which time two day service nurses were summoned and provided CPR (cardiopulmonary resuscitation) as client A was "ashen" and not breathing. Client A resumed shallow breathing after 5-6 sets of compressions and mouth to mouth breathing. A mouth sweep was completed "with a large amount of peanut butter expelled." Her respirations ceased again, and CPR was resumed until EMS (emergency medical services) arrived. Client A was transported to the hospital via EMS who arrived "within 5 minutes." The report indicated client A "had a choking risk plan in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowly, using the plate to plate method (one spoon of food at a time). She is currently prescribed a pureed</p>		<p>plans. The QIDP will observe lunch at the workshop at least one time per week and document those observations. The Supported Group Living Manager and/or Quality will complete workshop observations at least two times a month that will ensure the clients' individual rights are protected.</p>	

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	diet due to her high risk for choking. Additional staff is to monitor her at all times with food and fluid intake due to high risk for choking. [Client A] has a behavior support plan which includes...targeted behaviors of stealing, non-compliance, and gorging." The report indicated "according to the ResCare Director of Supported Living [name], [client A] had arrived at approximately 7:45 AM. [Client A's] group home staff had checked [client A] prior to leaving to be sure she had not stolen or hid any food in her pockets. Finding none, ResCare staff left. At approximately 8:15 AM, [workshop staff #1] and staff #10 from [group home] had spoken to [client A]...." Other identified staff had observed client A talking about her birthday and had seen client A sit at a work station, though she had not engaged in a work activity. The report indicated client A "typically greets other consumers and staff upon their arrival to the day program." The report indicated client I arrived at the workshop and proceeded to her work station. The staff from client I's group home "accompanied [client I] to the workshop, ...made eye contact with [workshop staff #1] and left. During the course of the investigation, it was verified that [client I] had a peanut butter sandwich in her lunch and her sandwich was missing from her lunch box. The next			

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	<p>time [client A] was observed was at 8:30 AM when she came into the work services area from the ladies room and appeared to be in distress." A follow up report dated 8/14/13 indicated client A passed away at the Intensive Care Unit on 8/14/13 after the choking incident on 8/6/13. The report indicated client A did not regain consciousness and was placed on a ventilator. After an EEG revealed there was no brain activity, client A's guardians made the decision to take her off the ventilator.</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 8/13/13 at 3:45 PM. She indicated the investigation into client A's choking was ongoing and being conducted by day services staff. She indicated the group home staff and workshop staff were going to meet the following day regarding the incident and corrective action to prevent future incidents.</p> <p>An investigation completed by the PMSGL dated 8/7/13 regarding the incident of choking by client A was reviewed on 8/13/13 at 4:00 PM. It indicated staff #6 had taken client A to workshop and secured her lunch in her locker, and checked to ensure client A did not have anything she was not supposed to have and left her at the workshop area.</p>			

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	<p>Staff #10 indicated she had arrived "a little late" with the clients from client I's group home due to a consumer who had been incontinent prior to leaving for the workshop. She indicated client I walked to the workshop and "put away their own belongings, including their lunches into their lockers." The investigation did not indicate if client I or staff had secured client I's locker. She indicated she had left the workshop after she gave workshop staff (unidentified) a communication book.</p> <p>The PMSGL was interviewed again on 8/13/13 at 4:14 PM. She indicated workshop staff were aware of client A's history of taking and gorging on food and that her food was to be of pureed consistency. She was unaware of the procedures at the workshop for securing food.</p> <p>The interim PD of the workshop was interviewed on 8/14/13 at 11:45 AM. She indicated the plan to secure food had been in place prior to the incident of choking by client A. She indicated workshop staff were to ensure lunches were locked in client lockers in the morning upon arrival, and indicated training was offered to teach clients to use the locks if they were not able to do so independently. She indicated the workshop started at 8:00</p>			

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	<p>AM and client I arrived late at 8:25 AM. She indicated group home staff made eye contact with workshop staff, but no staff saw client I put her lunch in her locker. She indicated staff had noticed the peanut butter sandwich was missing from client I's lunchbox after the incident and a new procedure was put into place to lock the lockers in the evening so clients would not be able to put their lunches in the lockers without staff assistance or monitoring. She indicated group home staff will now walk clients into the area, talk to workshop staff to notify them of clients' arrival and ensure client lunches are secured before leaving the workshop.</p> <p>The workshop QDDP was interviewed on 8/14/13 at 12:30 PM. She indicated client A had arrived at 7:45 AM and had a routine of greeting staff and clients. Client A had been talking about her birthday prior to the incident. Workshop staff had last observed client A in the workshop area between 8:15 AM and 8:25 AM. The next time she was observed, she was in distress. She indicated client I had arrived at 8:25 AM and client A was found choking at 8:30 AM. She stated there was a procedure in place prior to the incident that workshop staff were to ensure client lunches were locked, but "since she (client I) came late, staff hadn't gotten over to ensure it (her lunch) was locked."</p>			

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	<p>She indicated workshop staff #5 often ensured client lunches are locked, but it was not an assigned role. She indicated workshop staff had realized client I's sandwich was gone after client A was taken to the hospital. She indicated the workshop had sent out a memo to all clients and providers they would not allow peanut butter to be brought into the workshop due to the risk of choking it presented to clients at risk for choking. She indicated lockers would now be locked at night to reduce the risk of clients placing their lunches unsecured into lockers upon their arrival in the morning. She indicated the group home staff would now be working together with the workshop staff to ensure lunches are secured before group home staff leave the workshop area.</p> <p>The investigation (undated) into the incident of client A's choking was reviewed on 8/14/13 at 12:45 PM. It indicated in part, "At approximately 8:15 AM, [client A] spoke to ResCare staff about her birthday at the workshop. At 8:25 AM, [client I] arrived from another ResCare group home arrived and sat at her work station, the staff delivered the communication book and made eye contact with day services staff and left." According to ResCare staff (unidentified) the individual who transported client I to</p>			

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	<p>day services "was filling in for the regular staff that was on vacation and did not lock [client I's] locker when her lunch was placed in it. [Day services] had a system in place whereby staff would check lockers to be sure lunches and belongings were secured. On this day, they had not had a chance to check [client I's] locker before this incident happened...[Day services] staff did not observe [client A] steal the sandwich, therefore was unable to redirect her, or provide any type of oversight when she was eating the sandwich, per her choking plan."</p> <p>The investigation indicated client A has a history of stealing other's food off their plates and also getting food out of the trash and eating it. "[Client A] has been observed to watch staff carefully and other consumers to see what they put in the trash. When staff turns their head, she would swiftly grab the food and shove it in her mouth within just a second. When this behavior occurs, she is prompted to spit the food out. At times she would comply, other times she would continue chewing and swallow the food. At the time of the incident, [client A] had a choking risk in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowing, using the plate to plate method. She was currently prescribed a pureed diet</p>			

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	<p>due to her high risk for choking. [Client A] has a behavior support plan which includes targeted behaviors of stealing, non-compliance, and gorging. Staff working at the day program on the day of the incident all were able to describe the interventions from [client A's] choking plan and were aware of her targeted behaviors of stealing and gorging food."</p> <p>The investigation indicated an administrative memo dated 8/8/13 was delivered to all clients, families, group home and waiver sites that peanut butter in any form is no longer allowed in the day services program. It indicated day services DSP (direct support professionals) would ensure all lockers would be locked at the end of the day, and "to ensure lunches are secured at the beginning of the day, and day services janitor would be responsible to clean the break room after lunch to ensure trash containers, and floor and table are cleared of any food items...."</p> <p>Included in the investigation were client A's records as follows: A 6/1/13 Gastritis (stomach upset) and risk of choke and Nutritional Supports which indicated, "[client A] will receive diet as ordered by physician, staff will be in constant attendance during meals and will assist consumer with healthy food choices,</p>			

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	<p>encourage [client A] to eat slowly, using plate to plate method, staff will monitor [client A] for signs and symptoms of increased swallow difficulties, staff will monitor [client A] at all times with food and fluid intake due to high risk for choking, staff will encourage [client A] to have slow intake of food and fluid, staff will be trained in when to notify the nurse and when to call 911...." There were no guidelines in the plan to indicate client A's supervision needs to prevent her from ingesting items she shouldn't have.</p> <p>A choking/dysphagia assessment dated 6/24/13 included in the investigation indicated client A is at risk for choking and a choking plan is to be completed. Client A's Behavior Support Plan 6/27/11 included in the investigation packet indicated the targeted behaviors included stealing and gorging. A section of the plan for non-compliance behavior for food items indicated client A will often refuse to give up a food item that she has stolen, or safely ingest a food item she had purchased. "This puts her at increased risk for choking as the food item is most likely not modified for the texture she needs for safe eating." Interventions included redirection, and supervision of staff while client A was eating the item and providing water to drink. A section on gorging indicated "[client A] has been</p>			

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	<p>known to take large amounts of food such as entire packages of cheese, lunchmeat and other food items. She will try to stuff things in her mouth before she is caught or will attempt to hide items and come back and eat them later. [Client A] has had gorging issues since childhood. Interventions included redirection, block and asking her to expel." There were no guidelines in the plan to indicate client A's supervision needs to prevent her gorging or non-compliant food behavior.</p> <p>An ISP (Individual Support Plan) objective dated 6/27/11 indicated client A would put only one spoonful of food in her mouth, and the methodology included staff would provide direct plate to plate assistance and prompt her to take sips of liquid between bites. Group home staff were responsible for implementing the objective.</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. She indicated she was aware client A's food was to be pureed, and client A would take food, and had two risk plans for choking. She indicated client A was to be supervised while eating and had a plate to plate method during dining. She was not aware of a formal intervention in her plan regarding her supervision needs while not dining, but indicated it was common</p>			

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	<p>practice of workshop staff to know the whereabouts of clients at all times. She stated client A was "very quick" when she obtained food others threw away and staff would follow her around during lunch time to ensure she did not obtain food from the trash or from other clients. She indicated she was unaware client A had left the workshop area until she saw her in distress after leaving the restroom at 8:30 AM. Workshop staff #1 indicated she had initiated the Heimlich maneuver when she noticed client A was choking after alerting staff and 911 had been called by other staff after client A went limp.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated client A had two risk plans to address her choking, and she had assisted with giving the Heimlich maneuver client A after she choked. She indicated client A's plan indicated staff were to watch for client A's stealing of food.</p> <p>Client A's records were reviewed at the facility's administrative offices on 8/14/13 at 3:11 PM. A 5/13/13 dining plan indicated a Heart Health diet with pureed texture. Eating Behaviors/Precautions indicate "HIGH RISK FOR CHOKING. Takes large bites, eats too fast, doesn't chew thoroughly. Takes more than recommended portions, gorges</p>			

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	<p>throughout the day, talks, screams with food in her mouth. Difficulty swallowing." The plan did not indicate instructions to staff to address her identified behaviors. A Social History update dated 6/24/13 indicated in part, "All of [client A's] behavioral rates saw decreases in the last year except for non-compliance with food items, which remained the same." The 6/24/13 Lifestyle Plan indicated client A "requires 24 hour supervision and care, with supervision needed every 15 minutes in the home and eyesight supervision when in the community." A dining objective dated 6/24/13 indicated client A was to take a drink between bites. A BSP dated 6/24/13 included the interventions for non-compliant food behavior and gorging as indicated in her 6/27/11 plan at the workshop.</p> <p>The PMSGL, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. When asked what had been in place to prevent client A from choking while at day services, the QIDP indicated she had included interventions for staff to take when she obtained food she wasn't to have including offering water to prevent choking. She indicated client A was to have eyesight supervision while in the community and every 15 minute checks while at the group home,</p>			

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	<p>but there were no guidelines in her plan to indicate her supervision level needs while at workshop.</p> <p>2. A BDDS report dated 8/7/13 indicated client B was eating a piece of bread during break time at day services. Client B began coughing and staff encouraged her to continue to cough. When staff observed that she was no longer able to cough on her own they began the Heimlich maneuver and the bread was able to come up out of her throat. "QDDP (Qualified Developmental Disabilities Professional) of ResCare was notified and per their policy [client B] was taken to [hospital] for evaluation. Evaluation was negative for any signs or symptoms of aspiration. [Client B] does not currently have a choking risk plan, however staff noted that they had encouraged her to take small bites and chew thoroughly prior to [client B] choking on the bread. Treating physician at Emergency room stated no injury was noted." There was no evidence of a change in client B's dining plan or other corrective action to prevent further choking incidents on bread for client B indicated in the report.</p> <p>The PMSGL was interviewed on 8/13/13 at 4:14 PM. She stated the incident of client B choking was being investigated and it was thought the incident may have</p>			

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	<p>been an "emotional reaction" by client B and "over-reaction by workshop staff."</p> <p>Observations were completed at the group home on 8/13/13 from 4:55 PM to 5:30 PM. Client D ate her dinner sitting at the dining room table. Staff #1 sat beside her placing one teaspoonful of food on her plate at a time. Client D's onion rings, chicken nuggets were ground and mixed vegetables were soft.</p> <p>Client B's record was reviewed at the group home on 8/13/13 at 4:01 PM. A dining plan dated 5/13/13 indicated client B was to receive a Heart Health diet with regular texture and had Behaviors/Precautions of takes large bites, eats too fast, alternate between solids and liquids. There were no instructions to staff as to how address client B's behaviors noted on the plan.</p> <p>Client D's record was reviewed in the group home on 8/13/13 at 5:21 PM. A dining plan dated 5/13/13 indicated client D was to receive a Heart Health diet, regular texture with toast cut into bite sized pieces, monitor portion size. Eating Behaviors/Precautions included, takes large bites, talks with mouth full of food, eats quickly, guzzles her drinks, stuffs solids, alternate between solids and liquids. There were no instructions to</p>			

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	<p>have staff use a plate to plate method or other instructions for staff to address her behaviors noted on the plan.</p> <p>Staff #2 was interviewed on 8/13/13 at 5:00 PM. She stated client D recently was placed on a mechanical soft diet as a "precaution" due to too large of a bite size and "watery eyes" (when eating).</p> <p>Observations were completed at the workshop on 8/14/13 from 11:10 AM to 12:25 PM. Client I showed the surveyor her locker with a combination lock securing the contents of a vinyl bag at 11:11 AM. At 12:00 PM, clients B and F got their lunches from their locked lockers after workshop staff #4 opened the combination locks for them. Client D got her lunch from her locker after using a key to open the lock on the door. Client D heated her mixed vegetables up in the microwave and ate them without assistance from staff. Client B ate her mixed vegetables at a table seated with clients D and F and without prompts from staff to chew her food thoroughly or to put her utensil down between bites. Workshop staff #1, #2, #3 and the QDDP from the workshop walked past the clients eating, but did not provide constant and direct supervision. At the conclusion of her meal, client D drank 5 large gulps of her water bottle without intervention from</p>			

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	<p>staff.</p> <p>The interim Program Director (PD) was interviewed on 8/14/13 at 12:20 PM. When asked if client D had a dining plan, she stated, "No I don't think so. She's a safe eater."</p> <p>The interim PM at the workshop was interviewed again on 8/14/13 at 1:20 PM regarding client B's choking incident. She indicated client B had choked on bread. Client B had been asked by the PM if she choked on purpose and client B stated, "I wanted to go to the hospital." She indicated staff thought client B was pretending to choke at first and then she did choke. When asked what plans were in place to prevent future incidents of choking for client B, the PM indicated staff were watching her more closely, but no formal interventions had been put into place. She stated, "They haven't changed anything as far as I know."</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. Workshop staff #1 indicated client B did not have a plan for dining, but that she ate rapidly and stated, "She's done (eating lunch) in two minutes." and "We have to constantly tell her to slow down. She put a whole piece of bread in her mouth that day." She indicated staff had reminded client B to</p>			

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	<p>slow down and take small bites.</p> <p>Workshop staff #1 indicated she had spoken to the nurse about reviewing the needs of all clients for dining plans, but there was nothing specific in place for client B regarding dining. She indicated she had prompted client B to slow down before she choked and had assisted in giving the Heimlich maneuver when client B choked. She indicated client B's rapid rate of eating was common.</p> <p>Client B's records at the facility's office were reviewed on 8/14/13 at 4:01 PM. A dining objective indicated she was to put her fork/spoon down between bites. Methodology indicated staff should remind client B to "chew her food completely and thoroughly before putting another bite in her mouth in order to prevent her from choking. Throughout the meal, staff will prompt [client B] to lay her eating utensil down between bites. Staff should sit near [client B] during the meal to provide continuous training. The goal is to be trained at all meals and snacks, with data collected during the morning and evening meals."</p> <p>Client D's records were reviewed on 8/14/13 at 4:31 PM at the facility's administrative offices. An ISP (Individual Support Plan) objective dated 11/21/12 indicated client D "will</p>			

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	<p>independently use her napkin." There was nothing in the dining objective to indicate additional staff interventions to assist client D with dining.</p> <p>The QIDP was interviewed on 8/14/13 at 4:05 PM and indicated she was unsure if the dining precautions were available to workshop staff except in their dining objectives. She indicated the definition of "near" for client D was to sit right next to her during meals.</p> <p>A revised risk plan for choking dated 8/9/13 for client B was reviewed on 8/14/13 at 4:25 PM. It indicated staff would "monitor" for signs and symptoms of increased swallowing difficulties, and would "monitor" at all times with food and fluid intake due to high risk of choking. Staff will encourage slow intake and fluid. There were no instructions as to what type of monitoring or staff supervision were needed to address her high risk of choking.</p> <p>A Risk Assessment for Choking dated 8/7/13 for client B was reviewed on 8/14/13 at 4:26 PM and indicated client B had a previous history of Heimlich use, a swallow study was requested and rate and size, and rapid spooning were noted.</p> <p>The PMSGL, QIDP and Quality</p>			

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	<p>Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. The QIDP indicated the incident of choking with client B on 8/7/13 had been reported as choking with struggle. She indicated she was unaware of an investigation into the incident and no interventions had been made by the QIDP to address client B's risk of choking to prevent future episodes. She indicated staff sit next to client B at home to encourage client B to cut up her food into bite sized pieces. She indicated client D had recently been switched to a mechanical soft diet with plate to plate as needed by staff to address unsafe eating practices of large bites and not drinking between bites. She indicted the intervention for client D was not communicated to workshop, and they should have been notified.</p> <p>The QIDP was interviewed on 8/14/13 at 5:30 PM. She indicated she had not trained workshop staff on the revised plan.</p> <p>The QDDP for the workshop was interviewed on 8/15/13 at 8:30 AM and indicated there were no other plans for clients A, B, and D available at the workshop.</p> <p>The interim workshop Program Director was interviewed on 8/15/13 at 1:30 PM.</p>			

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	<p>She indicated workshop staff were trained on clients' ISP objectives included dining objectives, but did not document their progress. She indicated workshop staff were to implement the objectives contained in the ISP.</p> <p>The facility' Operations Standard Reporting Abuse/Neglect/Exploitation/Mistreatment dated 6/11 was reviewed on 8/14/13 at 6:00 PM and indicated in part, "ResCare strictly prohibits abuse/neglect/exploitation/mistreatment." The policy indicated "All incident reports are used as a basis for examining individual safety, are tracked through a database and reviewed by ResCare Northern Region Indiana management team, support team and safety committee. The database allows for examination of trends in incidents per home, individual, location, type of injury, etc. The safety committee will make recommendations to the management team to improve the quality of services provided to individual (sic)....."</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon observation, record review, and interview for 3 of 3 sampled clients (clients A, B and D), the facility failed to develop and ensure implementation of sufficient supervision to prevent a choking incident resulting in death for client A and failed to develop and implement plans to protect clients B and D from choking after a risk of choking had been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/13/13 at 3:45 PM and included the following:</p> <p>1. A BDDS report dated 8/6/13 indicated "At approximately 8:30 AM, [client A] entered the [day services] workshop coming from the ladies restroom and [workshop staff #1] noticed that [client A] was choking...." Workshop staff #1 immediately alerted other staff in the area that client A was choking and began performing the Heimlich maneuver. No food was expelled after several thrusts. No food was expelled after Heimlich maneuver attempts and she was placed</p>	W000157	The facility will ensure implementation of sufficient supervision to prevent a choking incident and protect clients from choking after a risk of choking has been identified. Any client who has a BSP that includes stealing food or any other non-compliant food behavior will have the level of supervision needed by the workshop staff. The QIDP was given a corrective disciplinary action as related to the lack of communication with day services/workshop regarding dining plans and dietary interventions. All dining plans and risk plans associated with dietary were reviewed by the team and modified as needed. The dining and risk plans for clients B and D were reviewed and revised by their IDT. Workshop staff has been trained on these plans along with E, F, and G dining and risk plans. The QIDP will observe lunch at the workshop at least one time per week and document those observations. The Supported Group Living Manager and Quality will complete workshop observations at least two times a month that will ensure the clients' individual rights are protected.	09/21/2013			

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	<p>back on the floor at which time two day service nurses were summoned and provided CPR (cardiopulmonary resuscitation) as client A was "ashen" and not breathing. Client A resumed shallow breathing after 5-6 sets of compressions and mouth to mouth breathing. A mouth sweep was completed "with a large amount of peanut butter expelled." Her respirations ceased again, and CPR was resumed until EMS arrived and took client A to the hospital. The report indicated client A "had a choking risk plan in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowly, using the plate to plate method (one spoon of food at a time). She is currently prescribed a pureed diet due to her high risk for choking. Additional staff is to monitor her at all times with food and fluid intake due to high risk for choking. [Client A] has a behavior support plan which includes...targeted behaviors of stealing, non-compliance, and gorging." The report indicated "according to the ResCare Director of Supported Living [name], [client A] had arrived at approximately 7:45 AM. [Client A's] group home staff had checked [client A] prior to leaving to be sure she had not stolen or hid any food in her pockets. Finding none, ResCare staff left. At approximately 8:15 AM, [workshop staff</p>			

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	<p>#1] and staff #10 from [group home] had spoken to [client A]...." Other identified staff had observed client A talking about her birthday and had seen client A sit at a work station, though she had not engaged in a work activity. The report indicated client A "typically greets other consumers and staff upon their arrival to the day program." The report indicated client I arrived at the workshop and proceeded to her work station. The staff from client I's group home "accompanied [client I] to the workshop, ...made eye contact with [workshop staff #1] and left. During the course of the investigation, it was verified that [client I] had a peanut butter sandwich in her lunch and her sandwich was missing from her lunch box. The next time [client A] was observed was at 8:30 AM when she came into the work services area from the ladies room and appeared to be in distress." A follow up report dated 8/14/13 was reviewed on 8/16/13 at 10:30 AM indicated client A passed away at the Intensive Care Unit on 8/14/13 after the choking incident on 8/6/13. The report indicated client A did not regain consciousness and was placed on a ventilator. After an EEG revealed there was no brain activity, client A's guardians made the decision to take her off the ventilator.</p> <p>The Program Manager of Supported</p>			
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	<p>Group Living (PMSGGL) was interviewed on 8/13/13 at 3:45 PM. She indicated the investigation into client A's choking was ongoing and being conducted by day services staff. She indicated the group home staff and workshop staff were going to meet the following day regarding the incident and corrective action to prevent future incidents.</p> <p>An investigation completed by the PMSGGL dated 8/7/13 regarding the incident of choking by client A was reviewed on 8/13/13 at 4:00 PM. It indicated staff #6 had taken client A to workshop and secured her lunch in her locker, and checked to ensure client A did not have anything she was not supposed to have and left her at the workshop area. Staff #10 indicated she had arrived "a little late" with the clients from client I's group home due to a consumer who had been incontinent prior to leaving for the workshop. She indicated client I walked to the workshop and "put away their own belongings, including their lunches into their lockers." The investigation did not indicate if client I or staff had secured client I's locker. She indicated she had left the workshop after she gave workshop staff (unidentified) a communication book.</p> <p>The PMSGGL was interviewed again on</p>			

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	<p>8/13/13 at 4:14 PM. She indicated workshop staff were aware of client A's history of taking and gorging on food and that her food was to be of pureed consistency. She was unaware of the procedures at the workshop for securing food.</p> <p>The interim PD of the workshop was interviewed on 8/14/13 at 11:45 AM. She indicated the plan to secure food had been in place prior to the incident of choking by client A. She indicated workshop staff were to ensure lunches were locked in client lockers in the morning upon arrival, and indicated training was offered to teach clients to use the locks if they were not able to do so independently. She indicated the workshop started at 8:00 AM and client I arrived late at 8:25 AM. She indicated group home staff made eye contact with workshop staff, but no staff saw client I put her lunch in her locker. She indicated staff had noticed the peanut butter sandwich was missing from client I's lunchbox after the incident and a new procedure was put into place to lock the lockers in the evening so clients would not be able to put their lunches in the lockers without staff assistance or monitoring. She indicated group home staff will now walk clients into the area, talk to workshop staff to notify them of clients' arrival and ensure client lunches</p>			

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	<p>are secured before leaving the workshop.</p> <p>The workshop QDDP was interviewed on 8/14/13 at 12:30 PM. She indicated client A had arrived at 7:45 AM and had a routine of greeting staff and clients. Client A had been talking about her birthday prior to the incident. Workshop staff had last observed client A in the workshop area between 8:15 AM and 8:25 AM. The next time she was observed, she was in distress. She indicated client I had arrived at 8:25 AM and client A was found choking at 8:30 AM. She stated there was a procedure in place prior to the incident that workshop staff were to ensure client lunches were locked, but "since she (client I) came late, staff hadn't gotten over to ensure it (her lunch) was locked." She indicated workshop staff #5 often ensured client lunches are locked, but it was not an assigned role. She indicated workshop staff had realized client I's sandwich was gone after client A was taken to the hospital. She indicated the workshop had sent out a memo to all clients and providers they would not allow peanut butter to be brought into the workshop due to the risk of choking it presented to clients at risk for choking. She indicated lockers would now be locked at night to reduce the risk of clients placing their lunches unsecured into lockers upon their arrival in the</p>			

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	<p>morning. She indicated the group home staff would now be working together with the workshop staff to ensure lunches are secured before group home staff leave the workshop area.</p> <p>The investigation (undated) into the incident of client A's choking was reviewed on 8/14/13 at 12:45 PM. It indicated in part, "At approximately 8:15 AM, [client A] spoke to ResCare staff about her birthday at the workshop. At 8:25 AM, [client I] arrived from another ResCare group home arrived and sat at her work station, the staff delivered the communication book and made eye contact with day services staff and left." According to ResCare staff (unidentified) the individual who transported client I to day services "was filling in for the regular staff that was on vacation and did not lock [client I's] locker when her lunch was placed in it. [Day services] had a system in place whereby staff would check lockers to be sure lunches and belongings were secured. On this day, they had not had a chance to check [client I's] locker before this incident happened...[Day services] staff did not observe [client A] steal the sandwich, therefore was unable to redirect her, or provide any type of oversight when she was eating the sandwich, per her choking plan."</p>			

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	<p>The investigation indicated client A has a history of stealing other's food off their plates and also getting food out of the trash and eating it. "[Client A] has been observed to watch staff carefully and other consumers to see what they put in the trash. When staff turns their head, she would swiftly grab the food and shove it in her mouth within just a second. When this behavior occurs, she is prompted to spit the food out. At times she would comply, other times she would continue chewing and swallow the food. At the time of the incident, [client A] had a choking risk in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowing, using the plate to plate method. She was currently prescribed a pureed diet due to her high risk for choking. [Client A] has a behavior support plan which includes targeted behaviors of stealing, non-compliance, and gorging. Staff working at the day program on the day of the incident all were able to describe the interventions from [client A's] choking plan and were aware of her targeted behaviors of stealing and gorging food."</p> <p>The investigation indicated an administrative memo dated 8/8/13 was delivered to all clients, families, group home and waiver sites that peanut butter in any form is no longer allowed in the</p>			

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	<p>day services program. It indicated day services DSP (direct support professionals) would ensure all lockers would be locked at the end of the day, and to ensure lunches are secured at the beginning of the day, and day services janitor would be responsible to clean the break room after lunch "to ensure trash containers, and floor and table are cleared of any food items...."</p> <p>Included in the investigation were client A's records as follows: A 6/1/13 Gastritis (stomach upset) and risk of choke and Nutritional Supports which indicated, "[client A] will receive diet as ordered by physician, staff will be in constant attendance during meals and will assist consumer with healthy food choices, encourage [client A] to eat slowly, using plate to plate method, staff will monitor [client A] for signs and symptoms of increased swallow difficulties, staff will monitor [client A] at all times with food and fluid intake due to high risk for choking, staff will encourage [client A] to have slow intake of food and fluid, staff will be trained in when to notify the nurse and when to call 911...." There were no guidelines in the plan to indicate client A's supervision needs to prevent her from ingesting items she shouldn't have.</p> <p>A choking/dysphagia assessment dated</p>			

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	<p>6/24/13 included in the investigation indicated client A is at risk for choking and a choking plan is to be completed. Client A's Behavior Support Plan 6/27/11 included in the investigation packet indicated the the targeted behaviors included stealing and gorging. A section of the plan for non-compliance behavior for food items indicated client A will often refuse to give up a food item that she has stolen, or safely ingest a food item she had purchased. "This puts her at increased risk for choking as the food item is most likely not modified for the texture she needs for safe eating."</p> <p>Interventions included redirection, and supervision of staff while client A was eating the item and providing water to drink. A section on gorging indicated "[client A] has been known to take large amounts of food such as entire packages of cheese, lunchmeat and other food items. She will try to stuff things in her mouth before she is caught or will attempt to hide items and come back and eat them later. [Client A] has had gorging issues since childhood. Interventions included redirection, block and asking her to expel." There were no guidelines in the plan to indicate client A's supervision needs to prevent her gorging or non-compliant food behavior.</p> <p>An ISP (Individual Support Plan)</p>			

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	<p>objective dated 6/27/11 indicated client A would put only one spoonful of food in her mouth, and the methodology included staff would provide direct plate to plate assistance and prompt her to take sips of liquid between bites. Group home staff were responsible for implementing the objective.</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. She indicated she was aware client A's food was to be pureed, and client A would take food, and had two risk plans for choking. She indicated client A was to be supervised while eating and had a plate to plate method during dining. She was not aware of a formal intervention in her plan regarding her supervision needs while not dining, but indicated it was common practice of workshop staff to know the whereabouts of clients at all times. She stated client A was "very quick" when she obtained food others threw away and staff would follow her around during lunch time to ensure she did not obtain food from the trash or from other clients. She indicated she was unaware client A had left the workshop area until she saw her in distress after leaving the restroom at 8:30 AM. Workshop staff #1 indicated she had initiated the Heimlich maneuver when she noticed client A was choking after alerting staff and 911 had been called by</p>			

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	<p>other staff after client A went limp.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated client A had two risk plans to address her choking. She indicated client A's plan indicated staff were to watch for client A's stealing of food.</p> <p>Client A's records were reviewed at the facility's administrative offices on 8/14/13 at 3:11 PM. A 5/13/13 dining plan indicated a Heart Health diet with pureed texture. Eating Behaviors/Precautions indicate "HIGH RISK FOR CHOKING. Takes large bites, eats too fast, doesn't chew thoroughly. Takes more than recommended portions, gorges throughout the day, talks, screams with food in her mouth. Difficulty swallowing." The plan did not indicate instructions to staff to address her identified behaviors. A Social History update dated 6/24/13 indicated in part, "All of [client A's] behavioral rates saw decreases in the last year except for non-compliance with food items, which remained the same." The 6/24/13 Lifestyle Plan indicated client A "requires 24 hour supervision and care, with supervision needed every 15 minutes in the home and eyesight supervision when in the community." A dining objective dated 6/24/13 indicated client A</p>			

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	<p>was to take a drink between bites. A BSP dated 6/24/13 included the interventions for non-compliant food behavior and gorging as indicated in her 6/27/11 plan at the workshop.</p> <p>The PMSGL, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. When asked what had been in place to prevent client A from choking while at day services, the QIDP indicated she had included interventions for staff to take when she obtained food she wasn't to have including offering water to prevent choking and a dining plan for meals. She indicated client A was to have eyesight supervision while in the community and every 15 minute checks while at the group home, but there were no guidelines in her plan to indicate her supervision level needs while at workshop.</p> <p>2. A BDDS report dated 8/7/13 indicated client B was eating a piece of bread during break time at day services. Client B began coughing and staff encouraged her to continue to cough. When staff observed that she was no longer able to cough on her own they began the Heimlich maneuver and the bread was able to come up out of her throat. "QDDP (Qualified Developmental Disabilities Professional) of ResCare was notified and</p>			

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	<p>per their policy [client B] was taken to [hospital] for evaluation. Evaluation was negative for any signs or symptoms of aspiration. [Client B] does not currently have a choking risk plan, however staff noted that they had encouraged her to take small bites and chew thoroughly prior to [client B] choking on the bread. Treating physician at Emergency room stated no injury was noted." There was no evidence of a change in client B's dining plan or other corrective action to prevent further choking incidents on bread for client B indicated in the report.</p> <p>Observations were completed at the group home on 8/13/13 from 4:55 PM to 5:30 PM. Client D ate her dinner sitting at the dining room table. Staff #1 sat beside her placing one teaspoonful of food on her plate at a time. Client D's onion rings, chicken nuggets were ground and mixed vegetables were soft.</p> <p>Client B's record was reviewed at the group home on 8/13/13 at 4:01 PM. A dining plan dated 5/13/13 indicated client B was to receive a Heart Health diet with regular texture and had Behaviors/Precautions of takes large bites, eats too fast, alternate between solids and liquids. There were no instructions to staff as to how address client B's behaviors noted on the plan.</p>			

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	<p>Client D's record was reviewed in the group home on 8/13/13 at 5:21 PM. A dining plan dated 5/13/13 indicated client D was to receive a Heart Health diet, regular texture with toast cut into bite sized pieces, monitor portion size. Eating Behaviors/Precautions included, takes large bites, talks with mouth full of food, eats quickly, guzzles her drinks, stuffs solids, alternate between solids and liquids. There were no instructions to have staff use a plate to plate method or other instructions for staff to address her behaviors noted on the plan.</p> <p>Staff #2 was interviewed on 8/13/13 at 5:00 PM. She stated client D recently was placed on a mechanical soft diet as a "precaution" due to too large of a bite size and "watery eyes" (when eating).</p> <p>Observations were completed at the workshop on 8/14/13 from 11:10 AM to 12:25 PM. Client I showed the surveyor her locker with a combination lock securing the contents of a vinyl bag at 11:11 AM. At 12:00 PM, Client D heated her mixed vegetables up in the microwave and ate them without assistance from staff. Client B ate her mixed vegetables at a table seated with clients D and F and without prompts from staff to chew her food thoroughly or to put her utensil</p>			

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	<p>down between bites. Workshop staff #1, #2, #3 and the QDDP from the workshop walked past the clients eating, but did not provide constant and direct supervision. At the conclusion of her meal, client D drank 5 large gulps of her water bottle without intervention from staff.</p> <p>The interim Program Director (PD) was interviewed on 8/14/13 at 12:20 PM. When asked if client D had a dining plan, she stated, "No I don't think so. She's a safe eater."</p> <p>The interim PM at the workshop was interviewed again on 8/14/13 at 1:20 PM regarding client B's choking incident. She indicated client B had choked on bread. Client B had been asked by the PM if she choked on purpose and client B stated, "I wanted to go to the hospital." She indicated staff thought client B was pretending to choke at first and then she did choke. When asked what plans were in place to prevent future incidents of choking for client B, the PM indicated staff were watching her more closely, but no formal interventions had been put into place. She stated, "They haven't changed anything as far as I know."</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. Workshop staff #1 indicated client B did not have a plan for</p>			

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	<p>dining, but that she ate rapidly and stated, "She's done (eating lunch) in two minutes." and "We have to constantly tell her to slow down. She put a whole piece of bread in her mouth that day." She indicated staff had reminded client B to slow down and take small bites. Workshop staff #1 indicated she had spoken to the nurse about reviewing the needs of all clients for dining plans, but there was nothing specific in place for client B regarding dining.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated she had prompted client B to slow down before she choked. She indicated client B's rapid rate of eating was common.</p> <p>The PMSGL, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. The QIDP indicated the incident of choking with client B on 8/7/13 had been reported as choking with struggle. She indicated she was unaware of an investigation into the incident and no interventions had been made by the QIDP to address client B's risk of choking to prevent future episodes. She indicated staff sit next to client B at home to encourage client B to cut up her food into bite sized pieces. She indicated client D had recently been switched to a mechanical soft diet with plate to plate as</p>			
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	<p>needed by staff to address unsafe eating practices of large bites and not drinking between bites. She indicted the intervention for client D was not communicated to workshop, and they should have been notified.</p> <p>Client B's records at the facility's office were reviewed on 8/14/13 at 4:01 PM. A dining objective indicated she was to put her fork/spoon down between bites. Methodology indicated staff should remind client B to "chew her food completely and thoroughly before putting another bite in her mouth in order to prevent her from choking. Throughout the meal, staff will prompt [client B] to lay her eating utensil down between bites. Staff should sit near [client B] during the meal to provide continuous training. The goal is to be trained at all meals and snacks, with data collected during the morning and evening meals."</p> <p>Client D's records were reviewed on 8/14/13 at 4:31 PM at the facility's administrative offices. An ISP (Individual Support Plan) objective dated 11/21/12 indicated client D "will independently use her napkin." There was nothing in the dining objective to indicate additional staff interventions to assist client D with dining.</p>			

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	<p>The QIDP was interviewed on 8/14/13 at 4:05 PM and indicated she was unsure if the dining precautions were available to workshop staff except in their dining objectives. She indicated the definition of "near" for client D was to sit right next to her during meals.</p> <p>A revised risk plan for choking dated 8/9/13 for client B was reviewed on 8/14/13 at 4:25 PM. It indicated staff would "monitor" for signs and symptoms of increased swallowing difficulties, and would "monitor " at all times with food and fluid intake due to high risk of choking. Staff will encourage slow intake and fluid. There were no instructions as to what type of monitoring or staff supervision were needed to address her high risk of choking.</p> <p>A Risk Assessment for Choking dated 8/7/13 for client B was reviewed on 8/14/13 at 4:26 PM and indicated client B had a previous history of Heimlich use, a swallow study was requested and rate and size, and rapid spooning were noted.</p> <p>The QIDP was interviewed on 8/14/13 at 5:30 PM. She indicated she had not provided or trained workshop staff on the revised plan.</p> <p>The QDDP for the workshop was</p>			

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	<p>interviewed on 8/15/13 at 8:30 AM and indicated there were no other plans for clients A, B, and D available at the workshop other than those reviewed on 8/14/13.</p> <p>The interim workshop Program Director was interviewed on 8/15/13 at 1:30 PM. She indicated workshop staff were trained on clients' ISP objectives included dining objectives, but did not document their progress. She indicated workshop staff were to implement the objectives contained in the ISP.</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-2(a)</p>				

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W000159	<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. Based upon record review, interview and observation, the QIDP (Qualified Intellectual Disabilities Professional) failed for 3 of 3 sampled clients (clients A, B and D) to ensure client A's plan included her supervision needs to prevent gorging and non-compliant food behavior, failed to immediately develop a plan to address client B's choking risk after an incident of choking occurred, and failed to ensure outside services were provided training to implement plans to prevent choking for clients B and D after a risk of choking had been identified.</p> <p>Findings included:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 8/13/13 at 3:45 PM and included the following:</p> <p>1. A BDDS report dated 8/6/13 indicated client A was found choking at 8:30 AM, was given the Heimlich maneuver and CPR without success in expelling the food from her throat. Day service nursing staff who had administered CPR noted "a</p>	W000159	<p>The QIDP will ensure client plans include supervision needs to prevent stealing food or any other non-compliant food behaviors. The QIDP will immediately develop a plan to address client choking risk after an incident of choking occurs and ensure outside services are provided training to implement these plans. The QIDP was given corrective disciplinary action for not communicating client D's dining plan to the workshop and for not thoroughly reviewing and addressing client B's incident at the workshop. The QIDP has received training to ensure that ISP/BSP will include supervision needs to prevent stealing food or any other non-compliant food behavior and that outside services will be provided training to implement plans to prevent choking for clients at risk for choking. The QIDP will observe lunch at the workshop at least one time per week and document those observations. The Supported Group Living Manager and/or Quality will complete monthly audits of this home to ensure compliance with interventions for consumers.</p>	09/21/2013			

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	<p>large amount of peanut butter"was expelled and client A had shallow respirations. Her respirations ceased again, and CPR was resumed until EMS (emergency medical services) arrived. Client A was transported to the hospital via EMS who arrived "within 5 minutes." The report indicated client A "had a choking risk plan in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowly, using the plate to plate method (one spoon of food at a time). She is currently prescribed a pureed diet due to her high risk for choking. Additional staff is to monitor her at all times with food and fluid intake due to high risk for choking. [Client A] has a behavior support plan which includes...targeted behaviors of stealing, non-compliance, and gorging." The report indicated client A had arrived at the workshop at "approximately" 7:45 AM. "[Client A's] group home staff had checked [client A] prior to leaving to be sure she had not stolen or hid any food in her pockets. Finding none, ResCare staff left. At approximately 8:15 AM, [workshop staff #1] and staff #10 from [group home] had spoken to [client A]...." Other unidentified staff had observed client A talking about her birthday and had seen client A sit at a work station, though she had not engaged in a work</p>			

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	<p>activity. The report indicated client A "typically greets other consumers and staff upon their arrival to the day program." The report indicated client I arrived at the workshop at 8:25 AM and proceeded to her work station. The staff from client I's group home "accompanied [client I] to the workshop, ...made eye contact with [workshop staff #1] and left. During the course of the investigation, it was verified that [client I] had a peanut butter sandwich in her lunch and her sandwich was missing from her lunch box. The next time [client A] was observed was at 8:30 AM when she came into the work services area from the ladies room and appeared to be in distress." A follow up report dated 8/14/13 was reviewed on 8/16/13 at 10:30 AM and indicated client A passed away at the Intensive Care Unit on 8/14/13 after the choking incident on 8/6/13. The report indicated client A did not regain consciousness and was placed on a ventilator. After an EEG revealed there was no brain activity, client A's guardians made the decision to take her off the ventilator.</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 8/13/13 at 3:45 PM. She indicated the investigation into client A's choking was ongoing and being conducted by day</p>			

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	<p>services staff. She indicated the group home staff and workshop staff were going to meet the following day regarding the incident and corrective action to prevent future incidents.</p> <p>The interim PD of the workshop was interviewed on 8/14/13 at 11:45 AM. She indicated the plan to secure food had been in place prior to the incident of choking by client A. She indicated workshop staff were to ensure lunches were locked in client lockers in the morning upon arrival, and indicated training was offered to teach clients to use the locks if they were not able to do so independently. She indicated the workshop started at 8:00 AM and client I arrived late at 8:25 AM. She indicated group home staff made eye contact with workshop staff, but no staff saw client I put her lunch in her locker. She indicated staff had noticed the peanut butter sandwich was missing from client I's lunchbox after the incident and a new procedure was put into place to lock the lockers in the evening so clients would not be able to put their lunches in the lockers without staff assistance or monitoring. She indicated group home staff will now walk clients into the area, talk to workshop staff to notify them of clients' arrival and ensure client lunches are secured before leaving the workshop.</p>			

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	<p>The workshop QDDP (Qualified Developmental Disabilities Professional) was interviewed on 8/14/13 at 12:30 PM. She indicated client A had arrived at 7:45 AM and had a routine of greeting staff and clients. Client A had been talking about her birthday prior to the incident. Workshop staff had last observed client A in the workshop area between 8:15 AM and 8:25 AM. The next time she was observed, she was in distress. She indicated client I had arrived at 8:25 AM and client A was found choking at 8:30 AM. She stated there was a procedure in place prior to the incident that workshop staff were to ensure client lunches were locked, but "since she (client I) came late, staff hadn't gotten over to ensure it (her lunch) was locked." She indicated workshop staff #5 often ensured client lunches are locked, but it was not an assigned role. She indicated workshop staff had realized client I's sandwich was gone after client A was taken to the hospital. She indicated the workshop had sent out a memo to all clients and providers they would not allow peanut butter to be brought into the workshop due to the risk of choking it presented to clients at risk for choking. She indicated lockers would now be locked at night to reduce the risk of clients placing their lunches unsecured into lockers upon their arrival in the morning. She indicated the</p>			

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	<p>group home staff would now be working together with the workshop staff to ensure lunches are secured before group home staff leave the workshop area.</p> <p>The investigation (undated) into the incident of client A's choking was reviewed on 8/14/13 at 12:45 PM. It indicated in part, "At approximately 8:15 AM, [client A] spoke to ResCare staff about her birthday at the workshop. At 8:25 AM, [client I] arrived from another ResCare group home arrived and sat at her work station, the staff delivered the communication book and made eye contact with day services staff and left". According to ResCare staff (unidentified) the individual who transported client I to day services "was filling in for the regular staff that was on vacation and did not lock [client I's] locker when her lunch was placed in it. [Day services] had a system in place whereby staff would check lockers to be sure lunches and belongings were secured. On this day, they had not had a chance to check [client I's] locker before this incident happened...[Day services] staff did not observe [client A] steal the sandwich, therefore was unable to redirect her, or provide any type of oversight when she was eating the sandwich, per her choking plan."</p> <p>The investigation indicated client A has a</p>			

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	<p>history of stealing other's food off their plates and also getting food out of the trash and eating it. "[Client A] has been observed to watch staff carefully and other consumers to see what they put in the trash. When staff turns their head, she would swiftly grab the food and shove it in her mouth within just a second. When this behavior occurs, she is prompted to spit the food out. At times she would comply, other times she would continue chewing and swallow the food. At the time of the incident, [client A] had a choking risk in place with interventions which include constant attendance during meals; encouraging [client A] to eat slowing, using the plate to plate method. She was currently prescribed a pureed diet due to her high risk for choking. [Client A] has a behavior support plan which includes targeted behaviors of stealing, non-compliance, and gorging. Staff working at the day program on the day of the incident all were able to describe the interventions from [client A's] choking plan and were aware of her targeted behaviors of stealing and gorging food."</p> <p>Included in the investigation were client A's records as follows: A 6/1/13 Gastritis (stomach upset) and risk of choke and Nutritional Supports which indicated, "[client A] will receive diet as ordered by physician, staff will be in constant</p>			

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	<p>attendance during meals and will assist consumer with healthy food choices, encourage [client A] to eat slowly, using plate to plate method, staff will monitor [client A] for signs and symptoms of increased swallow difficulties, staff will monitor [client A] at all times with food and fluid intake due to high risk for choking, staff will encourage [client A] to have slow intake of food and fluid, staff will be trained in when to notify the nurse and when to call 911...." There were no guidelines in the plan to indicate client A's supervision needs to prevent her from ingesting items she shouldn't have.</p> <p>A choking/dysphagia assessment dated 6/24/13 included in the investigation indicated client A was at risk for choking and a choking plan is to be completed. Client A's Behavior Support Plan 6/27/11 included in the investigation packet indicated the targeted behaviors included stealing and gorging. A section of the plan for non-compliance behavior for food items indicated client A will often refuse to give up a food item that she has stolen, or safely ingest a food item she had purchased. "This puts her at increased risk for choking as the food item is most likely not modified for the texture she needs for safe eating." Interventions included redirection, and supervision of staff while client A was eating the item</p>			

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	<p>and providing water to drink. A section on gorging indicated "[client A] has been known to take large amounts of food such as entire packages of cheese, lunchmeat and other food items. She will try to stuff things in her mouth before she is caught or will attempt to hide items and come back and eat them later. [Client A] has had gorging issues since childhood. Interventions included redirection, block and asking her to expel." There were no guidelines in the plan to indicate client A's supervision needs to prevent her gorging or non-compliant food behavior.</p> <p>An ISP (Individual Support Plan) objective dated 6/27/11 indicated client A would put only one spoonful of food in her mouth, and the methodology included staff would provide direct plate to plate assistance and prompt her to take sips of liquid between bites. Group home staff were responsible for implementing the objective.</p> <p>Workshop staff #1 was interviewed on 8/14/13 at 1:35 PM. She indicated she was aware client A's food was to be pureed, and client A would take food, and had two risk plans for choking. She indicated client A was to be supervised while eating and had a plate to plate method during dining. She was not aware of a formal intervention in her plan</p>			

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	<p>regarding her supervision needs while not dining, but indicated it was common practice of workshop staff to know the whereabouts of clients at all times. She stated client A was "very quick" when she obtained food others threw away and staff would follow her around during lunch time to ensure she did not obtain food from the trash or from other clients. She indicated she was unaware client A had left the workshop area until she saw her in distress after leaving the restroom at 8:30 AM. Workshop staff #1 indicated she had initiated the Heimlich maneuver when she noticed client A was choking after alerting staff and 911 had been called by other staff after client A went limp. Workshop staff #1 indicated client B did not have a plan for dining, but that she ate rapidly and stated, "She's done (eating lunch) in two minutes." and "We have to constantly tell her to slow down. She put a whole piece of bread in her mouth that day." She indicated staff had reminded client B to slow down and take small bites. Workshop staff #1 indicated she had spoken to the nurse about reviewing the needs of all clients for dining plans, but there was nothing specific in place for client B regarding dining.</p> <p>Workshop staff #2 was interviewed on 8/14/13 at 2:00 PM. She indicated client A had two risk plans to address her</p>			

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	<p>choking, and she had assisted with giving the Heimlich maneuver to both clients A and B after they choked. She indicated client A's plan indicated staff were to watch for client A's stealing of food. She indicated she had prompted client B to slow down before she choked. She indicated client B's rapid rate of eating was common.</p> <p>Client A's records were reviewed at the facility's administrative offices on 8/14/13 at 3:11 PM. A 5/13/13 dining plan indicated a Heart Health diet with pureed texture. Eating Behaviors/Precautions indicate "HIGH RISK FOR CHOKING. Takes large bites, eats too fast, doesn't chew thoroughly. Takes more than recommended portions, gorges throughout the day, talks, screams with food in her mouth. Difficulty swallowing." The plan did not indicate instructions to staff to address her identified behaviors. A Social History update dated 6/24/13 indicated in part, "All of [client A's] behavioral rates saw decreases in the last year except for non-compliance with food items, which remained the same." The 6/24/13 Lifestyle Plan indicated client A "requires 24 hour supervision and care, with supervision needed every 15 minutes in the home and eyesight supervision when in the community." A dining</p>			

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	<p>objective dated 6/24/13 indicated client A was to take a drink between bites. A BSP dated 6/24/13 included the interventions for non-compliant food behavior and gorging as indicated in her 6/27/11 plan at the workshop. There was nothing in client A's record to indicate client A's supervision needs at the workshop except during dining.</p> <p>The PMSG, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. When asked what had been in place to prevent client A from choking while at day services, the QIDP indicated she had included interventions for staff to take when she obtained food she wasn't to have including offering water to prevent choking. She indicated client A was to have eyesight supervision while in the community and every 15 minute checks while at the group home, but there were no guidelines in her plan to indicate her supervision level needs while at workshop other than at mealtimes.</p> <p>The PMSG was interviewed again on 8/13/13 at 4:14 PM. She indicated workshop staff were aware of client A's history of taking and gorging on food and that her food was to be of pureed consistency. She was unaware of the procedures at the workshop for securing food.</p>			

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	<p>2. A BDDS report dated 8/7/13 indicated client B was eating a piece of bread during break time at day services. Client B began coughing and staff encouraged her to continue to cough. When staff observed that she was no longer able to cough on her own they began the Heimlich maneuver and the bread was able to come up out of her throat. "QDDP (Qualified Developmental Disabilities Professional) of ResCare was notified and per their policy [client B] was taken to [hospital] for evaluation. Evaluation was negative for any signs or symptoms of aspiration. [Client B] does not currently have a choking risk plan, however staff noted that they had encouraged her to take small bites and chew thoroughly prior to [client B] choking on the bread. Treating physician at Emergency room stated no injury was noted." There was no evidence of a change in client B's dining plan or other corrective action to prevent further choking incidents on bread for client B indicated in the report.</p> <p>Observations were completed at the group home on 8/13/13 from 4:55 PM to 5:30 PM. Client D ate her dinner sitting at the dining room table. Staff #1 sat beside her placing one teaspoonful of food on her plate at a time. Client D's onion rings, chicken nuggets were ground and mixed</p>			
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	<p>vegetables were soft.</p> <p>Client B's record was reviewed at the group home on 8/13/13 at 4:01 PM. A dining plan dated 5/13/13 indicated client B was to receive a Heart Health diet with regular texture and had Behaviors/Precautions of takes large bites, eats too fast, alternate between solids and liquids. There were no instructions to staff as to how address client B's behaviors noted on the plan.</p> <p>Client D's record was reviewed in the group home on 8/13/13 at 5:21 PM. A dining plan dated 5/13/13 indicated client D was to receive a Heart Health diet, regular texture with toast cut into bite sized pieces, monitor portion size. Eating Behaviors/Precautions included, takes large bites, talks with mouth full of food, eats quickly, guzzles her drinks, stuffs solids, alternate between solids and liquids. There were no instructions to have staff use a plate to plate method or other instructions for staff to address her behaviors noted on the plan.</p> <p>Staff #2 was interviewed on 8/13/13 at 5:00 PM. She stated client D recently was placed on a mechanical soft diet as a "precaution" due to too large of a bite size and "watery eyes" (when eating).</p>			

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	<p>Observations were completed at the workshop on 8/14/13 from 11:10 AM to 12:25 PM. Client I showed the surveyor her locker with a combination lock securing the contents of a vinyl bag at 11:11 AM. At 12:00 PM, clients B and F got their lunches from their locked lockers after workshop staff #4 opened the combination locks for them. Client D got her lunch from her locker after using a key to open the lock on the door. Client D heated her mixed vegetables up in the microwave and ate them without assistance from staff. Client B ate her mixed vegetables at a table seated with clients D and F and without prompts from staff to chew her food thoroughly or to put her utensil down between bites. Workshop staff #1, #2, #3 and the QDDP from the workshop walked past the clients eating, but did not provide constant and direct supervision. At the conclusion of her meal, client D drank 5 large gulps of her water bottle without intervention from staff.</p> <p>The interim Program Director (PD) was interviewed on 8/14/13 at 12:20 PM. When asked if client D had a dining plan, she stated, "No I don't think so. She's a safe eater."</p> <p>The interim PM at the workshop was interviewed again on 8/14/13 at 1:20 PM</p>			

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	<p>regarding client B's choking incident. She indicated client B had choked on bread. Client B had been asked by the PM if she choked on purpose and client B stated, "I wanted to go to the hospital." She indicated staff thought client B was pretending to choke at first and then she did choke. When asked what plans were in place to prevent future incidents of choking for client B, the PM indicated staff were watching her more closely, but no formal interventions had been put into place. She stated, "They haven't changed anything as far as I know."</p> <p>The PMSG, QIDP and Quality Assurance Coordinator were interviewed on 8/14/13 at 3:15 PM. The QIDP indicated the incident of choking with client B on 8/7/13 had been reported as choking with struggle. She indicated she was unaware of an investigation into the incident and no interventions had been made by the QIDP to address client B's risk of choking to prevent future episodes. She indicated staff were to sit next to client B at home to encourage client B to cut up her food into bite sized pieces. She indicated client D had recently been switched to a mechanical soft diet with plate to plate bites provided as needed by staff to address unsafe eating practices of large bites and not drinking between bites. She indicted the intervention for client D</p>			

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	<p>was not communicated to workshop, and they should have been notified. She indicated the intervention for staff to sit with client B during meals had not been communicated to workshop staff.</p> <p>Client B's records at the facility's office were reviewed on 8/14/13 at 4:01 PM. A dining objective indicated she was to put her fork/spoon down between bites. Methodology indicated staff should remind client B to "chew her food completely and thoroughly before putting another bite in her mouth in order to prevent her from choking. Throughout the meal, staff will prompt [client B] to lay her eating utensil down between bites. Staff should sit near [client B] during the meal to provide continuous training. The goal is to be trained at all meals and snacks, with data collected during the morning and evening meals."</p> <p>Client D's records were reviewed on 8/14/13 at 4:31 PM at the facility's administrative offices. An ISP (Individual Support Plan) objective dated 11/21/12 indicated client D "will independently use her napkin." There was nothing in the dining objective to indicate additional staff interventions to assist client D with dining.</p> <p>The QIDP was interviewed on 8/14/13 at</p>			

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	<p>4:05 PM and indicated she was unsure if the dining plan precautions were available to workshop staff except in their dining objectives. She indicated the definition of "near" for client D was to sit right next to her during meals and indicated there were no dining plans at the day service/workshop other than dining objectives in the ISP.</p> <p>A revised risk plan for choking dated 8/9/13 for client B was reviewed on 8/14/13 at 4:25 PM. It indicated staff would "monitor" for signs and symptoms of increased swallowing difficulties, and would "monitor " at all times with food and fluid intake due to high risk of choking. Staff will encourage slow intake and fluid. There were no instructions as to what type of monitoring or staff supervision were needed to address her high risk of choking.</p> <p>The PMSGGL was interviewed again on 8/13/13 at 4:14 PM. She stated the incident of client B choking was being investigated and it was thought the incident may have been an "emotional reaction" by client B and "over-reaction by workshop staff."</p> <p>A Risk Assessment for Choking dated 8/7/13 for client B was reviewed on 8/14/13 at 4:26 PM and indicated client B</p>			

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	<p>had a previous history of Heimlich use, a swallow study was requested and rate and size, and rapid spooning were noted.</p> <p>The QIDP was interviewed on 8/14/13 at 5:30 PM. She indicated she had not trained workshop staff on the revised plan for client B.</p> <p>The QDDP for the workshop was interviewed on 8/15/13 at 8:30 AM and indicated there were no other plans for clients A, B, and D available at the workshop.</p> <p>This federal tag relates to complaint #IN00134375.</p> <p>9-3-3(a)</p>			