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During an interview with E10 on 3/9/11 at 6:35am, E10 was asked if R14 received his medications on the morning of 3/8/11, since no signatures were present on the MAR. E10 explained that she was the staff member who gave R14 his pills on the morning of 3/8/11, and that she must have forgot to initial the MAR after giving them. E10 stated that she will sign them later. The MAR was reviewed on 3/10/11, and E10's initials were now present on the MAR for the date of 3/8/11 for R14's 6:00am medications. E10 signed her initials a day or two after the actual medications were administered, and not immediately after R14 received his medications.

W9999 FINAL OBSERVATIONS — W9999

LICENSURE VIOLATIONS

350.620a)
350.1210
350.1060h)
350.3240a)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1210 Health Services

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W9999	Continued From page 43 The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1060 Training and Habilitation Services h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person who is a Qualified Mental Retardation Professional. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement the policy to prevent neglect of one clients (R17) who choked on 10/17/10 and expired on 10/18/10 when they failed to: - Provide R17 with necessary supervision during the 5:00pm meal on 10/17/10 and - Ensure R17's eating program was implemented during the 5:00pm meal on 10/17/10. The facility failed to identify and reassess clients noted to have special diets. The facility failed to retrain staff on appropriate supervision and monitoring during meals. The facility failed to ensure staff were retrained regarding implementing eating goals.	W9999		

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Continued From page 44

Findings include:

R17, per review of his Face Sheet dated 8/23/10, was a 74 year old male whose diagnoses included Profound Mental Retardation, Pituitary Dwarfism and Osteoarthritis Bilateral Knees.
E1 (Residential Director) was interviewed on 3/10/11 at 12:10pm. E1 stated that R17 was verbal. E1 was asked about R17's hearing and E1 stated that R17 could hear, however he was hard of hearing.

Review of facility's Accident / Incident Reports noted that on 10/17/10 R17 choked during dinner at approximately 5:05pm. R17 was transported to the hospital on 10/17/10. On 10/18/10 at 11:47am the facility received a phone call from the attending physician stating that R17 expired on 10/18/10 at 0300 hours (3:00am).

The facility's "Resident Abuse / Neglect Policy / Procedure," undated, was reviewed. The policy includes the following:
"Policy Statement: Resident abuse or punishment (physical, verbal, sexual, or psychological) and / or neglect by facility staff, another resident, family, or a visitor will not be tolerated at Meadows. Prevention will be the focus in an effort to avoid any such incident."
"Definition of Abuse / Neglect: ...
 - Neglect - failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a Resident's physical or mental condition. Neglect means the failure to provide adequate medical or personal care or maintenance, which

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W9999	Continued From page 45 failure results in physical injury to a Resident or in the deterioration of a Resident's physical or mental condition. This shall include any allegations where: - The alleged failure causing injury or deterioration is ongoing or repetitious or - The failure is alleged to have caused a noticeable negative impact on a Resident's health, behavior or activities for 24 -hours. ..." E15 (nurse) documented the following in R17's nursing progress notes: "10/17/10 At around 5:15pm, aide (E17) rushed to the nursing station and stated 'We need a nurse to the dining room, (R17) is choking and he is turning blue!' Writer and (E6) (nurse on duty) then rushed to the dining room. On arrival (E12) (direct care staff) was performing Heimlich maneuver on resident who appeared to have discoloration (purplish - blue) to his face as he appeared to be choking. Writer, then, continued with the Heimlich maneuver as a foreign object was observed coming out of the resident's mouth - (E6) removed 1/2 a grape like piece from the resident's mouth as writer with the help of the aide turned resident to the side for assessment. Resident was unresponsive and CPR was initiated as the Emergency Personnel arrived and took over. SpO2 = 100% (on the paramedics machine) as he was taken out the door for evaluation at the ER (Emergency Room) (local hospital). Guardian (sister), (attending physician), DON (Director of Nursing) as well as administrator were notified - Resident was transferred to ER accompanied by (E8)." E15 also documented: "10/17/10 10:15pm Writer spoke to (nurse on	W9999		

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duty) at (local hospital) who reported that Pt. (patient) was admitted with a DX (diagnosis) of aspiration pneumonia. She said that a grape was found and he had aspirated on gastric fluids. She reported that he was started on ABT (anti-biotic therapy) in the ICU (Intensive Care Unit) with an intubator as vital signs were stable."

E3 (DON) documented the following in R17's nursing progress notes:
"10/18/10 1147 (Attending physician) called to notify (facility) that (R17) expired at 0300 in the critical care unit. (Attending physician) stated that (R17) was 'maxed out' on vasopressors and they were still unable to maintain vital signs; they were also unable to maintain patent airway, and he was in shock. Guardian (sister) was notified by writer & RSD (Residential Services Director), administrator notified and (crematory service) notified."

E1 completed a summary of the 10/17/10 incident in which R17 choked. E1 documented that the facility's camera system was reviewed with E3 (Director of Nursing) on 10/18/10. E1 documented extensive interviews with all staff were conducted.
The following is a summary of E1's documentation:
- On 10/17/10 at approximately 1700 (5:00pm) R17 was observed eating his dinner. It appeared as if R17 began to cough at approximately 1705. E8 (direct care) was at the opposite end of the table when R17 began to cough. R17 suddenly slumped over to the right. E8 prevented R17 from falling on the floor.
E12 was at the adjoining table and aided with the abdominal thrusting. E8 went to dial 911 from

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W9999	Continued From page 47 the nearest telephone. At approximately 1706 (5:06pm) E15 (nurse) arrived at the scene and took over the abdominal thrusting. The paramedics arrived at the facility at approximately 1710 (5:10pm) and took over R17's care. - E15 was interviewed for the investigation by E1 and E3, and stated the following: E15 was at the nurses' station when he was notified by E17 (direct care) that his assistance was needed in the dining room as a resident was choking. E15 stated he ran from the nurses' station to the dining room. E15 stated that when he arrived in the dining room he took over the abdominal thrusting technique from E12. While E15 was doing the abdominal thrusting he saw a red grape come out of R17's mouth along with other small pieces of food. E15 pulled out the red grape from (R17's) mouth. E15 stated R17's jaw was clenched and unable to be pried open. E15 stated he began the abdominal thrusting again and put him (R17) on his side to attempt to get food particles out of his mouth. R17 then became unresponsive and CPR was initiated. R17 became responsive after CPR was initiated. E15 stated that when the paramedics arrived at the facility R17 was breathing on his own and was responsive. E15 stated the paramedics could not get a good suction because R17's jaw was clenched. E15 stated the paramedics could not intubate R17 due to his clenched jaw. - E6 (nurse) was interviewed for the investigation by E1 and E3, and stated the following: E6 stated she was at the nurses' station with E15 when she was notified by E17 that a resident was choking in the dining room. E6 stated that she immediately responded to the dining room with E15. E6 stated that E15 got to the dining room	W9999		

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W9999	Continued From page 48 before her and E15 initiated the abdominal thrusting with R17. E6 called 911 from her cell phone, however the 911 operator told E6 that someone from the facility already called 911. E6 then began to assist E15. E6 did a finger sweep to R17's mouth and pulled out a red grape. E6 stated that R17's jaw was clenched but she was still able to complete a finger sweep. E6 then went to copy the necessary paperwork for the hospital. E6 stated when she returned to the dining room the paramedics were on the scene. A "Certification of Death Record" issued on 10/22/10 for R17 identifies R17's cause of death as "Aspiration of a Food Bolus." Describe how injury occurred is documented as, "Aspirated Food Bolus (Grape)." R17's Annual Nutritional Assessment, dated 2/3/10 and R17's Quarterly Nutritional Assessment dated 8/16/10 document R17's diet as Regular - solids cut up. R17's Discharge Summary, dated 10/18/10, also identifies R17's diet as Regular with all solid foods cut up. R17's Eating Assessment, dated 2/2/10, was reviewed. The assessment documents that R17 does not possess the skill in the area of, "Puts only bite-sized amounts of food in mouth." R17's 2/11/10 IPP (Individual Program Plan) was reviewed. R17 had an eating program with a short term goal identified as, "(R17) will chew food and swallow before next bite with 2 verbal	W9999		

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cues 60% of the month for 3 consecutive months by 11/30/10." R17's September 2010 monthly program progress notes, written by E5 (QMRP), note that R17's data for this goal during this time period was "0%".

R17's "Speech Language and Communication Evaluation," dated 4/23/08, was reviewed. Z1 (Speech Language Pathologist) completed R17's evaluation. Z1 documented, in the area of "Oral Motor and Swallowing Concerns: 2/14/08 Annual dietary / nutritional assessment indicates chewing, swallowing, feeding adequate. Consultation with staff indicated that food is 'cut up' due to resident attempting to put large amounts of food into mouth without chewing. Staff monitors this by cutting up food and providing supervision."

Z1 was interviewed on 3/11/11 at 11:07am via a phone call. Z1 verified that R17's 4/23/08 speech assessment was his most current assessment. Z1 stated that clients are assessed every 3 years. Z1 stated that R17 had a program in the area of eating. Z1 stated that every bite of food that R17 took should have been monitored. Z1 stated that R17 should put his fork down between each bite of food. Z1 stated that staff should monitor R17 during the meal and it would not be acceptable to walk away from the table when R17 was eating.

E1 was interviewed on 3/10/11 at 12:10pm. E1 verified that R17 had an eating goal. E1 stated the expectation was that R17 would finish what was in his mouth before taking another bite of food. E1 was asked to identify R17's level of supervision during meal time. E1 stated that staff

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were to be at R17's table during the meal. E1 stated that staff were expected to monitor every bite of food that R17 put in his mouth.

E5 (QMRP) was interviewed on 3/9/11 at 2:05pm. E5 verified that R17 had an eating program. E5 stated this goal was recommended and implemented as R17 would put too much food in his mouth when eating. E5 stated when R17 was observed eating, food could be observed stored in his cheek. E5 stated that R17 would stuff food into his cheek before swallowing and that is why the goal was created. The goal was to have R17 chew, slow down and swallow.

E5 was again interviewed on 3/9/11 at 3:25pm. E5 verified that R17's eating goal was to - chew and swallow food before taking a 2nd bite. E5 stated this eating goal was to be implemented throughout the meal. E5 stated staff should have monitored R17 throughout the meal.

The facility's summary investigation of this incident identified that E8 (direct care) was the staff that was monitoring the table when R17 was eating his dinner on 10/17/10. E8 was interviewed on 3/11/11 at 7:55am via a phone call. E8 verified she was working on 10/17/10 (2nd shift) when R17 choked. E8 summarized the following details from 10/17/10: E8 stated that on 10/17/10, R17 participated in family style dining for the dinner meal. E8 stated that she left the table (where R17 was eating) to get something from the kitchen for another client at the table. E8 stated when she returned she circled around the table and as she was walking towards R17 she observed him to be slumping over to the right. E8 stated that R17's back was

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W9999	Continued From page 51 towards her. E8 stated that R17 slumped over and fell back on her. E8 stated she called R17's name and E12 (supervisor) immediately came to the table and started to perform the Heimlich. E8 stated she called 911. E8 stated she observed R17 turning blue and mucous was coming out of his mouth. E8 was asked if she left R17 unsupervised when she went to the kitchen (approximately 25 to 30 feet away). E8 stated she asked another staff to watch her table. E8 stated she could not remember who the staff was that she asked to watch the table. E8 stated, "I watched him as good as I could." E8 was asked about R17's diet order. E8 stated that R17 was on a general diet. E8 was asked if R17's food was cut up. E8 stated that R17's food was not cut up. E8 stated that R17 could pick up his food and eat it. E8 verified that grapes were served to R17 on 10/17/10 with his meal. E1 provided that facility's menu for 10/17/10. The dinner meal consisted of: vegetable soup, saltines, egg salad sandwich with lettuce and tomato and red grapes. The facility obtained hospital records and the following was documented in hospital reports: - 10/17/10 17:47 "74 (year old male) brought in by EMS (Emergency Management Services) (with) report that prior to arrival pt (patient) was eating grapes, started choking on a grape, became unresponsive. EMS attempted to intubate, removed grape, but was unable to intubate, Pt. arrives to ED (Emergency Department) unresponsive." R17's "Certification of Death Record" identifies that R17 was pronounced dead on 10/18/10 at	W9999		