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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| W 154 | Continued From page 15<br>as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness".<br>The policy further states, that any employee of the facility that is reviewed for Abuse/Neglect has to be reassigned to nonresident care duties until the results of the investigation has been reviewed by the Administrator. In addition a copy of a completed resident abuse investigation report will be provided to the Administrator within five working days of the reported incident. | W 154 | | |
| W9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS:<br><br>350.620a)<br>350.1060e)<br>350.1210<br>350.1230d)1)2)3)<br>350.3240a)<br>350.3240e)<br><br>Section 350.620 Resident Care Policies<br><br>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.<br><br>Section 350.1060 Training and Habilitation | W9999 | | |

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| W9999 | Continued From page 16<br>Services<br><br>e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.<br><br>Section 350.1210 Health Services<br><br>The facility shall provide all services necessary to maintain each resident in good physical health.<br><br>Section 350.1230 Nursing Services<br><br>d) Direct care personnel shall be trained in, but are not limited to, the following:<br><br>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.<br><br>2) Basic skills required to meet the health needs and problems of the residents.<br><br>3) First aid in the presence of accident or illness. | W9999 | | |

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| W9999 | Continued From page 17<br>g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications.<br><br>Section 350.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)<br><br>These Regulations were not met as evidenced by:<br><br>Based on record review and interview the facility failed to:<br><br>Ensure the development and implementation of polices and procedures to prevent neglect for 1 resident, (R1), who became choked on a sandwich in the evening and the client expired @ the facility and failed to have reproducible evidence that all allegations of neglect are | W9999 | | |

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| W9999 | Continued From page 18<br>thoroughly investigated for 1 resident, (R1), who expired from asphyxia due to aspiration of food.<br><br>The facility failed to ensure:<br><br>1. The facility has a policy related to the supervision of individuals on modified diets and that require increased supervision due to eating fast, difficulty in chewing or swallowing and requiring prompting for eating @ an appropriate pace.<br><br>2. The facility failed to determine the root cause of this incident related to the lack of completing a thorough investigation.<br><br>3. Each client on a modified diet, receives snacks of the same modification.<br><br>4. Individuals who require modified diets are provided a snack item in the dining area; where supervision is provided while eating.<br><br>Findings include:<br><br>R1 expired at the facility related to complications associated with choking on a food item at the residential facility, (time period of being unattended during feeding; evidence of non-mechanical soft food) . It was determined @ that time the facility had not determined the root cause of this incident ensuring sufficient safeguards had been put in place.<br><br>Review of R1's "Admission Face Sheet"no date | W9999 | | |

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| W9999 | Continued From page 19 | W9999 | | |

stated & "Individual Program Plan" dated 10/17/12. R1 was a 78 year old male with a diagnosis of Profound Mental Retardation, GERD, Hiatal Hernia, Adult Onset Diabetes-Type II, Impulse Control Disorder-explosive type, Generalized Anxiety Disorder & Organic Personality Disorder. It was reviewed that under the "need for Active Treatment/Specialized Services" section R1 has "weakness/deficits" stated as: eats too fast, overfills mouth, Type II Diabetes, engages in self abusive behavior when stressed, cyclic behavioral changes & requires medication to balance mental health, control explosive disorder. Review of the "Medical/Physical Review" section; R1 eats too fast, regurgitates and has erosive esophagitis. R1 requires a mechanical soft/low fat/ increased protein diet. In addition it noted R1 "eats too fast, R1 then regurgitates and eventually vomits." R1's "Dining Skills Assessment" dated 3/14/12 noted R1 requires verbal prompting to eat at a normal pace and physical prompting to serve appropriate amounts of food, take appropriate size bites & chews with his mouth closed. R1 had a program to address his eating deficit "R1 will eat meals appropriately-R1 eats too fast, takes bites that are too large."

Review of facility"Incident/Accident Report" dated 12/15/12. "At 7:05PM on 12/15/12 R1 aspirated on food blocking his airway. Heimlich Maneuver performed & suctioning. R1's level of consciousness was non-responsive."

Interview with E2, (Direct Care), on 1/14/13 @2:15PM. E2 stated she is currently employed at the residential facility and is currently enrolled in habilitation Technician classes E2 stated she is

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| W9999 | Continued From page 20 | W9999 | | |

currently training as staff on the job training and is required to be with a certified staff member while performing duties with individuals at the facility.
E2 confirmed the incident involving R1 on 12/15/12. E2 stated that she participated in PM snack on 12/15/12 with other staff members E3, E4 & E5, (Direct Care staff members). E2 stated she "gave R1 a sandwich from the snack cart as he was sitting on the couch in the living room. Then walked to the snack cart to grab drinks and gave out several glasses to individuals. E2 stated she turned around and noticed R1 was blue in the face. E2 then yelled out to R1 and received no response. E3 ran over to R1 and started to do the Heimlich. E2 then went to R1 and assisted holding him up as they attempted to continue doing the Heimlich. E2 then yelled for E6, (Direct Care), to go get the nurse.
E2 confirmed giving a statement on 12/17/12, (no time noted). E2 noted that R1 was sitting upright on the couch and had received a whole sandwich from E2. E2 stated the sandwich was chicken salad sandwich. E2 noted that she had worked with R1 in the recent past and recalled that R1 would eat at a rapid pace and required prompting to slow down during food consumption. E2 stated that she had witnessed R1 coughing in the dining room in recent history due to food consumption at a fast pace. E2 stated she had been informed that she had to watch R1 during meals due to his history of choking during meals. E2 stated that when she assisted with the Heimlich she saw parts of the chicken salad sandwich on the floor and noted later during the maneuver that R1 had thrown up parts of food from the PM meal consumed earlier on 12/15/12.

Interview with E3, (Direct Care), on 1/14/13

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| W9999 | Continued From page 21<br>@2:30PM. E3 confirmed the incident of 12/15/12 involving R1. E3 stated that she brought the snack cart to the living room for the PM snack. E3 confirmed that the sandwiches where chicken salad and R1 would have received a whole sandwich that would have been presented in a sandwich bag. E3 observed R1 slumped over on the couch as she heard staff members yell out R1's name. E3 noted R1 had his mouth open and a piece of sandwich fell out of his mouth to the floor. R1 made no sounds or movements during the Heimlich Maneuver.<br><br>Review of facility "Incident Investigation" dated 12/19/12. On "12/15/12 @ 7:15PM E7, (LPN), reported that R1 had been seated on a sofa in the living room watching television. R1 had received his snack and then R1 was noted to have discoloration to his face. E 3 immediately started emergency protocol, (Heimlich Maneuver), and sent another employee, (no name stated), to get the nurse. E7 and other Direct Support Staff attempted to do the Heimlich but was unsuccessful. R1 was then lowered to the floor and abdominal thrusts were done, The EMS, (911) was activated. Respirations were attempted with an artificial respirator and oxygen, abdominal thrusts and resuscitation were continued. First responders arrived, then ambulance personnel. AED (Automatic External Defibillator), was applied and the EMS personnel pronounced the individual as deceased and notified the coroner. Individual was a DNR-do not resuscitate order on file signed by his guardian.<br><br>Conclusion:<br>1. As of this date, the coroner has not sent a copy of the death certificate for the exact cause of | W9999 | | |

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| W9999 | Continued From page 22<br>death.<br>2. Injury was determined to be accidental.<br><br>Review of "Certificate of Death Worksheet" dated 12/17/12. It was reviewed that R1 expired on 12/15/12 and cause of death is listed as "Asphyxiation due to choking on food." In addition it was reviewed that "significant condition contributing to death: Time period of being unattended during feeding; evidence of non-mechanical soft food & approximal interval between onset and death-minutes."<br><br>Interview with E1, (Administrator), on 12/24/12 @5:00PM. E1 confirmed the incident of 12/15/12 involving R1. E1 confirmed the facility incident investigation and stated the facility received the death certificate. E1 confirmed that R1 had a history of rapid pace eating and required staff monitoring during meals. E1 confirmed that the facility could not confirm that R1 received the appropriate modified diet on 12/15/12.<br>E1 confirmed that E2 had not been a certified staff member at the time of the incident. E1 confirmed the facility now requires all meals/snacks to be consumed in the dining room & a nurse will be present during meals. E1 confirmed that the facility currently has 19 individuals, (R2-R20), on mechanical soft diets. E1 confirmed that the facility as of 12/24/12 had not completed an investigation into any aspects of abuse/neglect related to the death of R1. In addition E1 confirmed the facility did not remove any staff after the incident of 12/15/12 and did not conduct a staff training until 12/17/12 in the PM to address dietary concerns with individual's having modified diets and supervision during meals/snacks. | W9999 | | |

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| W9999 | Continued From page 23<br><br>Review of facility "Abuse Reporting" no date noted at time of review. "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness".<br><br>The policy further states, any employee of the facility that is reviewed for Abuse/Neglect has to be reassigned to nonresident care duties until the results of the investigation have been reviewed by the Administrator. In addition a copy of a completed resident abuse investigation report will be provided to the Administrator within five working days of the reported incident.<br><br>Review of facility "Policy/Procedure for Family Style Dining & Mechanical Soft Diet" no date noted at the time of review. The "mechanical soft diet is a modification in texture and consistency of the regular diet, (or therapeutic diet), designed to minimize the amount of chewing necessary for the ingestion of food". In addition "All residents are encouraged to eat in the dining areas & residents who require assistance with eating will be provided with self-help devices or provided help as needed."<br><br>(A) | W9999 | | |