

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the investigation of Complaint #IN00108475 and Complaint #IN00107965. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00108475: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W155, W156, W157, and W189.</p> <p>Complaint #IN00107965: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W155, W156, W157, and W189.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: May 14, 15, 16, 17, 18, 21, 22, and 23, 2012</p> <p>Facility Number: 000622 Provider Number: 15G079 AIM Number: 100272170</p> <p>Survey Team: Brenda Nunan RN, Public Health Nurse Surveyor III - Team Leader Paula Chika, Medical Surveyor III (May 16, 22, 23, 2012) Amber Bloss, Medical Surveyor III (May</p>	W0000	<p><u>DISCLAIMER STATEMENT</u></p> <p>- Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal & State Law.</p> <p>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."</p>	

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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	16, 2012) These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 5/30/12 by Ruth Shackelford, Medical Surveyor III.			

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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of a client in regard to an incident where client C ate another client's sandwich and choked, resulting in death. The governing body failed to ensure facility staff monitored/supervised client C to prevent her from eating another client's sandwich, causing her to choke resulting in death.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (C). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client C by not providing supervision when food was present to a client who required a modified diet texture and had a history of attempting to take food from peers which resulted in an Immediate Jeopardy for client C. Please see W122. The facility's governing body failed to 	W0102	<p>W 102 Governing Body and Management</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p><u>I Corrective Action for Cited Clients:</u> Residents have been assessed as to whether they attempt to steal food, whether successful or not. If they do, a plan will be implemented to address the issue. Staff are to supervise residents at all times when consuming food. During meals formal monitoring takes place. An audit process is being used to ensure the monitoring is completed. Formal monitoring for meals and snacks is scheduled through June 15, 2012. After this date monitoring will be completed by QMRP/Designee for Breakfast, lunch and dinner during the week and the Manager on Duty will complete rounds to each dining room on the weekends for lunch, dinner and snack time. Nursing will be present during meal times. Any resident eating will be supervised. Training has been completed to assure staff are aware of this procedure.</p>	06/22/2012			

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	<p>ensure the facility implemented its policy and procedures to prevent neglect of client C in regard to an incident where the client ate another client's sandwich and choked, resulting in death. The governing body failed to ensure facility staff monitored/supervised a client to prevent her from eating another client's sandwich, causing her to choke and die for 1 of 3 sampled clients (client C). Please see W104.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-13(s) 3.1-28(a) 3.1-28(d) 3.1-28(e)</p>		<p>Orientation has been updated to include this information.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> The Functional Skills Assessment has been updated to include food stealing or attempts to steal food as an area of assessment with required formal intervention for these issues. Program Directors review information from dining audits and assure issues of concern are addressed. Orientation has been updated to include supervision of residents when eating and nursing and QMRP/Designee monitoring of meals and snacks.</p> <p>-</p> <p><u>IV Monitoring Corrective Measures:</u> Program Directors review Functional Skill Assessments for accuracy and needed interventions. Issues and concerns from Dining audits are reported to the ED/DNS for systemic follow up or further action. To be completed by 6-22-12.</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the governing body failed to exercise operating direction over the facility to ensure staff supervision was sufficient to meet the needs of the client C. The governing body failed to exercise general policy and operating direction over the facility to ensure its policy and procedures were implemented to prevent neglect of client C in regard to an incident where client C ate another client's sandwich and choked, resulting in death.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility's governing body failed to exercise operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect in regard to an incident where staff neglected to provide supervision to prevent client C from eating another client's sandwich, resulting in choking and death. Please see 149. The facility's governing body failed to exercise operating direction over the facility to ensure the facility implemented 	W0104	<p>W 104 Governing Body</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p><u>I Corrective Action for Cited Clients:</u> An audit process is being used to ensure the monitoring is completed. Formal monitoring for meals and snacks is scheduled through June 15, 2012. After this date monitoring will be completed by QMRP/Designee for Breakfast, lunch and dinner during the week and the Manager on Duty will complete rounds to each dining room on the weekends for lunch, dinner and snack time. Nursing will be present during meal times. Any resident eating will be supervised. Training has been completed to assure staff are aware of this procedure. Orientation has been updated to include this information. Staff have been trained in RESQ techniques that address needed intervention for a conscious and unconscious choking victim.</p> <p><u>II Other Clients Potentially at Risk:</u></p>	06/22/2012			

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	<p>its policy and procedures to ensure the facility staff provided necessary supervision of client C when snacks were available in the North hall classroom and failed to exercise operating direction over the facility to ensure staff were trained to recognize and respond to conscious and unconscious choking. Please see W189.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-13(s) 3.1-13 (b)(1) 3.1-12(b)(2)</p>		<p>All residents might be at risk for this deficient practice.</p> <p>- <u>III Corrective Measures or Systemic Changes:</u> Program Directors review information from dining audits and assure issues of concern are addressed. Issues and concerns from Dining audits will be brought to morning meeting for follow up and information even if already addressed. Program Directors review the Safe Eating and Active Treatment Audits for issues and concerns and those issues are reported to the ED/DNS for systemic or further action.</p> <p>- <u>IV Monitoring Corrective Measures:</u> Issues and concerns from Dining audits will be brought to morning meeting for follow up and information even if already addressed. RESQ techniques are now included in the orientation process. To be completed by 6-22-12.</p>		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (C). The facility neglected to implement its policy and procedures to prevent neglect of clients in regard to ensuring the facility staff monitored/supervised clients to ensure client C did not have access to solid foods and/or thin liquids.</p> <p>This non-compliance resulted in an Immediate Jeopardy. The facility neglected to ensure staff were trained to recognize and react to signs and symptoms of choking after client B choked on 05/01/2012 and neglected to ensure staff responded with prompt/appropriate interventions when client C choked. The facility neglected to implement its policy and procedure to suspend all staff, pending investigation, who allegedly neglected client C. The facility neglected to ensure client C did not consume a regular textured bologna sandwich which resulted in her choking and dying. The Immediate Jeopardy was identified on 05/16/2012 at 5:30 p.m. The Administrator and Director of Nursing were notified of the Immediate</p>	W0122	<p>W 122 Client Protections</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p><u>I Corrective Action for Cited Clients:</u> An audit process is being used to ensure the monitoring is completed. Formal monitoring for meals and snacks is scheduled through June 15, 2012. After this date monitoring will be completed by QMRP/Designee for Breakfast, lunch and dinner during the week and the Manager on Duty will complete rounds to each dining room on the weekends for lunch, dinner and snack time. Nursing will be present during meal times. Any resident eating will be supervised. Training has been completed to assure staff are aware of this procedure. Orientation has been updated to include this information. Staff have been trained in RESQ techniques that address needed intervention for a conscious and unconscious choking victim. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly</p>	06/22/2012			

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	<p>Jeopardy on 05/16/2012 at 5:30 p.m. The Immediate Jeopardy began on 05/01/2012. The facility submitted a plan of removal of the Immediate Jeopardy on 05/16/2012 at 9:39 p.m.</p> <p>The Immediate Jeopardy was removed on 5/22/12 through observation, interview and record review. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. During the 5/22/12 observation periods between 1:15 PM and 3:00 PM and 5:07 PM to 6:00 PM, at the facility, clients ate their snacks and were served dinner in the main dining rooms on each floor. The afternoon snacks consisted of pudding and/or ice cream with water to drink. Facility staff were present in the dining room and located at each table with clients. Each table had 1 to 3 staff present with 4 to 5 clients at each table. The table which had pureed diets and/or modified diets had 2 to 3 staff present at the table. Nursing staff were also present in the dining room for each meal and for some snack areas. Qualified Mental Retardation Professionals were also present for each snack and/or meal to monitor the Certified Nurse Aides (CNAs) and the meals. Administrative staff were also present in the dining room monitoring the meals. No choking</p>		<p>investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p>- <u>II Other Clients Potentially at Risk:</u></p> <p>- All residents might be at risk for this deficient practice.</p> <p><u>III Corrective Measures or Systemic Changes:</u> Program Directors review information from dining audits and assure issues of concern are addressed. Issues and concerns from Dining audits will be brought to morning meeting for follow up and information even if already addressed. Program Directors review the Safe Eating and Active Treatment Audits for issues and concerns and those issues are reported to the ED/DNS for systemic or further action. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p>- <u>IV Monitoring Corrective Measures:</u> Issues and concerns from Dining audits will be brought to morning meeting for follow up and information even if already</p>		

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	<p>occurred during the observation periods. Clients were redirected to slow down and place their forks down between bites. Specifically with client #144, the client was upset over staff taking the client's graham crackers and pretzels away.</p> <p>Interview with administrative staff #1 on 5/22/12 at 2:05 PM, indicated the client went to the hospital and returned to the facility with the items as the hospital gave them to the client. Administrative staff #1 indicated the client was on a mechanical soft diet and the food needed to be modified so the client could eat it safely. The Director of Nursing (DON) took the graham crackers and soaked the crackers in some chocolate milk and placed a small amount of water in the bag of pretzels to soften the pretzels so the client could safely chew them and not choke. CNA staff and a LPN staff were located at the dining room table with client #144.</p> <p>Interview with CNA #11 on 5/22/12 at 4:40 PM indicated the facility staff knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #12 on 5/22/12 at 4:44 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview</p>		<p>addressed. RESQ techniques are now included in the orientation process. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. North Willow's abuse and neglect policy has been reviewed by the QAA committee to assure understanding and that it meets regulatory requirements. To be completed by 6-22-12.</p>		

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	<p>with CNA #13 on 5/22/12 at 4:49 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #14 on 5/22/12 at 5:00 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #15 on 5/22/12 at 5:02 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #16 on 5/22/12 at 6:00 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #17 on 5/22/12 at 6:02 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking. Interview with CNA #18 on 5/22/12 at 6:14 PM indicated the CNA knew when to call for help and what to do if a client choked and/or became unconscious due to choking.</p> <p>Interview with LPN #11 on 5/22/12 at 6:06 PM indicated the nursing staff knew where the crash cart was kept/located to utilize in case of a choking. LPN #11 knew what to do in case of a choking, knew when to call 911 and how to</p>						

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	<p>respond to a choking incident. LPN #12 was interviewed on 5/22/12 at 6:17 PM and indicated LPN #12 knew where the crash cart was located, knew when to call 911 and how to respond to a choking incident. Interview with LPN #13 on 5/22/12 at 6:25 PM indicated the LPN knew to call for help when a client choked and how to respond to a choking incident. Interviews with LPN #11, #12 and #13 indicated clients ate their snacks and meals in the dining rooms and nursing staff monitored the meals and/or snacks. The LPNs also indicated the facility's QMRPs monitored the dining room at snack times.</p> <p>Interview with administrative staff #1, the DON, and corporate staff #1 and #2 on 5/22/12 at 6:32 PM indicated administrative staff also conducted monitoring of dining rooms to ensure CNAs and nursing staff were monitoring clients and clients' diets were being followed. Administrative staff #1 indicated the facility was still conducting its investigation in regard to the 5/10/12 choking incident which resulted in death.</p> <p>The facility's inservice records were reviewed on 5/22/12 at 3:15 PM. The facility's inservice records indicated the following trainings were conducted (not all inclusive):</p>			

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	<p>-5/7/12 through 5/11/12 High Choking Risk Residents' Safe Feeding Intervention Plan Inservice</p> <p>-Choking Response Inservice 5/16 through 5/19/12 (when and what to do)</p> <p>-5/14/12 Snacks Inservice for pureed, mechanical soft and regular diets</p> <p>-5/16/12 Dining Room Inservice (monitoring clients and risk plans)</p> <p>-5/10/12 through 5/21/12 Choking first aid and clients with modified diets</p> <p>-5/11/12 through 5/14/12 Choking risk/rapid eating/dysphagia and pocketing food.</p> <p>Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition Level (Client Protections) in that the facility needed to continue to monitor its corrective actions/plan for effectiveness.</p> <p>Findings include:</p> <p>Please see W149. The facility neglected to implement its policy and procedures to prevent neglect of client C in regard to ensuring the facility staff monitored/supervised clients to ensure client C did not have access to solid foods and/or thin liquids. The facility neglected to ensure staff responded with</p>			

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	<p>prompt/appropriate interventions when client C choked.</p> <p>Please see W154. The facility neglected to complete a thorough investigation after a specific allegation of neglect was made after client C choked.</p> <p>Please see W155. The facility neglected to suspend all staff, pending investigation, who allegedly neglected client C.</p> <p>Please see W156. The facility failed to complete its investigation within 5 working days after client C choked.</p> <p>Please see W157. The facility neglected to take sufficient corrective action to ensure staff were trained to recognize and react to signs and symptoms of choking after client B choked on 05/01/2012 and neglected to ensure staff responded with prompt/appropriate interventions when client C choked.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-28(a) 3.1-28(d) 3.1-28(e)</p>						

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W0130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure client F's privacy by failing to prevent visibility of client F's exposed breasts to visitors entering the building through the North entrance.</p> <p>Findings include:</p> <p>During observations on 05/15/2012 at 8:40 a.m., client F was observed through uncovered and untinted windows at the North entrance to the building standing in the West hallway wearing incontinence briefs. Her breasts were exposed. No clients were in the hall. Client advocate (CA) #1 was trying to cover client F's breasts with a hospital gown.</p> <p>During an interview on 05/15/2012 at 8:40 a.m., CA #1 stated, "I decided to try to quickly cover her up rather than cause a behavior where she lays on the floor and screams." She stated, "[Client F] is free-spirited and likes to be naked."</p> <p>Client F's record was reviewed on 05/16/2012 at 9:52 a.m. The Individual Support Plan, dated 11/01/2011, indicated</p>	W0130	<p>W 130 Protection of Client's Rights</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p><u>I Corrective Action for Cited Clients:</u> The IDT has assessed Client F for undressing in public and needed interventions are included in her plan to address this issue.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> Residents have been assessed by the IDT for undressing in public and if an issue appropriate interventions are included in their plan.</p> <p><u>IV Monitoring Corrective Measures:</u> Program Directors review plans and resident BIRs and when the issue of undressing in public is identified, the IDT meets and</p>	06/22/2012			

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	<p>client F had a goal for dressing/changing clothes in her bedroom.</p> <p>A Behavior Support Plan, dated 11/01/2011, did not indicate a maladaptive behavior of dressing/changing clothes in areas other than her bedroom and did not include interventions to redirect/prevent the behavior.</p> <p>An Interdisciplinary Team (IDT) note, dated 05/15/2012, indicated, "...Met to discuss [client F's] continual clothes stripping issue. The IDT indicated the stripping was sufficiently addressed in her ISP goal. The IDT indicated relocating client F to an alternate bedroom to reduce visibility to clients/visitors approaching the North entrance of the building "has not been considered at this point."</p> <p>3.1-3(p)(4)</p>		develops appropriate interventions that are included in their plan. To be completed by 6-22-12.		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the facility neglected to implement its policy and procedures to prevent neglect of client C in regard to ensuring the facility staff monitored/supervised clients to ensure client C did not have access to solid foods and/or thin liquids. The facility neglected to ensure staff were trained to recognize and react to signs and symptoms of choking after client B choked on 05/01/2012 and neglected to ensure staff responded with prompt/appropriate interventions when client C choked. The facility neglected to implement its policy and procedure to suspend all staff, pending investigation, who allegedly neglected client C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2012 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 04/28/2012 at 12:45 p.m., indicated client D choked on garlic bread and required</p>	W0149	<p>W 149 Staff treatment of Clients</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p><u>I Corrective Action for Cited Clients:</u> Residents have been assessed as to whether they attempt to steal food, whether successful or not. If they do, a plan will be implemented to address the issue. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. Nurses have been trained on the location of the emergency cart. Staff have been trained on seizure recognition, communication and signs and symptoms of aspiration. The Choking Protocol has been revised to include signs and symptoms of choking and how staff proceed from conscious</p>	06/22/2012			

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	<p>abdominal thrusts to clear the food from her airway.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, dated 05/01/2012 at 12:50 p.m., indicated, "... [Client B] coughed as he was eating...She (Certified Nurse Aide) called out, 'he is having a seizure.' The nurse was alerted. Another Certified Nurse Aide (CNA) came over to assist [client B] from another table. This CNA performed abdominal thrusts. The nurse took over and she gave [client B] abdominal thrusts. This was not effective so the nurse and the CNA moved [client B] from the chair to the floor. There the nurse gave abdominal thrust (sic) and did finger sweeps pulling food out of his mouth. This was repeated a few times bringing up and out food that consist (sic) of ground beef and liquid. [Client B] was placed in the recovery position and oxygen was applied via mask. 911 was activated. EMS (Emergency Medical Services) arrived and took over. EMS then took client on to the hospital...."</p> <p>3. An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency</p>		<p>choking victim to unconscious choking interventions. CNA staff have been trained to document only when 2 staff are present. Staff have been trained in RESQ techniques that address needed intervention for a conscious and unconscious choking victim.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>- - - - -</p> <p><u>III Corrective Measures or Systemic Changes:</u> The Functional Skills Assessment has been updated to include food stealing or attempts to steal food as an area of assessment with required formal intervention for these issues. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. The revised Choking Protocol has been trained with Nursing staff. An audit for safe dining and active treatment is being completed that checks that 2 staff are present when documentation is completed and to verbalize what</p>				

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	<p>Room)...."</p> <p>4. An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated, "...Date of Death: 05/11/2012...Circumstances immediately preceding the death, IF KNOWN: Client (C) was in her classroom with two CNA staff and two of her peers. One of her peers had brought a sandwich snack into the classroom without the two attending CNA's informed. [Client C] (Puree diet) inadvertently (sic) took the sandwich and ate it without CNA knowledge...when [client C] wheeled her W/C (wheel chair) to staff and was flapping her hands. Staff unsure what happened and immediately called for nurse. Nursing recognized choking, 911 called and nurse performed abdominal thrusts, unsuccessful. Client then lowered to floor and CPR initiated. 911 arrived (and) preceded with appropriate treatment, stabilized and transported to [hospital] ER...."</p> <p>Client C's record was reviewed on 05/15/12 at 11:20 a.m. A hospital "History and Physical," dated 05/10/2012, indicated, "...The patient...is supposed to be on a puree diet; however, she had a bologna sandwich and aspirated on it. She went into cardiac arrest. Downtime is unspecified, anywhere from 10 minutes</p>		<p>to do when a person is choking. Auditing has been completed to assure the nurses know where the emergency cart is located.</p> <p>- <u>IV Monitoring Corrective Measures:</u> Program Directors review Functional Skill Assessments for accuracy and needed interventions. North Willow's abuse and neglect policy has been reviewed by the QAA committee to assure understanding and that it meets regulatory requirements. RESQ techniques are now included in the orientation process. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. The revised Choking Protocol has been reviewed and approved by the QAA committee. To be completed by 6-22-12.</p>				

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	<p>to 15 minutes. EMS (Emergency Medical Services) got there, got her intubated, and she was in asystolic arrest and then had PEA (Pulseless Electrical Activity). She was successfully resuscitated...and transferred to the Emergency Room...."</p> <p>A "Neurology Imaging," dated 05/11/2012 at 11:09 a.m., indicated, "...The EEG (Electroencephagraphy-test to detect the brain's electrical activity) is abnormal...highly suggestive of severe degree of anoxic encephalopathy (lack of oxygen to the brain) and may suggest extremely poor prognosis...."</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated client C died in the hospital at 11:31 p.m. on 05/11/2012.</p> <p>The facility's investigation related to the 05/10/2012 choking incident should have been completed by 05/18/2012. Documentation of interviews conducted by the facility was reviewed on 05/15/2012 at 1:06 p.m. and on 05/16/2012 at 2:45 p.m.</p> <p>A facility interview, dated 05/11/2012, indicated the Qualified Developmental Disabilities Professional (QDDP) #1 left the facility prior to client C choking. The</p>						

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	<p>record indicated, "...I saw CNA #2 getting snacks. I think it was 8:50 p.m...."</p> <p>A facility interview with LPN #1, dated 05/10/2012, indicated LPN #1 was in the nurse's station when CNA #2 summoned her to assess client C. The interview documentation indicated, "...[Client C] was gasping for breath. Her arms were moving. I picked her up out of her wheelchair and attempted abdominal thrusts...[CNA #3] stated [client C] grabbed the sandwich and stuffed it in her mouth...[CNA #3] said she (client C) has attempted to steal food on occasion...She started foaming from her mouth. Some bread, foam mucous and bologna came out after I laid her on the floor. I had to begin CPR. The paramedics arrived and took over.... (narrative written along side of page in a different hand writing) I will guess it was 8:55 p.m. CNA came to get me. Said she wasn't breathing. As I got (symbol for up) I was calling for [LPN #2]. Went to room. She (client C) was flalling (sic) arms. Air exchange heard. Looked in mouth-nothing seen. Untapped seat belt. Moved (client C) to floor. Hooked B/P (blood pressure) cuff to arm. I was not totally aware of (sic) is this seizure or is this choking cuz (because) CNA stated she had grabbed-assumed she had grabbed sandwhich (sic) from [client E] because they did not see the sandwhich</p>				

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	<p>(sic). Abdominal thrust and rescue breathing started cuz (sic) then she lost consciousness. Told LPN #3 go get crash cart. LPN #2 called 911...didn't get a chance to use machine (Automated External Defibrillator) or suction before EMT's (Emergency Medical Technicians) arrived and took over."</p> <p>A facility interview with CNA #2, dated 05/14/2012, indicated CNA #2 gave client E a sandwich "around 7:00 p.m." The interview documentation indicated CNA #2 was sitting in the classroom when client C choked. The documentation indicated, "...[CNA #3] told me to get the nurse. She was in the nurses' station. Then all the nurses were there in a split second. The CNA indicated, "I saw the bologna come up" when asked by the facility interviewer if any food came up during the abdominal thrusts.</p> <p>An undated facility interview with CNA #4 indicated, "...I gave her (client E) a glass of water and a sandwich and told her to go to the shower room...." The interview documentation indicated, "Maybe right at 9:00 p.m." as the time the sandwich was given to client E.</p> <p>An undated facility interview with LPN #3 indicated, "...I heard [LPN #1] screaming. [LPN #2] was doing g-tube</p>						

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	<p>care and I called her. We went to North. I saw [client C] sitting in the w/c (wheel chair) trying to breathe. One of the aides said she may have swallowed something... We all got her and laid her on the floor and then I went to get O2 (oxygen), BP (blood pressure), AED. [LPN #2] was with me. We then went back to classroom on N (North). We tried to get BP but didn't get anything. We listened to her heart and did hear a thready type pulse. Did not get O2 (oxygen) sat (saturation). [LPN #2] then called 911. [LPN #1] and I were both doing CPR and kept doing it till (sic) EMT's came...."</p> <p>A facility interview with LPN #2, dated 05/11/2012, indicated, "...I was ...doing G-tubes. I went and asked what happened. [Client C] was sitting on floor. I asked if she had a seizure? She was sort of foaming at the mouth. Her lips were turning blue and I called 911. She started to go unconscious. We laid her on the floor. I was trying to get VS (vital signs) and put O2 (oxygen) on her. I got the AED machine. [LPN #1] was doing CPR and swiping her mouth. Stuff was coming out. [LPN #3] was getting the suction. By that time the EMT's arrived...I asked what had happened and was told she had gotten a sandwich. I asked who was in the classroom and they told me it was [CNAs</p>						

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	<p>#2, #3, and #4]...."</p> <p>An undated facility interview with CNA #5 indicated, "...I was on the South hall. I noticed North hall was having a problem so I listened at the door and heard someone say, 'She's not breathing.' I went down there because I know CPR and I wanted to see if they needed help...[Client C] was on the floor and her lips were blue. I got a pillow, put it under her head. I checked for a pulse. No response at all. No pulse, no breathing. I started CPR. [LPN #1] was right there next to me. I heard her gurgling. Someone went to get the suction, O2. I was doing the chest compressions and [LPN #1] was doing the breathing by mouth until she got the mouthpiece and she used it. We switched the roles when I and [LPN #1] got tired. I really don't remember who else was in the room. The next thing I know, the EMT's walked in and took over. I then returned to my hall."</p> <p>A second facility interview with LPN #1 was conducted on 05/15/2012. The interview documentation indicated, "Q (Question): I need to clarify when you were told that [client C] could be choking on a sandwich? A (Answer): Well, [CNA #4] said she gave her a sandwich before she went to the shower...We didn't know it was a sandwich till (sic) after the</p>						

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	<p>paramedics suctioned up bologna...When we were doing CPR-bread had come up. Q: Did you know it was bread at the time? A: No it looked like a bunch of saliva (symbol for with) mucous in it. After the fact we figured out that it must have been bread. Q: So when you first responded [CNA #3] did not mention possibility of her choking on sandwich? A: No cause (sic) I didn't know what I was dealing with. I didn't think she was choking cause (sic) she was making noises. Didn't know if she was having a seizure or going into respiratory distress for unknown reason...."</p> <p>A facility interview with CNA #3 was conducted on 05/15/2012. The interview documentation indicated, "...Nurse said you told her [client C] had grabbed the sandwich and stuffed it in her mouth. No I didn't say that. When were you aware that [client C] had choked on a sandwich? The paramedics said that. I may have said it after we knew for sure what happened but not before. It was crazy...."</p> <p>An EMS record, dated 05/10/2012 at 9:02 p.m., indicated, "...Responded...on a cardiac arrest...Pulses absent, no breath sounds noted noted...asystole (no cardiac electrical activity)...CPR was performed for approximately 10-15 minutes...manual pulse check. CPR continued...for</p>			

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	<p>approximate (sic) 5 minutes...transported...[Hospital] advised of patient and care and report given to RN on duty on arrival...."</p> <p>Client C's record was reviewed on 05/15/2012 at 11:20 a.m. A physician's order, dated May 2012, indicated, "...Diets (sic) Type: Regular Large Portion. Texture: Puree. Fluid consistency: Thickened Liquid Nectar. Special Instructions: ENCOURAGE RESIDENT TO TAKE SMALL BITES/SIPS. NO STRAWS. SLIGHTLY (SIC) (@ 90 DEGREE ANGLE FOR ALL ORAL INTAKE AND (SIC) 20 MIN AFTER (SIC) MEAL. OBSERVE FOR POCKETING...."</p> <p>A Behavior Support Plan(BSP), dated 11/15/11, indicated interventions to reduce/eliminate target behaviors of refusals, AWOL (Absent without Leave), temper tantrums, and physical aggression. The BSP did not address client C attempting to obtain food from peers, food cart, or other sources.</p> <p>A speech-language pathology report, dated 11/22/11, indicated, "...Swallowing Ability...agree with nectar thick liquids. Risk of pocketing (symbol for with) non-pureed foods...."</p>						

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	<p>A Comprehensive Functional Assessment, dated 12/2011 did not indicate client C attempted to take food from peers, food cart, or other sources.</p> <p>An Individual Support Plan (ISP) dated, 12/21/11, indicated, "...Risk for swallowing difficulty...monitor for signs and symptoms of aspirations...provide thickened liquids as ordered...non pureed snacks as requested with supervision...90 (degrees) for oral intake 20 minutes after meal, observe for pocketing (of food in mouth)...."</p> <p>A risk plan, dated 12/21/2011, indicated a health risk of "Swallowing Difficulty." The risk plan indicated, "...Provide a Puree diet...with Nectar thick liquids...Monitor for S/Sx (signs and symptoms) of aspiration...Proper positioning at meals (position not specified in plan)...."</p> <p>An "Interdisciplinary Diagnostic and Evaluation," dated 01/14/2011, indicated, "...[Client C] needs extensive medical monitoring and treatment to address potential for choking, respiratory issues, feeding issues...."</p> <p>A Behavior Incident Report (BIR), dated 04/24/2012 at 8:10 a.m., indicated client C took a piece of French toast from the</p>						

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	<p>serving cart. The BIR indicated she was redirected from eating the toast.</p> <p>A hospital admission "History and Physical," dated 05/10/2012, indicated, "...ADMISSION DIAGNOSES: Cardiac arrest following aspiration eating a bologna sandwich. Unspecified downtime...."</p> <p>During an interview on 05/15/2012 at 10:00 a.m., CNA #4 indicated CNAs #2 and #3 were in the classroom with client C when she choked. She indicated she was assisting another client with his shower. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:05 a.m., CNA #2 indicated she was charting in the classroom when client C choked. She indicated client C had a history of trying to take peer's food. CNA #2 stated, "[CNA #3] told me to get the nurse. I didn't know why I was getting a nurse." She indicated she went to the nurses' station and asked LPN #1 to assist in the classroom. CNA #2 stated, "[Client C] was standing when I got back to the classroom with the nurse." She stated, "[Client C] doesn't stand on her own so it was kind of hard for [CNA #3]." CNA #2 indicated she and CNA #3 helped client C to the floor after LPN #1 tried the</p>						

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	<p>Heimlich maneuver on client C. She indicated once client C was on the floor CPR was initiated by CNA #3 and LPN #1. CNA #2 stated, "[LPN #2] told her to go wait for the fire truck." The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:20 a.m., CNA #3 stated, "I was documenting" when asked what she was doing when client C choked. She indicated she and CNA #2 were in the classroom with client C and 3 other clients. CNA #3 stated, "[Client C] scooted her wheel chair next to me. She looked funny and had foam coming from her mouth. I told [CNA #2] to get the nurse. That's all I did." CNA #3 indicated the nurse asked if client C had a seizure. She indicated LPN #1, LPN #2, and LPN #3 responded to calls for help in the classroom. She stated, "The nurses took over. The nurses checked [client C]." She indicated she did not know what interventions each nurse provided because she took the other clients and left the classroom. She indicated she did not provide any interventions when client C choked. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:45 a.m., LPN #2 indicated CNAs #2</p>			

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	<p>and #3 were present in the classroom when client C choked. She indicated client C and 5 other clients were present in the classroom. LPN #2 stated, "I assessed [client C] by asking questions." She stated, "I was in the room less than 3 minutes and saw her lips turning blue and I called 911." She indicated client C was on the floor. LPN #2 stated, "I don't recall who said she may have gotten a hold of [client E's] sandwich. That's when I decided she might be choking and called 911." She indicated LPN #1 and LPN #3 were also present. She stated, "They were assessing [client C] too." She indicated LPN #3 got the suction machine. LPN #2 stated, "[Client C] went unconscious after I called 911. I told [CNA #2] to go meet the ambulance." LPN #2 indicated she retrieved the AED and LPN #1 and CNA #5 were doing CPR. She stated, "[Client C] coughed. [LPN #1] swiped her mouth but [client C] bit down so she took her hand out." She indicated LPN #1 and CNA #5 continued performing CPR. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 11:40 a.m., CNA #1 indicated she was not working when client C choked. She stated, "[Client C] reaches her hand out towards food and says, 'I want some!'"</p>			

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	<p>The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 2:35 p.m., LPN #3 indicated CNAs #2 and #3 were in the classroom when client C choked. She stated, "I think it was [CNA #3] who said client E may have given some of her sandwich to [client C]." LPN #3 indicated client C tried to get food from peers. She stated, "I got the O2 sat (saturation) machine and tried to get an O2 sat but couldn't get a reading." She indicated she listened with her stethoscope to determine client C wasn't breathing. LPN #3 stated, "I looked in [client C's] mouth and didn't see anything. The other nurse did rescue breathing. I did chest compressions." She stated, "The pulse was high, one hundred thirty something." LPN #3 indicated client C coughed up mucous. LPN #3 stated, "EMS arrived before I got to use the suction machine." She stated she "worked on [client C] 5-10 minutes before EMS arrived." The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 2:45 p.m., LPN #1 indicated CNAs #2 and #3 were in the classroom when client C choked. She indicated she was at the nurses' station when she learned of the incident. She indicated she went to the</p>						

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	<p>classroom immediately after CNA #2 summoned her. LPN #1 stated, "I looked at her (client C) to see if she was in distress. She was dangling her arms (LPN raised her arms above her head and waved them around as she described client C dangling her arms) in the air. I asked the CNAs what was going on. They said she was having trouble breathing. I looked in her mouth and didn't see anything." She stated she "felt for a pulse" when asked how she checked for respirations. LPN #1 stated, "I took her out of the wheel chair and did the Heimlich." LPN #1 indicated she guided client C to the ground and started CPR. She indicated client C was not breathing and her lips were turning blue. LPN #1 indicated no food dislodged during CPR. The Administrator was present during the interview.</p> <p>During an interview on 05/16/2012 at 11:15 a.m., CNA #5 stated, "There was commotion on the North hall." She indicated she positioned herself where she could observe and listen to what was going on. CNA #5 stated, "I saw people like pacing in the hall. I went to the classroom after I heard some say she's not breathing. I walked past the 3 nurses and told them I know CPR." CNA #5 indicated 3 nurses (LPNs #1, #2, and #3) and CNA #6 were in the classroom. She</p>			

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	<p>indicated she was focused on the client and was not aware if other staff were in the room. She stated, "I looked at her (client C). She was blue and no one was doing anything so I said I know CPR. That's when [LPN #1] and I started CPR." CNA #5 indicated LPN #1 checked the airway. CNA #5 indicated she did chest compressions and LPN #1 did rescue breathing. She indicated CNA #6 relieved her from chest compressions when she got tired. CNA #5 stated, "I heard someone say she probably choked on a sandwich after the EMT's (Emergency Medical Technicians) got there." The Administrator was present during the interview.</p> <p>On 05/16/2012 at 2:35 p.m., the Administrator accompanied LPN #1 and indicated LPN #1 had information that needed clarification. LPN #1 stated, "A CNA said [client C] was having trouble breathing. I went in and looked at her and got down to see if she was breathing. I called the other 2 nurses (LPNs #2 and #3). LPN #1 indicated client C was in her wheel chair when she entered the room. She stated, "[Client C] started dangling arms in the air. I picked her up out of the wheel chair and did 5 abdominal thrusts. She was bearing weight on her legs." LPN #1 indicated client C's lips and finger tips were blue. She stated, "I felt</p>			

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	<p>for air and felt for a pulse. I started CPR because I didn't feel anything. I told staff to get the crash cart and AED. One of the CNA's helped me do CPR." LPN #1 indicated she and CNA #5 were the only staff who performed CPR. The Administrator was present during the interview. She indicated she suspended LPN #1.</p> <p>During an interview on 05/16/2012 at 2:50 p.m., CNA #6 stated, "I was going to get wash cloths when I noticed commotion on the North hall." She indicated she assisted LPN #1 and CNAs #2 and #3 to get client C out of her wheel chair. She stated, "[LPN #1] started checking for a pulse and took her temperature and blood pressure. The nurse did the mouth to mouth (rescue breathing) and did a finger sweep." CNA #6 indicated she did not see staff hold client C up and attempt the Heimlich maneuver. The Administrator asked CNA #6, "Is it possible the nurse was standing behind [Client C] and you just didn't see her do the Heimlich?" The CNA indicated it was a possibility. The CNA stated, "I heard [CNAs #2 and #3] saying [client C] may have eaten a sandwich (prior to choking)." CNA #6 stated, "[LPN #3] was just standing around. [LPN #1] told [LPN #3] to get the crash cart. CNA #6 stated, "[LPN #3]</p>			

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	<p>didn't know where the crash cart was." She stated, "[LPN #1] 100 percent did not participate in the code." The Administrator was present during the interview. The Administrator indicated LPN #3 would be suspended as a result of the allegation of neglect.</p> <p>During a confidential interview on 05/16/2012 at 6:10 p.m., Confidential Interview (CI) #1 stated "I heard two ladies, who were holding the elevator, talking to each other about how mad they would be if they knew someone fed solid food to someone in their family who was supposed to be on a pureed diet." CI #1 indicated client C was unconscious on the floor when CI #1 arrived in the classroom. CI #1 indicated CI #1 did not see any staff performing rescue breathing. CI #1 indicated only one person was doing chest compressions and stated, "6-10 people were just standing around." CI #1 indicated an unidentified facility staff informed CI #1 CPR was in process for 5 minutes before 911 was called. CI #1 indicated another unidentified facility staff indicated CPR was in process for 15 minutes before 911 was called. CI #1 indicated CI #1 saw more than five facility staff congregated in the 1st floor nurses' station after client C was transported to the hospital. CI #1 stated, "I heard one staff say, 'we need to get all</p>						

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	<p>of our stories straight or we'll be in deep sh--."</p> <p>A facility document, titled, "Interview with [LPN #1] for the night of 5/10/2012," indicated, "...I followed [CNA #2] to the classroom and [CNA #3] (the word hysterically was scratched out with ink marks) said, 'you need to look at this woman, I think she is having trouble breathing.'...I looked at [client C] and did not see any signs of distress. Color good, eyes looked normal, I laid my hand on her chest, normal rise and fall of chest. I looked in her mouth and didn't see anything. I then turned to [CNA #3] and asked what was going on? What did she see was the problem? At that time [CNA #3] said that she may have gotten a sandwich. I then looked back at [client C] and she was flapping her arms up in the air. I believe I unbuckled her seatbelt and lifted her from behind...Then I attempted the Heimlich and she went limp on me...I felt for a carotid pulse. I leaned my head over her face, listening and feeling for breathing. I didn't see her chest rise and fall...I started chest compressions...then found a plastic bag that was laying on the floor right beside me, and I ripped a piece of plastic off the bag, poked a hole in the middle of the plastic, and then put the plastic over my mouth just to cover my lips up. Then I pinched her nose, tilted</p>			

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	<p>her head, and leaned over onto [client C's] mouth and gave her two breaths. After the two breaths were given, mucous and other debris came up out of her mouth...." The document was signed by LPN #1 and dated 05/16/2012.</p> <p>A facility interview, dated 05/16/2012, indicated LPN #3 was gathering trash from the West hall when client C choked. LPN #3 indicated, "...We all said, let's get her out of w/chair (wheel chair). I saw this lady (Client C) gasping for air. We didn't know what was (wrong). We put her on the floor...." The interview documentation indicated CNAs #2 and #3 and and LPNs #1 and #3 put client C on the floor. The interview documentation indicated, "...I ran to get the 02 sat while they were transferring her...[LPN #1] (checked), swabbed mouth. We saw little blood and mucous from mouth. Then she turned blue while we were assessing. I started CPR (chest compressions) while [LPN #1] did respirations...[CNA #5] took over for me. I then ran to get the suction machine...Q (question): Did you go get supplies own or did somebody ask you to get it. (sic). A (answer): [LPN #1] said before I got to room to see what was going on to get the 02 sat (monitor). No. I went to see what the emergency was and then [LPN #1] said, "Go get the 02 (oximeter)...Q: When you came back,</p>						

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	<p>what was [LPN #1] doing? (Answer): Trying to check B/P (blood pressure) and assessing..."</p> <p>Documentation of a facility interview with CNA #6, dated 05/16/2012, indicated 4 staff assisted client C out of her wheel chair. The documentation indicated, "...The nurse asked [LPN #3] to get the crash cart. She said she didn't know where it was...There was never any food, even when we were doing the CPR...."</p> <p>Documentation of a 3rd facility interview with CNA #2, dated 5/16/2012, indicated, "...Q (question): When did you first hear anyone mention a sandwich. (sic) A (answer): When the paramedics were leaving...I found bologna on the floor..."</p> <p>Documentation of a 2nd facility interview with CNA #5, dated 05/17/2012, indicated, "...you all are getting on my nerves. When something like this happens, you all panic and you don't pay attention to specifics...I already gave my statement. I'm not changing it..."</p> <p>The facility's undated choking protocol was reviewed on 05/16/2012 at 10:00 a.m. The protocol indicated, "Ensure safety of client. Call Nursing supervisor immediately. Heimlich maneuver if</p>			

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	<p>needed. Call 911 if in respiratory distress...." The policy did not indicate signs and symptoms of choking and did not indicate how to distinguish choking from a seizure. The protocol did not indicate how staff proceed from conscious choking to unconscious choking interventions.</p> <p>The facility's staff training records were reviewed on 05/16/2012 at 10:00 a.m. The records did not indicate staff were trained to recognize signs and symptoms of choking and trained on interventions for conscious and unconscious choking after client B choked on 05/01/2012. Training did not occur prior to client C's death as a result of choking on 05/10/2012.</p> <p>The following "Employee Memorandums" were reviewed on 05/16/2012 at 4:30 p.m.:</p> <ul style="list-style-type: none"> -An "Employee Memorandum," indicated LPN #1 was suspended on 05/16/2012. -An "Employee Memorandum," indicated LPN #3 was suspended on 05/16/2012. -An "Employee Memorandum," indicated CNA #4 was suspended on 05/11/2012. -An "Employee Memorandum," indicated CNA #2 was suspended on 05/11/2012. -An "Employee Memorandum," indicated CNA #3 was suspended on 05/11/2012. <p>The record did not indicate LPN #2 was</p>						

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	<p>suspended and did not indicate LPNs #1 and #3 were immediately suspended after the Administrator became aware of allegations of neglect. The employee work schedule was reviewed on 05/16/2012 at 9:50 a.m. The schedule indicated LPN #1 was scheduled to work on 05/16/2012 from 2:30 p.m. to 11:00 p.m. The schedule indicated LPN #2 was scheduled to work 6:30 a.m.-3:00 p.m. on 05/17/2012 and LPN #3 was scheduled to work 05/16/2012 from 2:30 p.m. to 11:00 p.m.</p> <p>During an interview on 05/16/2012 at 12:45 p.m., the Administrator indicated no nursing staff had been suspended following an allegation of neglect reported during an interview on 05/16/2012 at 11:15 a.m.</p> <p>During an interview on 05/16/2012 at 2:50 p.m., the Administrator indicated LPN #1 and #3 had been suspended. She did not indicate LPN #2 was suspended.</p> <p>The facility's policy and procedures were reviewed on 05/14/2012 at 10:35 a.m. The facility's May 2011 policy, titled, "Reporting Alleged Violations, " indicated,"...It is the policy of this facility to take appropriate steps to prevent occurrence of...neglect...." The facility's May 2001 policy indicated neglect was</p>						

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	<p>defined as "...failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...."</p> <p>This federal tag relates to complaints #IN00108475 and #IN00107965.</p> <p>3.1-28(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of neglect, resulting in death was thoroughly investigated for 1 of 16 allegations reviewed for abuse, neglect, and/or injuries of unknown origin (client C) .</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2012 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency Room)...."</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated, "...Date of Death: 05/11/2012...Circumstances immediately preceding the death, IF KNOWN: Client (C) was in her classroom with two CNA staff and two of her peers. One of her</p>	W0154	<p>W 154 Staff Treatment of Clients</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p><u>I Corrective Action for Cited Clients:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p>-</p> <p><u>IV Monitoring Corrective</u></p>	06/22/2012			

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	<p>peers had brought a sandwich snack into the classroom without the two attending CNA's informed. [Client C] (Puree diet) inadvertently (sic) took the sandwich and ate it without CNA knowledge...when [client C] wheeled her W/C (wheel chair) to staff and was flapping her hands. Staff unsure what happened and immediately called for nurse. Nursing recognized choking, 911 called and nurse performed abdominal thrusts, unsuccessful. Client then lowered to floor and CPR initiated. 911 arrived (and) preceded with appropriate treatment, stabilized and transported to [hospital] ER...."</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated client C died in the hospital at 11:31 p.m. on 05/11/2012.</p> <p>The facility's investigation related to the 05/10/2012 choking incident was ongoing at the time of the review. Some staff who witnessed interventions/care provided to client C following a choking incident occurring on 05/10/2012 were interviewed on multiple dates and times. Conflicting statements and discrepancies in responses to interview questions were not addressed during the follow up interviews. Documentation of interviews conducted by the facility was reviewed on</p>		<p>Measures: North Willow's abuse and neglect policy has been reviewed by the QAA committee to assure understanding and that it meets regulatory requirements. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. To be completed by 6-22-12.</p>				

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	<p>05/15/2012 at 1:06 p.m., on 05/16/2012 at 2:45 p.m., and on 05/22/2012 at 6:46 p.m.</p> <p>A facility interview, dated 05/11/2012, indicated the Qualified Developmental Disabilities Professional (QDDP) #1 left the facility prior to client C choking. The record indicated, "...I saw CNA #2 getting snacks. I think it was 8:50 p.m...."</p> <p>A facility interview with LPN #1, dated 05/10/2012, indicated LPN #1 was in the nurse's station when CNA #2 summoned her to assess client C. The interview documentation indicated, "...[Client C] was gasping for breath. Her arms were moving. I picked her up out of her wheelchair and attempted abdominal thrusts...[CNA #3] stated [client C] grabbed the sandwich and stuffed it in her mouth...[CNA #3] said she (client C) has attempted to steal food on occasion...She started foaming from her mouth. Some bread, foam mucous and bologna came out after I laid her on the floor. I had to begin CPR. The paramedics arrived and took over.... (narrative written along side of page in a different hand writing) I will guess it was 8:55 p.m. CNA came to get me. Said she wasn't breathing. As I got (symbol for up) I was calling for [LPN #2]. Went to room. She (client C) was flalling (sic) arms. Air exchange heard. Looked in mouth-nothing seen. Untapped</p>						

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	<p>seat belt. Moved (client C) to floor. Hooked B/P (blood pressure) cuff to arm. I was not totally aware of (sic) is this seizure or is this choking cuz (because) CNA stated she had grabbed-assumed she had grabbed sandwich (sic) from [client E] because they did not see the sandwich (sic). Abdominal thrust and rescue breathing started cuz (sic) then she lost consciousness. Told [LPN #3] go get crash cart. [LPN #2] called 911...didn't get a chance to use machine (Automated External Defibrillator) or suction before EMT's (Emergency Medical Technicians) arrived and took over."</p> <p>A facility interview with CNA #2, dated 05/14/2012, indicated CNA #2 gave client E a sandwich "around 7:00 p.m." The interview documentation indicated CNA #2 was sitting in the classroom when client C choked. The documentation indicated, "...[CNA #3] told me to get the nurse. She was in the nurses' station. Then all the nurses were there in a split second. The CNA indicated, "I saw the bologna come up" when asked by the facility interviewer if any food came up during the abdominal thrusts.</p> <p>An undated facility interview with CNA #4 indicated, "...I gave her (client E) a glass of water and a sandwich and told her to go to the shower room...." The</p>						

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	<p>interview documentation indicated, "Maybe right at 9:00 p.m." as the time the sandwich was given to client E.</p> <p>An undated facility interview with LPN #3 indicated, "...I heard [LPN #1] screaming. [LPN #2] was doing g-tube care and I called her. We went to North. I saw [client C] sitting in the w/c (wheel chair) trying to breathe. One of the aides said she may have swallowed something... We all got her and laid her on the floor and then I went to get O2 (oxygen), BP (blood pressure), AED. [LPN #2] was with me. We then went back to classroom on N (North). We tried to get BP but didn't get anything. We listened to her heart and did hear a thready type pulse. Did not get O2 (oxygen) sat (saturation). [LPN #2] then called 911. [LPN #1] and I were both doing CPR and kept doing it till (sic) EMT's came...."</p> <p>A facility interview with LPN #2, dated 05/11/2012, indicated, "...I was ...doing G-tubes. I went and asked what happened. [Client C] was sitting on floor. I asked if she had a seizure? She was sort of foaming at the mouth. Her lips were turning blue and I called 911. She started to go unconscious. We laid her on the floor. I was trying to get VS (vital signs) and put O2 (oxygen) on her. I got the</p>			

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	<p>AED machine. [LPN #1] was doing CPR and swiping her mouth. Stuff was coming out. [LPN #3] was getting the suction. By that time the EMT's arrived...I asked what had happened and was told she had gotten a sandwich. I asked who was in the classroom and they told me it was [CNAs #2, #3, and #4]...."</p> <p>An undated facility interview with CNA #5 indicated, "...I was on the South hall. I noticed North hall was having a problem so I listened at the door and heard someone say, 'She's not breathing.' I went down there because I know CPR and I wanted to see if they needed help...[Client C] was on the floor and her lips were blue. I got a pillow, put it under her head. I checked for a pulse. No response at all. No pulse, no breathing. I started CPR. [LPN #1] was right there next to me. I heard her gurgling. Someone went to get the suction, O2. I was doing the chest compressions and [LPN #1] was doing the breathing by mouth until she got the mouthpiece and she used it. We switched the roles when I and [LPN #1] got tired. I really don't remember who else was in the room. The next thing I know, the EMT's walked in and took over. I then returned to my hall."</p> <p>A second facility interview with LPN #1 was conducted on 05/15/2012. The</p>						

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	<p>interview documentation indicated, "Q (Question): I need to clarify when you were told that [client C] could be choking on a sandwich? A (Answer): Well, [CNA #4] said she gave her a sandwich before she went to the shower... We didn't know it was a sandwich till (sic) after the paramedics suctioned up bologna... When we were doing CPR-bread had come up. Q: Did you know it was bread at the time? A: No it looked like a bunch of saliva (symbol for with) mucous in it. After the fact we figured out that it must have been bread. Q: So when you first responded [CNA #3] did not mention possibility of her choking on sandwich? A: No cause (sic) I didn't know what I was dealing with. I didn't think she was choking cause (sic) she was making noises. Didn't know if she was having a seizure or going into respiratory distress for unknown reason...."</p> <p>A facility interview with CNA #3 was conducted on 05/15/2012. The interview documentation indicated, "...Nurse said you told her [client C] had grabbed the sandwich and stuffed it in her mouth. No I didn't say that. When were you aware that [client C] had choked on a sandwich? The paramedics said that. I may have said it after we knew for sure what happened but not before. It was crazy...."</p>			

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	<p>During an interview on 05/15/2012 at 10:00 a.m., CNA #4 indicated CNAs #2 and #3 were in the classroom with client C when she choked. She indicated she was assisting another client with his shower. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:05 a.m., CNA #2 indicated she was charting in the classroom when client C choked. She indicated client C had a history of trying to take peer's food. CNA #2 stated, "[CNA #3] told me to get the nurse. I didn't know why I was getting a nurse." She indicated she went to the nurses' station and asked LPN #1 to assist in the classroom. CNA #2 stated, "[Client C] was standing when I got back to the classroom with the nurse." She stated, "[Client C] doesn't stand on her own so it was kind of hard for [CNA #3]." CNA #2 indicated she and CNA #3 helped client C to the floor after LPN #1 tried the Heimlich maneuver on client C. She indicated once client C was on the floor CPR was initiated by CNA #3 and LPN #1. CNA #2 stated, "[LPN #2] told her to go wait for the fire truck." The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:20 a.m., CNA #3 stated, "I was</p>						

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	<p>documenting" when asked what she was doing when client C choked. She indicated she and CNA #2 were in the classroom with client C and 3 other clients. CNA #3 stated, "[Client C] scooted her wheel chair next to me. She looked funny and had foam coming from her mouth. I told [CNA #2] to get the nurse. That's all I did." CNA #3 indicated the nurse asked if client C had a seizure. She indicated LPN #1, LPN #2, and LPN #3 responded to calls for help in the classroom. She stated, "The nurses took over. The nurses checked [client C]." She indicated she did not know what interventions each nurse provided because she took the other clients and left the classroom. She indicated she did not provide any interventions when client C choked. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 10:45 a.m., LPN #2 indicated CNAs #2 and #3 were present in the classroom when client C choked. She indicated client C and 5 other clients were present in the classroom. LPN #2 stated, "I assessed [client C] by asking questions. She stated, "I was in the room less than 3 minutes and saw her lips turning blue and I called 911." She indicated client C was on the floor. LPN #2 stated, "I don't recall who said she may have gotten a</p>						

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	<p>hold of [client E's] sandwich. That's when I decided she might be choking and called 911." She indicated LPN #1 and LPN #3 were also present. She stated, "They were assessing [client C] too." She indicated LPN #3 got the suction machine. LPN #2 stated, "[Client C] went unconscious after I called 911. I told [CNA #2] to go meet the ambulance." LPN #2 indicated she retrieved the AED and LPN #1 and CNA #5 were doing CPR. She stated, "[Client C] coughed. [LPN #1] swiped her mouth but [client C] bit down so she took her hand out." She indicated LPN #1 and CNA #5 continued performing CPR. The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 11:40 a.m., CNA #1 indicated she was not working when client C choked. She stated, "[Client C] reaches her hand out towards food and says, 'I want some'." The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 2:35 p.m., LPN #3 indicated CNAs #2 and #3 were in the classroom when client C choked. She stated, "I think it was [CNA #3] who said client E may have given some of her sandwich to [client C]." LPN #3 indicated client C tried to get</p>			

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	<p>food from peers. She stated, "I got the O2 sat (saturation) machine and tried to get an O2 sat but couldn't get a reading." She indicated she listened with her stethoscope to determine client C wasn't breathing. LPN #3 stated, "I looked in [client C's] mouth and didn't see anything. The other nurse did rescue breathing. I did chest compressions." She stated, "The pulse was high, one hundred thirty something." LPN #3 indicated client C coughed up mucous. LPN #3 stated, "EMS arrived before I got to use the suction machine." She stated she "worked on [client C] 5-10 minutes before EMS arrived." The Administrator was present during the interview.</p> <p>During an interview on 05/15/2012 at 2:45 p.m., LPN #1 indicated CNAs #2 and #3 were in the classroom when client C choked. She indicated she was at the nurses' station when she learned of the incident. She indicated she went to the classroom immediately after CNA #2 summoned her. LPN #1 stated, "I looked at her (client C) to see if she was in distress. She was dangling her arms (LPN raised her arms above her head and waved them around as she described client C dangling her arms) in the air. I asked the CNAs what was going on. They said she was having trouble breathing. I looked in her mouth and didn't see anything." She</p>			

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	<p>stated she "felt for a pulse" when asked how she checked for respirations. LPN #1 stated, "I took her out of the wheel chair and did the Heimlich." LPN #1 indicated she guided client C to the ground and started CPR. She indicated client C was not breathing and her lips were turning blue. LPN #1 indicated no food dislodged during CPR. The Administrator was present during the interview.</p> <p>During an interview on 05/16/2012 at 11:15 a.m., CNA #5 stated, "There was commotion on the North hall." She indicated she positioned herself where she could observe and listen to what was going on. CNA #5 stated, "I saw people like pacing in the hall. I went to the classroom after I heard some say she's not breathing. I walked past the 3 nurses and told them I know CPR." CNA #5 indicated 3 nurses (LPNs #1, #2, and #3) and CNA #6 were in the classroom. She indicated she was focused on the client and was not aware if other staff were in the room. She stated, "I looked at her (client C). She was blue and no one was doing anything so I said I know CPR. That's when [LPN #1] and I started CPR." CNA #5 indicated LPN #1 checked the airway. CNA #5 indicated she did chest compressions and LPN #1 did rescue breathing. She indicated CNA #6</p>			

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	<p>relieved her from chest compressions when she got tired. CNA #5 stated, "I heard someone say she probably choked on a sandwich after the EMT's (Emergency Medical Technicians) got there." The Administrator was present during the interview.</p> <p>On 05/16/2012 at 2:35 p.m., the Administrator accompanied LPN #1 and indicated LPN #1 had information that needed clarification. LPN #1 stated, "A CNA said [client C] was having trouble breathing. I went in and looked at her and got down to see if she was breathing. I called the other 2 nurses (LPNs #2 and #3). LPN #1 indicated client C was in her wheel chair when she entered the room. She stated, "[Client C] started dangling arms in the air. I picked her up out of the wheel chair and did 5 abdominal thrusts. She was bearing weight on her legs." LPN #1 indicated client C's lips and finger tips were blue. She stated, "I felt for air and felt for a pulse. I started CPR because I didn't feel anything. I told staff to get the crash cart and AED. One of the CNA's helped me do CPR." LPN #1 indicated she and CNA #5 were the only staff who performed CPR. The Administrator was present during the interview. She indicated she suspended LPN #1.</p>						

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	<p>During an interview on 05/16/2012 at 2:50 p.m., CNA #6 stated, "I was going to get wash cloths when I noticed commotion on the North hall." She indicated she assisted LPN #1 and CNAs #2 and #3 to get client C out of her wheel chair. She stated, "[LPN #1] started checking for a pulse and took her temperature and blood pressure. The nurse did the mouth to mouth (rescue breathing) and did a finger sweep." CNA #6 indicated she did not see staff hold client C up and attempt the Heimlich maneuver. The Administrator asked CNA #6, "Is it possible the nurse was standing behind [Client C] and you just didn't see her do the Heimlich?" The CNA indicated it was a possibility. The CNA stated, "I heard [CNAs #2 and #3] saying [client C] may have eaten a sandwich (prior to choking)." CNA #6 stated, "[LPN #3] was just standing around. [LPN #1] told [LPN #3] to get the crash cart. CNA #6 stated, "[LPN #3] didn't know where the crash cart was." She stated, "[LPN #1] 100 percent did not participate in the code." The Administrator was present during the interview. The Administrator indicated LPN #3 would be suspended as a result of the allegation of neglect.</p> <p>During a confidential interview on 05/16/2012 at 6:10 p.m., Confidential</p>			

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	<p>Interview (CI) #1 stated "I heard two ladies, who were holding the elevator, talking to each other about how mad they would be if they knew someone fed solid food to someone in their family who was supposed to be on a pureed diet." CI #1 indicated client C was unconscious on the floor when CI #1 arrived in the classroom. CI #1 indicated CI #1 did not see any staff performing rescue breathing. CI #1 indicated only one person was doing chest compressions and stated, "6-10 people were just standing around." CI #1 indicated an unidentified facility staff informed CI #1 CPR was in process for 5 minutes before 911 was called. CI #1 indicated another unidentified facility staff indicated CPR was in process for 15 minutes before 911 was called. CI #1 indicated CI #1 saw more than five facility staff congregated in the 1st floor nurses' station after client C was transported to the hospital. CI #1 stated, "I heard one staff say, 'we need to get all of our stories straight or we'll be in deep sh--.'"</p> <p>A facility document, titled, "Interview with [LPN #1] for the night of 5/10/2012," indicated, "...I followed [CNA #2] to the classroom and [CNA #3] (the word hysterically was scratched out with ink marks) said, 'you need to look at this woman, I think she is having trouble</p>						

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	<p>breathing.'...I looked at [client C] and did not see any signs of distress. Color good, eyes looked normal, I laid my hand on her chest, normal rise and fall of chest. I looked in her mouth and didn't see anything. I then turned to [CNA #3] and asked what was going on? What did she see was the problem? At that time [CNA #3] said that she may have gotten a sandwich. I then looked back at [client C] and she was flapping her arms up in the air. I believe I unbuckled her seatbelt and lifted her from behind...Then I attempted the Heimlich and she went limp on me...I felt for a carotid pulse. I leaned my head over her face, listening and feeling for breathing, I didn't see her chest rise and fall...I started chest compressions...then found a plastic bag that was laying on the floor right beside me, and I ripped a piece of plastic off the bag, poked a hole in the middle of the plastic, and then put the plastic over my mouth just to cover my lips up. Then I pinched her nose, tilted her head, and leaned over onto [client C's] mouth and gave her two breaths. After the two breaths were given, mucous and other debris came up out of her mouth...." The document was signed by LPN #1 and dated 05/16/2012.</p> <p>A facility interview, dated 05/16/2012, indicated LPN #3 was gathering trash from the West hall when client C choked.</p>			

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	<p>LPN #3 indicated, "...We all said, let's get her out of w/chair (wheel chair). I saw this lady (Client C) gasping for air. We didn't know what was (wrong). We put her on the floor...." The interview documentation indicated CNAs #2 and #3 and and LPNs #1 and #3 put client C on the floor. The interview documentation indicated, "...I ran to get the 02 sat while they were transferring her...[LPN #1] (checked), swabbed mouth. We saw little blood and mucous from mouth. Then she turned blue while we were assessing. I started CPR (chest compressions) while [LPN #1] did respirations...[CNA #5] took over for me. I then ran to get the suction machine...Q (question): Did you go get supplies own or did somebody ask you to get it. (sic). A (answer): [LPN #1] said before I got to room to see what was going on to get the 02 sat (monitor). No. I went to see what the emergency was and then [LPN #1] said, "Go get the 02 (oximeter)...Q: When you came back, what was [LPN #1] doing? (Answer): Trying to check B/P (blood pressure) and assessing...."</p> <p>Documentation of a facility interview with CNA #6, dated 05/16/2012, indicated 4 staff assisted client C out of her wheel chair. The documentation indicated, "...The nurse asked [LPN #3] to get the crash cart. She said she didn't</p>						

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	<p>know where it was...There was never any food, even when we were doing the CPR...."</p> <p>Documentation of a 3rd facility interview with CNA #2, dated 5/16/2012, indicated, "...Q (question): When did you first hear anyone mention a sandwich. (sic) A (answer): When the paramedics were leaving...I found bologna on the floor...."</p> <p>Documentation of 2nd facility interview with CNA #5, dated 05/17/2012, indicated, "...you all are getting on my nerves. When something like this happens, you all panic and you don't pay attention to specifics...I already gave my statement. I'm not changing it...."</p> <p>During an interview on 05/18/2012 at 10:00 a.m., the Director of Nursing indicated the investigation summary was complete. She stated, "We have not been able to determine a conclusion. Just because our five days are up doesn't mean we are going to stop investigating."</p> <p>This federal tag relates to complaints #IN00108475 and #IN00107965.</p> <p>3.1-28(d)</p>				

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W0155	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress.</p> <p>Based on record review and interview, the facility failed to prevent potential abuse, neglect, or mistreatment of clients by failing to immediately suspend LPN #1 and LPN #3 and allowing LPN #2 to continue working in the facility after an allegation that the nurses were not providing assistance to client C when she choked which potentially affected clients #1-#173.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2012 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency Room)...."</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated, "...Date of Death:</p>	W0155	<p>W 155 Staff Treatment of Clients</p> <p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p><u>I Corrective Action for Cited Clients:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p>-</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p>-</p>	06/22/2012	

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	<p>05/11/2012...Circumstances immediately preceding the death, IF KNOWN: Client (C) was in her classroom with two CNA staff and two of her peers. One of her peers had brought a sandwich snack into the classroom without the two attending CNA's informed. [Client C] (Puree diet) inadvertently (sic) took the sandwich and ate it without CNA knowledge...when [client C] wheeled her W/C (wheel chair) to staff and was flapping her hands. Staff unsure what happened and immediately called for nurse. Nursing recognized choking, 911 called and nurse performed abdominal thrusts, unsuccessful. Client then lowered to floor and CPR initiated. 911 arrived (and) preceded with appropriate treatment, stabilized and transported to [hospital] ER..."</p> <p>The following "Employee Memorandums" were reviewed on 05/16/2012 at 4:30 p.m.:</p> <ul style="list-style-type: none"> -An "Employee Memorandum," indicated LPN #1 was suspended on 05/16/2012. -An "Employee Memorandum," indicated LPN #3 was suspended on 05/16/2012. <p>The record did not indicate LPN #2 was suspended and did not indicate LPNs #1 and #3 were immediately suspended after the Administrator became aware of an allegations that the nurses were not providing assistance to client C when she choked. The employee work schedule</p>		<p><u>IV Monitoring Corrective Measures:</u> North Willow's abuse and neglect policy has been reviewed by the QAA committee to assure understanding and that it meets regulatory requirements. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. To be completed by 6-22-12.</p>				

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	<p>was reviewed on 05/16/2012 at 9:50 a.m. The schedule indicated LPN #1 was scheduled to work on 05/16/2012 from 2:30 p.m. to 11:00 p.m. The schedule indicated LPN #2 was scheduled to work 6:30 a.m.-3:00 p.m. on 05/17/2012 and LPN #3 was scheduled to work 05/16/2012 from 2:30 p.m. to 11:00 p.m.</p> <p>During an interview on 05/16/2012 at 12:45 p.m., the Administrator indicated no nursing staff had been suspended following an allegation of neglect reported during an interview on 05/16/2012 at 11:15 a.m.</p> <p>During an interview on 05/16/2012 at 2:50 p.m., the Administrator indicated LPN #1 and #3 had been suspended. She did not indicate LPN #2 was suspended.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-28(d)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to ensure investigation results for an allegation of neglect, resulting in death were reported to the administrator within five working days for 1 of 16 allegations reviewed for abuse, neglect, and/or injuries of unknown origin (client C).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2012 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency Room)...."</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated, "...Date of Death:</p>	W0156	<p>W 156 Staff Treatment of Clients</p> <p>The results of an investigation must be reported to the Administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p><u>I Corrective Action for Cited Clients:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p><u>III Corrective Measures or Systemic Changes:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse,</p>	06/22/2012			

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	<p>in responses to interview questions were not addressed during the follow up interviews. Documentation of interviews conducted by the facility was reviewed on 05/15/2012 at 1:06 p.m., on 05/16/2012 at 2:45 p.m., and on 05/22/2012 at 6:46 p.m.</p> <p>An undated facility investigation, titled, "Death Report," indicated, "...Conclusion: Staff was suspended pending investigation. [CNA #3], [CNA #2], and [CNA #4] were suspended 05/11/12. The nurse's (sic) [LPN #1] and [LPN #3] were suspended on 05/16/2012. The nurse's (sic) are to return with no disciplinary action, but with education training. [CNA #4] will be returning with training in communication with coworkers as well as supervision of resident. [CNA #3] and [CNA #2] will be returning with training in observation of residents and supervision of the classroom. Addendum to conclusion: There has been building wide in-service to reinforce the supervision of all residents during meals and snacks."</p> <p>During an interview on 05/18/2012 at 10:00 a.m., the Director of Nursing indicated the investigation summary was complete. She stated, "We have not been able to determine a conclusion. Just because our five days are up doesn't mean we are going to stop investigating."</p>						

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to take the appropriate corrective action in regard to training staff on recognition of and interventions for signs and symptoms of conscious and unconscious choking for 2 of 16 allegations reviewed for abuse, neglect, and/or injuries of unknown origin (clients B and C). The facility failed to suspend a nurse who allegedly neglected a client who choked, resulting in death until an investigation had been completed (client C).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2012 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 04/28/2012 at 12:45 p.m., indicated client D choked on garlic bread and required abdominal thrusts to clear the food from her airway.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, dated</p>	W0157	<p>W 157 Staff Treatment of Clients</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p><u>I Corrective Action for Cited Clients:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. Staff have been trained on seizure recognition, communication and signs and symptoms of aspiration. The Choking Protocol has been revised to include signs and symptoms of choking and how staff proceed from conscious choking victim to unconscious choking interventions. Staff have been trained in RESQ techniques that address needed intervention for a conscious and unconscious choking victim.</p> <p>- <u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>- <u>III Corrective Measures or</u></p>	06/22/2012	

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	<p>05/01/2012 at 12:50 p.m., indicated, "... [Client B] coughed as he was eating...She (Certified Nurse Aide) called out, 'he is having a seizure.' The nurse was alerted. Another Certified Nurse Aide (CNA) came over to assist [client B] from another table. This CNA performed abdominal thrusts. The nurse took over and she gave [client B] abdominal thrusts. This was not effective so the nurse and the CNA moved [client B] from the chair to the floor. There the nurse gave abdominal thrust (sic) and did finger sweeps pulling food out of his mouth. This was repeated a few times bringing up and out food that consist (sic) of ground beef and liquid. [Client B] was placed in the recovery position and oxygen was applied via mask. 911 was activated. EMS (Emergency Medical Services) arrived and took over. EMS then took client on to the hospital...."</p> <p>3. An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency Room)...."</p> <p>4. An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated,</p>		<p><u>Systemic Changes:</u> North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. The revised Choking Protocol has been trained with Nursing staff. An audit for safe dining and active treatment is being completed that checks to verbalize what to do when a person is choking.</p> <p><u>IV Monitoring Corrective Measures:</u> North Willow's abuse and neglect policy has been reviewed by the QAA committee to assure understanding and that it meets regulatory requirements. RESQ techniques are now included in the orientation process. North Willow has an abuse policy that states staff will be suspended pending investigation for allegations of neglect or abuse, investigations will be thoroughly investigated and the investigation will be completed within 5 working days. The ED and North Willow will adhere to this policy. The revised Choking Protocol has been reviewed and approved by the QAA committee. To be completed by 6-22-12.</p>				

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	<p>"...Date of Death: 05/11/2012...Circumstances immediately preceding the death, IF KNOWN: Client (C) was in her classroom with two CNA staff and two of her peers. One of her peers had brought a sandwich snack into the classroom without the two attending CNA's informed. [Client C] (Puree diet) inadvertently (sic) took the sandwich and ate it without CNA knowledge...when [client C] wheeled her W/C (wheel chair) to staff and was flapping her hands. Staff unsure what happened and immediately called for nurse. Nursing recognized choking, 911 called and nurse performed abdominal thrusts, unsuccessful. Client then lowered to floor and CPR initiated. 911 arrived (and) preceded with appropriate treatment, stabilized and transported to [hospital] ER...."</p> <p>The facility's undated choking protocol was reviewed on 05/16/2012 at 10:00 a.m., The protocol indicated, "Ensure safety of client. Call Nursing supervisor immediately. Heimlich maneuver if needed. Call 911 if in respiratory distress...." The policy did not indicate signs and symptoms of choking and did not indicate how to distinguish choking from a seizure. The protocol did not indicate how staff proceed from conscious choking to unconscious choking interventions.</p>						

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	<p>During an interview on 05/16/2012 at 11:15 a.m., CNA #5 stated, "There was commotion on the North hall." She indicated she positioned herself where she could observe and listen to what was going on. CNA #5 stated, "I saw people like pacing in the hall. I went to the classroom after I heard some say she's not breathing. I walked past the 3 nurses and told them I know CPR." CNA #5 indicated 3 nurses (LPNs #1, #2, and #3) and CNA #6 were in the classroom. She indicated she was focused on the client and was not aware if other staff were in the room. She stated, "I looked at her (client C). She was blue and no one was doing anything so I said I know CPR. That's when [LPN #1] and I started CPR." CNA #5 indicated LPN #1 checked the airway. CNA #5 indicated she did chest compressions and LPN #1 did rescue breathing. She indicated CNA #6 relieved her from chest compressions when she got tired. CNA #5 stated, "I heard someone say she probably choked on a sandwich after the EMT's (Emergency Medical Technicians) got there." The Administrator was present during the interview.</p> <p>The facility's staff training records were reviewed on 05/16/2012 at 10:00 a.m. The records did not indicate staff were</p>						

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	<p>trained to recognize signs and symptoms of choking and trained on interventions for conscious and unconscious choking after client B choked on 05/01/2012. Training did not occur prior to client C's death as a result of choking on 05/10/2012.</p> <p>The following "Employee Memorandums" were reviewed on 05/16/2012 at 4:30 p.m.:</p> <ul style="list-style-type: none"> -An "Employee Memorandum," indicated LPN #1 was suspended on 05/16/2012. -An "Employee Memorandum," indicated LPN #3 was suspended on 05/16/2012. -An "Employee Memorandum," indicated CNA #4 was suspended on 05/11/2012. -An "Employee Memorandum," indicated CNA #2 was suspended on 05/11/2012. -An "Employee Memorandum," indicated CNA #3 was suspended on 05/11/2012. <p>The record did not indicate LPN #2 was suspended and did not indicate LPNs #1 and #3 were immediately suspended after the Administrator became aware of allegations of neglect. The employee work schedule was reviewed on 05/16/2012 at 9:50 a.m. The schedule indicated LPN #1 was scheduled to work on 05/16/2012 from 2:30 p.m. to 11:00 p.m. The schedule indicated LPN #2 was scheduled to work 6:30 a.m.-3:00 p.m. on 05/17/2012 and LPN #3 was scheduled to</p>						

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	<p>work 05/16/2012 from 2:30 p.m. to 11:00 p.m.</p> <p>During an interview on 05/16/2012 at 1:15 p.m., the Administrator indicated staff were trained on client B's safe dining plan after he choked. She looked at the plan and stated, "I see what you mean," when asked if the plan addressed recognition of and interventions for choking. She did not respond when asked if staff were trained to recognize the difference between a seizure and choking.</p> <p>During an interview on 05/16/2012 at 12:45 p.m., the Administrator indicated no nursing staff had been suspended following an allegation of neglect reported during an interview on 05/16/2012 at 11:15 a.m.</p> <p>During an interview on 05/16/2012 at 2:50 p.m., the Administrator indicated LPN #1 and #3 had been suspended. She did not indicate LPN #2 was suspended.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-28(e)</p>			

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed to provide timely staff training in regard to recognizing and providing appropriate interventions for conscious and unconscious choking for 2 of 3 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 04/26/2011 through 05/14/2012 were reviewed on 05/14/2012 at 1:06 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 04/28/2012 at 12:45 p.m., indicated client D choked on garlic bread and required abdominal thrusts to clear the food from her airway.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, dated 05/01/2012 at 12:50 p.m., indicated, "... [Client B] coughed as he was eating...She (Certified Nurse Aide called out, 'he is having a seizure.' The nurse was alerted. Another Certified Nurse Aide (CNA) came over to assist [client B] from</p>	W0189	<p>W 189 Staff Training Program</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p><u>I Corrective Action for Cited Clients:</u> Staff have been trained in RESQ techniques that address needed intervention for a conscious and unconscious choking victim.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> An audit for safe dining and active treatment is being completed that checks to verbalize what to do when a person is choking.</p> <p><u>IV Monitoring Corrective Measures:</u> RESQ techniques are now included in the orientation process. To be completed by 6-22-12.</p>	06/22/2012			

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	<p>another table. This CNA performed abdominal thrusts. The nurse took over and she gave [client B] abdominal thrusts. This was not effective so the nurse and the CNA moved [client B] from the chair to the floor. There the nurse gave abdominal thrust (sic) and did finger sweeps pulling food out of his mouth. This was repeated a few times bringing up and out food that consist (sic) of ground beef and liquid. [Client B] was placed in the recovery position and oxygen was applied via mask. 911 was activated. EMS (Emergency Medical Services) arrived and took over. EMS then took client on to the hospital...."</p> <p>3. An Indiana Division of Disability and Rehabilitative Services report, dated 05/10/2012 at 8:45 p.m., indicated, "...Client (C) had choking episode in classroom...911 called and arrived (sic), taken to [hospital] ER (Emergency Room)...."</p> <p>4. An Indiana Division of Disability and Rehabilitative Services report, dated 05/11/2012 at 11:31 p.m., indicated, "...Date of Death: 05/11/2012...Circumstances immediately preceding the death, IF KNOWN: Client (C) was in her classroom with two CNA staff and two of her peers. One of her peers had brought a sandwich snack into</p>						

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	<p>the classroom without the two attending CNA's informed. [Client C] (Puree diet) inadvertently (sic) took the sandwich ate it without CNA knowledge...when [client C] wheeled her W/C (wheel chair) to staff and was flapping her hands. Staff unsure what happened and immediately called for nurse. Nursing recognized choking, 911 called and nurse performed abdominal thrusts, unsuccessful. Client then lowered to floor and CPR initiated. 911 arrived preceded with appropriate treatment, stabilized and transported to [hospital] ER...."</p> <p>Client B's record was reviewed on 05/15/2012 at 3:25 p.m. An undated "Incident Follow-up Report" indicated, "...[Client B] was in the dining room eating his lunch....[Client B] coughed as he was eating...gave him verbal redirection to slow down...She then reports that he began to shake. She called out 'he is having a seizure'...Another CNA ...performed abdominal thrusts...This was not effective so the nurse and the CNA moved [client B] from the chair to the floor. There the nurse gave abdominal thrust and did finger sweeps pulling food out of his mouth. This was repeated a few times bringing up and out food that consist (sic) of ground beef and liquid...."</p> <p>Client C's record was reviewed on</p>				

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	<p>05/15/2012 at 11:20 a.m. A physician's order, dated May 2012, indicated, "...Diets (sic) Type: Regular Large Portion. Texture: Puree. Fluid consistency: Thickened Liquid Nectar. Special Instructions: ENCOURAGE RESIDENT TO TAKE SMALL BITES/SIPS. NO STRAWS. SLIGHTLY (SIC) (@ 90 DEGREE ANGLE FOR ALL ORAL INTAKE AND (SIC) 20 MIN AFTER (SIC) MEAL. OBSERVE FOR POCKETING...."</p> <p>A speech-language pathology report, dated 11/22/11, indicated, "...Swallowing Ability...agree with nectar thick liquids. Risk of pocketing (symbol for with) non-pureed foods...."</p> <p>An Individual Support Plan (ISP) dated, 12/21/11, indicated, "...Risk for swallowing difficulty...monitor for signs and symptoms of aspirations...provide thickened liquids as ordered...non pureed snacks as requested with supervision...90 (degrees) for oral intake 20 minutes after meal, observe for pocketing (of food in mouth)...."</p> <p>A risk plan, dated 12/21/2011, indicated a health risk of "Swallowing Difficulty." The risk plan indicated, "...Provide a Puree diet...with Nectar thick liquids...Monitor for S/Sx (signs and</p>						

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	<p>symptoms) of aspiration...Proper positioning at meals (position not specified in plan)...."</p> <p>An "Interdisciplinary Diagnostic and Evaluation," dated 01/14/2011, indicated, "...[Client C] needs extensive medical monitoring and treatment to address potential for choking, respiratory issues, feeding issues...."</p> <p>A Behavior Incident Report (BIR), dated 04/24/2012 at 8:10 a.m., indicated client C took a piece of French toast from the serving cart. The BIR indicated she was redirected from eating the toast.</p> <p>A hospital admission "History and Physical," dated 05/10/2012, indicated, "...ADMISSION DIAGNOSES: Cardiac arrest following aspiration eating a bologna sandwich. Unspecified downtime...."</p> <p>The facility's staff training records were reviewed on 05/16/2012 at 10:00 a.m. The records did not indicate staff were trained to recognize signs and symptoms of choking and trained on interventions for conscious and unconscious choking after client B choked on 05/01/2012. Training did not occur prior to client C's death as a result of choking on 05/10/2012.</p>			

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	<p>A facility interview with LPN #1, dated 05/10/2012, indicated LPN #1 indicated, "...I was not totally aware of (sic) is this seizure or is this choking...."</p> <p>During an interview on 05/15/2012 at 2:45 p.m., LPN #1 indicated CNAs #2 and #3 were in the classroom when client C choked. She indicated she went to the classroom immediately after CNA #2 summoned her. LPN #1 stated, "I looked at her (client C) to see if she was in distress. She was dangling her arms (LPN raised her arms above her head and waved them around as she described client C dangling her arms) in the air. I asked the CNAs what was going on. They said she was having trouble breathing. I looked in her mouth and didn't see anything." She stated she "felt for a pulse" when asked how she checked for respirations. LPN #1 stated, "I took her out of the wheel chair and did the Heimlich." LPN #1 indicated she guided client C to the ground and started CPR. She indicated client C was not breathing and her lips were turning blue. LPN #1 indicated no food dislodged during CPR. The Administrator was present during the interview.</p> <p>During an interview on 05/16/2012 at 1:15 p.m., the Administrator indicated</p>				

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	<p>staff were trained to client B's safe dining plan after he choked. She looked at the plan and stated, "I see what you mean," when asked if the plan addressed recognition of and interventions for choking. She did not respond when asked if staff were trained to recognize the difference between a seizure and choking.</p> <p>This Federal tag relates to complaint #IN00108475 and complaint #IN00107965.</p> <p>3.1-13(b)(1) 3.1-13(b)(2)</p>			

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview, and record review for 1 additional client (client F), the facility failed to ensure the client's ISP (Individual Support Plan) specifically addressed the client's public nudity/clothes stripping behavior.</p> <p>Findings include:</p> <p>During observations on 05/15/2012 at 8:40 a.m., client F was observed through the North entrance windows standing in the West hallway wearing incontinence briefs. Her breasts were exposed. No clients were in the hall. Client advocate (CA) #1 was trying to cover client F's breasts with a hospital gown.</p> <p>During an interview on 05/15/2012 at 8:40 a.m., CA #1 stated, "I decided to try to quickly cover her up rather than cause a behavior where she lays on the floor and screams." She stated, "[Client F] is free-spirited and likes to be naked."</p> <p>Client F's record was reviewed on 05/16/2012 at 9:52 a.m. The Individual Support Plan, dated 11/01/2011, indicated</p>	W0227	<p>W 227 Individual Program Plan</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p><u>I Corrective Action for Cited Clients:</u> The IDT has assessed Client F for undressing in public and needed interventions are included in her plan to address this issue.</p> <p><u>II Other Clients Potentially at Risk:</u> All residents might be at risk for this deficient practice.</p> <p>-</p> <p><u>III Corrective Measures or Systemic Changes:</u> Residents have been assessed by the IDT for undressing in public and if an issue appropriate interventions are included in their plan.</p> <p><u>IV Monitoring Corrective</u></p>	06/22/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2012
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	<p>client F had a goal for dressing/changing clothes in her bedroom.</p> <p>A Behavior Support Plan, dated 11/01/2011, did not indicate a maladaptive behavior of dressing/changing clothes in areas other than her bedroom and did not include interventions to redirect/prevent the behavior.</p> <p>An Interdisciplinary Team (IDT) note, dated 05/15/2012, indicated, "...Met to discuss [client F's] continual clothes stripping issue." The IDT indicated the stripping was sufficiently addressed in her ISP goal. The IDT indicated alternate room location, "has not been considered at this point" to reduce visibility to clients/visitors approaching the North entrance of the building.</p> <p>During an interview on 05/16/2012 at 1:16 p.m., the Qualified Developmental Disabilities Professional (QDDP) Supervisor indicated client F's ISP addressed changing clothes in her bedroom. The QDDP Supervisor indicated CA #1 should have covered client F's exposed breasts and should have redirected client F to her bedroom to dress.</p> <p>3.1-35(a)</p>		<p>Measures: Program Directors review plans and resident BIRs and when the issue of undressing in public is identified, the IDT meets and develops appropriate interventions that are included in their plan. To be completed by 6-22-12.</p>		

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