STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G206	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK WEST	**3980 FAIRFAX ROLLING MEADOWS, IL 60008**

(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
W 000	INITIAL COMMENTS INCIDENT INVESTIGATION Incident of 9-2-16/IL88629	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a Dietary Policy and Procedure to provide operating direction and resources affecting 1 of 1 client in the sample (R1) with the potential to affect 15 of 15 clients residing at the facility (R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16). Findings include: A facility investigative summary completed on 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator) and reviewed by E1 (Administrator). The investigation includes the following: Summary of the Incident: On September 2nd 2016 (time not documented), R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital (on 9/3/16). The investigation notes the following information was gathered: - R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder,	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 104	Continued From page 1 Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease). - According to his Physician Order Sheet (charting from 9/2/16 - 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again. The facility's investigation concluded that on September 2nd 2016 while R1 was eating lunch at his day program he began to choke. Staff responded and performed abdominal thrusts and finger sweeps but could not completely dislodge the food item. The QIDP was informed and the paramedics were quickly notified by calling 911. The paramedics instructed staff to transfer R1 to the floor and to initiate CPR. The instructions were followed by staff. The paramedics obtained a pulse and R1 was transported to a local hospital. On September 3rd 2016, R1 was pronounced deceased at the hospital. The cause of death is listed as Asphyxia and Choking on Food. The facility concluded that R1 choked on a piece of a peanut butter and jelly sandwich despite staff immediate intervention and paramedics intervention to remove the food. E9 (cook) was interviewed on 9/16/16 at 12:50pm. E9 stated that she made R1's lunch for 9/2/16. E9 stated that R1's lunch consisted of a ground turkey sandwich on soft wheat bread, a soft nutri-grain bar, applesauce and apple juice. E9 stated R1's day program has packets of thickening agent to add to R1's juice to make it nectar thick. E9 was asked to provide a copy of the menu for 9/2/16 for lunch. The menu for lunch for 9/2/16	W 104		

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W 104	Continued From page 2 was reviewed and notes a bologna sandwich for regular diets. Mechanical soft diets note tuna salad is supposed to be served with 1/2 Cup of 3 bean salad and 1/2 Cup of applesauce and milk. E9 was asked why the menu was not followed for 9/2/16. E9 stated that bologna is not available so turkey was substituted. Ground turkey was used for the mechanical soft diets. E9 stated that a nutri-grain bar was substituted for the 3 bean salad. E9 stated that R1 was given apple juice for his beverage. E9 was asked how staff ensure that R1's juice is made to nectar thick consistency. E9 stated that staff are to pour the juice into a cup and mix it with 1 packet of thickener. E9 showed surveyor the packet of thickener and the apple juice that R1 should have received. The apple juice is identified as 6.75 fluid ounces. The packet of thickener notes that 1 packet of thickener should be mixed with 4 ounces of liquid to ensure nectar thick consistency. E9 observed the apple juice container (6.75 ounces) and 1 packet of thickener (for 4 ounces of liquid) and verified that 1 packet would not ensure nectar thick consistency when mixed with 6.75 ounces of apple juice. E9 was again interviewed on 9/20/16 at 12:35pm. E9 was asked if R1 was to be served a peanut butter and jelly sandwich as he is on a mechanical soft diet. E9 stated that R1 has previously been served peanut butter and jelly sandwiches because it is on the menu. E9 provided a copy of the facility's menu for Week 2 Thursday. The menu notes peanut butter and jelly sandwiches for lunch for regular diets. Mechanical soft diets notes cheese sandwich with ground turkey is to be served. E9 stated that she did not realize peanut butter and jelly sandwiches should not be served to persons	W 104		

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W 104	Continued From page 3 on mechanical soft diets. E1 (Administrator) was interviewed on 9/16/16 at 11:40am. E1 was asked to provide the facility's Dietary Manual and or Policy and Procedure regarding diet listing and definitions. E1 provided a document (no date) that includes the following: Mechanics of Swallowing, Signs of aspiration or choking, Diet Consistency, Liquid Consistencies and The Mealtime Experience. E1 stated this document is what is taught to new DSP's (Direct Support Person) in the Food Handler Class. E1 was again interviewed on 9/21/16 at 2:33pm and asked if the facility has a Dietary Manual. E1 stated the facility does not have a Dietary Manual / Policy. E1 stated there is no Dietary Manual that describes and identifies specially prescribed diets. R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16's dietary orders were reviewed. R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15 and R16 all have specially prescribed diets including puree, mechanical soft,calorie restricted, low concentrated sweets, no added salt. Z1 (Speech Language Pathologist) was interviewed on 9/20/16 at 11:50am. Z1 was asked if R1, who has a prescribed mechanical soft diet, should have received a peanut butter and jelly sandwich on 9/2/16. Z1 stated before this incident (R1 choking on 9/2/16 on a peanut butter and jelly sandwich) the organization started to re-evaluate all of their policies. A new policy was developed in mid August 2016 that addresses choking prevention. Z1 stated the policy was not fully implemented	W 104		

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W 104	Continued From page 4 and staff were not completely trained on this new policy. The facility's policy titled "Choking Prevention Policy and Procedure" dated August 2016 was reviewed. The policy includes the following: "Factors that Increase the Risk of Choking: Individual with Intellectual / Developmental Disabilities may have a number of factors that increase the risk of choking, including but not limited to: - Neurological and muscular disorders such as Cerebral Palsy and Seizure Disorders - Dysphagia (difficulty swallowing) ... - Incorrect diet texture - liquids or food items not prepared in accordance with prescribed diet ... Common Foods Identified as "High Risk" for Choking - Hot dogs served whole - Chicken on the bone - Grapes - Peanut butter - Peanut butter sandwiches on soft bread ... Awareness is the First Step of Prevention - Because of the risk factors associated with choking, it is critical that care givers ensure adequate supervision of persons served, and are trained and familiar with individual's: - Prescribed diets - Meal time or Pica precautions - History of previous choking incidents or difficulty swallowing - Properly assisted eating techniques - Positioning during and after meal time - Required supervision during meals ..." E1 (Administrator) was interviewed on 9/21/16 at 2:33pm. E1 reviewed the above noted policy and	W 104		

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W 104	Continued From page 5 verified there is no correlation between the Choking Prevention Policy and diet consistencies and / or food that can be served to clients based on their prescribed diet.	W 104		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure confidential information (full names and diet orders) is kept confidential affecting 11 of 11 clients (R2, R3, R4, R5, R7, R9, R10, R11, R12, R14 and R16) attending the facility's Day Training program. Findings include: Observations of the facility's Day Training program were conducted on 9/21/16. Observations were conducted during lunch time, beginning at approximately 11am. The first and last names as well as the complete diet orders were observed on the lunch bags. E12 (Coordinator of Day Services) was present during the observation and verified the first and last names as well as the diet orders were on the lunch bags of the clients attending this Day Training program. E1 (Administrator) was interviewed on 9/21/16 at approximately 2:30pm. E1 was asked about the labels that include the client's first and last names and diet orders that are on each individual lunch bag. E1 stated the facility put the labels on the	W 112		

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W 112	Continued From page 6 lunch bags. The clients attending this Day Training program include: R2, R3, R4, R5, R7, R9, R10, R11, R12, R14 and R16.	W 112		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 client in the sample (R1) received a specially prescribed mechanical soft diet with nectar thick liquids as ordered. R1 choked on a peanut butter and jelly sandwich on 9/2/16 and expired on 9/3/16. The facility failed to: 1. Ensure R1's mechanical soft diet with nectar thick liquids was served as prescribed 2. Ensure R1's food was cut into small bites as prescribed 3. Ensure R1's was supervised and prompted, during meal, to stop clear throat and swallow again 4. Ensure the facility developed and implemented a dietary manual and policies and procedures Refer to deficiencies cited under:	W 122		

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W 122	Continued From page 7 W104 - The governing body must exercise general policy, budget, and operating direction over the facility. W149 - The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. W154 - The facility must have evidence that all alleged violations are thoroughly investigated. W460 - Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets. W484 - Equip area with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has restricted the rights of 12 of 12 clients residing at the facility (R2, R3 R4, R5, R6, R7, R8, R9 , R10, R11, R12 and R13) when they removed and / or prohibited hot dogs and peanut butter from being served to clients. Findings include: A facility investigative summary completed on	W 125		

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W 125	Continued From page 8 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator) and reviewed by E1 (Administrator). The investigation includes the following: Summary of the Incident: On September 2nd 2016 (time not specified), R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital (on 9/3/16). The facility's investigation notes the following: - R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder, Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease). - According to his Physician Order Sheet (charting from 9/2/16 - 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again. E4 (DSP - Direct Support Person) was interviewed on 9/16/16 at 1:50pm. E4 stated that on 9/2/16 he obtained R1's sack lunch from the cooler in the kitchen area. E4 stated he opened up R1's sack lunch bag and saw that it was a meat sandwich. E4 stated that R1 does not like the mechanical soft sandwich so he switched it with a peanut butter and jelly sandwich that he took from another client. The facility concluded that R1 choked on a piece of a peanut butter and jelly sandwich despite staff immediate intervention and paramedics intervention to remove the food. As a result of this investigation ... Until further notice, peanut butter and hot dogs have been	W 125		

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W 125	Continued From page 9 removed from all programs. E1 (Administrator) was interviewed on 9/16/16 at approximately 11:40am. E1 stated that in response to R1 choking on a peanut butter and jelly sandwich (which resulted in his death) peanut butter and hot dogs have been removed from all programs.	W 125		
W 149	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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent neglect of 1 of 1 client in the sample (R1) who choked and died after receiving food that was not on his prescribed diet. Findings include: The facility's policy titled, "Client Treatment Policy" last revised October 2013 was reviewed and includes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. ... Any finding of abuse or neglect of a client is grounds for immediate dismissal. Other steps may be taken as necessary by the client or the Administrator If the allegations cannot be proved, it may still be necessary to remove the staff person from working directly with the client or clients. ... Neglect is defined as: The failure to provide adequate medical or personal care or maintenance, which failure results in physical or	W 149		

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W 149	Continued From page 10	W 149		

mental injury to an individual or in the deterioration of an individual's physical or mental condition. When care takers do not give a person the care for the goods or services needed to avoid harm or illness. ...
Egregious Neglect is defined as: The substantive failure by an employee to provide adequate medical or personal care or maintenance that result in the death, serious medical condition, or serious deterioration of an individual's physical or mental condition. ... "

A facility investigative summary completed on 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator) and reviewed by E1 (Administrator). The investigation includes the following:
Summary of the Incident:
On September 2nd 2016, R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital.
The following information was gathered:
- R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder, Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease).
- According to his Physician Order Sheet (charting from 9/2/16 0 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again.
- According is his Occupational Therapy Evaluation dated 7/30/15: R1's current equipment needs included a scoop plate with non-skid bottom, built up handled spoon and fork

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W 149	Continued From page 11 curved to the left for right hand use (not needed for finger foods). - According to his ICF-IID Family Style Dining Assessment dated 9/30/15: The form indicates that R1 needs hand over hand assistance for cutting his food, he can independently scoop his food, independently pierce his food, independently bring a utensil to his mouth independently able to hold a cup and independently able to use a napkin. The following day program staff members provided written statements that were obtained by E10 (Day Program Director): - E3 (DSP - Direct Support Person) - At 10:30am staff started to prepare lunch for the client and I (E3) fixed R1's lunch. R1 had a mechanical soft meat sandwich (unsure of the meat). After I fixed his lunch I started working on other lunches. I saw E4 (DSP) switch R1's sandwich. After the lunch clean up I threw away all garbage and cleaned my area and went outside to smoke a cigarette when I noticed paramedics approaching our parking lot. I did not give R1 his lunch I only prepared his plate. I came back inside to see what was going on that's when I saw staff performing CPR on R1. I then asked E4 if he (R1) choked on the peanut butter and jelly sandwich and he said, "no" R1 always eats peanut butter and jelly sandwiches. He stated that he believed it was another client's hot dog that he ate. Paramedics worked on R1 for 20 minutes and took him at 11:45am. - E4 (DSP) - The client had PB&J (peanut butter and jelly) for lunch. I went to finish cleaning the tables for lunch and when I came back the client was choking. I gave him CPR, Abdominal thrusts until the ambulance came.	W 149		

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W 149	Continued From page 12	W 149		

Additionally - During the process I scooped out a piece of a bun. I switched the client's sandwich because of preference that's what he would usually have. He refused the apple juice, apple sauce and nutri-bar. I didn't see him eat anyone else's food.

- E5 (DSP) - I looked up and saw R1 choking, was not coughing or able to speak, I gave him several blows to the back, followed by a finger sweep of the mouth. Then abdominal thrusts on R1 while in his chair. We called for the Q (QIDP) who called 911 and we removed him from his chair (wheelchair) and began CPR. I pulled out a big piece of bread from his mouth. Hearing him try to catch his breath. I had put my finger down his throat. He was pointing his his throat, pulled chunks of bread out of his throat. Client was turning blue as well as gray.

- E6 (QIDP - Qualified Intellectual Disability Professional) - On Friday September 2 2016, at approximately 11:16am, I was approached by staff. I was told R1 was choking. I ran to his location. I witnessed staff (E7 and E8 - DSP's) trying to get out what was obstructing his airway. They were using abdominal thrusts maneuver. I noticed his face looked blue in color. I announced I was calling 911. I had a 6 minute conversation with the dispatch officer which began at 11:18am. I told her R1 was not responding. She instructed we place him on his back and not to pat his back. She said to begin chest compressions. E8 began a round of 30 compressions. The dispatch officer counted with us. After two round he was still unresponsive. She instructed us to begin breaths. I did not want to wait for a mouth guard. I made the decision to begin mouth to mouth. E8 did the compressions

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and I did the breaths After 2 or 3 rounds,some food came out. E7 swiped the food out of his mouth with her finger. I believe we did one more round of chest compressions and breaths before the paramedics arrived at 11:24am. The paramedics continued to work on R1 for approximately 20 minutes. They finally got a heart rate. At that point, they got him ready for transport.

- E7 (DSP) - I witnessed E5 (DSP)trying to help R1. So I got up and went over to where he was and saw he was choking. R1 was aware he was choking and pointing to his throat. You could hear him trying to catch his breath. I tried the abdominal thrusts and finger sweep. Client was still, we called for the nurse so they got a Q. She called 911 and removed him from his chair. Began CPR and mouth breaths. Pulled out big pieces of bread. Was still responsive up until a couple minutes after he was on the floor. Did CPR and mouth to mouth until 911 arrived.

- E8 (DSP) - During lunch time I was feeding clients, and I noticed E5 walk over to R1. E5 was asking R1 if he was ok. And was not getting a response from R1. I walked over to them and asked R1 if he was ok which R1 responded to me saying that he was ok, so I went back to feeding my clients. After a little bit E7 went over and noticed R1 was choking. I went and grabbed E6 and told her R1 was choking. I also let E4 know - who had gone to bathroom. E4 started to do the abdominal thrusts maneuver to get whatever was stuck in his throat out. I relieved E4 and kept doing the abdominal thrusts until the emergency responder told us to take him out of chair (wheelchair) and start doing CPR until the paramedics came which we began immediately

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until they showed up.

- E13 (DSP) - Time 11:15 - 11:50am. I was helping cleaning off tables and clients hands when I noticed E5 bending down by R1 talking to him. Then E8 went over to R1 and asked if he was ok. E8 walked back towards me to finish feeding his client. I asked E8 what did R1 say and E8 said "Yes" that he was ok. Seconds later I heard E7 say he is not ok. E7 got up and ran over to R1 and started to do the abdominal thrusts on R1 and other staff taking turns performing the Abdominal thrusts maneuver on R1. Myself, E8 and E5.

The facility's investigation included 2 additional staff statements. These 2 staff documented they were not directly involved in providing any care to R1.

E2 documented that he reviewed the video camera footage. The video footage included:
- 10:20am R1 was assisted to his location at the lunch table
- 10:30am E4 gave R1 his plate of food
- 10:34am R1 picked up food from his plate and started to eat
- 10:41am E4 walked past R1
- 10:47am R1 continued to eat his food
- 10:54am R1 ate food from his plate
- 10:54am Other clients near R1 appeared to touch his plate
- 11am R1 continued eating his food
- 11:00am E5 approached R1
- 11:00am E5 is observed touching R1 on his upper back
- 11:02am E7 and E8 are observed attempting the Abdominal thrusts
- 11:03am - 11:04am E7, E5 and E13 attempting

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W 149	Continued From page 15 Abdominal thrusts - 11:04am E6 enters camera view and makes phone call on cell phone - 11:05am E4 attempts Abdominal thrusts - 11:07am E4, E5, E7 and E7 transfer R1 to the floor - 11:08am E8 performs chest compressions - 11:10am E8, E7 and E6 are on the floor performing CPR - 11:11am Paramedics arrived in camera view E2 documented that E9 (cook) was interviewed on 9/8/16 regarding R1's lunch for 9/2/16. E9 noted that R1's lunch consisted of a turkey mechanically soft blended sandwich. Apple sauce, nutri-grain (soft baked) bar and juice (day program has the thickening packets.). The facility's investigation concluded that on September 2nd 2016 while R1 was eating lunch at his day program he began to choke. Staff responded and performed abdominal thrusts and finger sweeps but could not completely dislodge the food item. The QIDP was informed and the paramedics were quickly notified by calling 911. The paramedics instructed staff to transfer R1 to the floor and to initiate CPR. The instructions were followed by staff. The paramedics obtained a pulse and R1 was transported to a local hospital. On September 3rd 2016, R1 was pronounced deceased at the hospital. The cause of death is listed as Asphyxia and Choking on Food. The investigation found conflicting statements regarding what R1 had for lunch. He was sent from the residence with a mechanical soft turkey sandwich but staff substituted this with a peanut butter and jelly sandwich due to his food	W 149		

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preference. A staff member reported seeing him eating a hotdog but no one observed anyone actually giving him a hotdog.
According to staff, R1 refused his juice drink. As mentioned, R1 was provided with a substitute peanut butter and jelly sandwich due to his food preference. According to the Physician's Order Sheet, R1 was on a mechanical soft diet with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident to stop clear throat and swallow again. Based on staff statements, it does not appear that the food was cut into small pieces nor was R1 reminded to stop, clear throat, and swallow again.

It is our conclusion that R1 choke on a piece of a peanut butter and jelly sandwich despite staff immediate intervention and paramedics intervention to remove the food.

E9 (cook) was interviewed on 9/16/16 at 12:50pm. E9 stated that she made R1's lunch for 9/2/16. E9 stated that R1's lunch consisted of a ground turkey sandwich on soft wheat bread, a soft nutri-grain bar, applesauce and apple juice. E9 stated R1's day program has packets of thickening agent to add to R1's juice to make it nectar thick.
E9 was asked to provide a copy of the menu for 9/2/16 for lunch. The menu for lunch for 9/2/16 was reviewed and notes a bologna sandwich for regular diets. Mechanical soft diets note tuna salad is supposed to be served with 1/2 Cup of 3 bean salad and 1/2 Cup of applesauce and milk. E9 was asked why the menu was not followed for 9/2/16. E9 stated that bologna is not available so turkey was substituted. Ground turkey was used for the mechanical soft diets. E9 stated that a

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nutri-grain bar was substituted for the 3 bean salad. E9 stated that R1 was given apple juice for his beverage. E9 was asked how staff ensure that R1's juice is made to nectar thick consistency. E9 stated that staff are to pour the juice into a cup and mix it with 1 packet of thickener. E9 showed surveyor the packet of thickener and the apple juice that R1 should have received. The apple juice is identified as 6.75 fluid ounces. The packet of thickener notes that 1 packet of thickener should be mixed with 4 ounces of liquid to ensure nectar thick consistency. E9 observed the apple juice container (6.75 ounces) and 1 packet of thickener (for 4 ounces of liquid) and verified that 1 packet would not ensure nectar thick consistency when mixed with 6.75 ounces of apple juice.

E9 was again interviewed on 9/20/16 at 12:35pm. E9 was asked if R1 was to be served a peanut butter and jelly sandwich as he is on a mechanical soft diet. E9 stated that R1 has previously been served peanut butter and jelly sandwiches because it is on the menu.
E9 provided a copy of the facility's menu for Week 2 Thursday. The menu notes peanut butter and jelly sandwiches for lunch for regular diets. Mechanical soft diets notes cheese sandwich with ground turkey is to be served. E9 stated that she did not realize peanut butter and jelly sandwiches should not be served to persons on mechanical soft diets.

E3 was interviewed on 9/16/16 at 1:45pm. E3 stated that on 9/2/16 she obtained R1's sack lunch to prepare for R1. E3 stated R1's lunch consisted of a ground meat (not sure what type of meat) sandwich, applesauce and a nutrigrain bar. E3 stated she took R1's sandwich and put it on a

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styrofoam plate, the sandwich was cut diagonally in 1/ 2. E3 stated that E4 got a packet of thickener to mix with R1's apple juice. E3 stated she did not serve R1 his lunch, she only got it ready for E4 to serve it to R1. E3 stated she then went to assist another client with lunch.

E4 was interviewed on 9/16/16 at 1:50pm. E4 stated that on 9/2/16 he obtained R1's sack lunch from the cooler in the kitchen area. E4 stated he opened up R1's sack lunch bag and saw that it was a meat sandwich. E4 stated that R1 does not like the mechanical soft sandwich so he switched it with a peanut butter and jelly sandwich that he took from another client. E4 stated he learned in his training class that it was ok to switch sandwiches with another client as long as it is part of their diet.
E4 stated that he cut the sandwich into 1/4's and then put it on a styrofoam plate. E4 stated that R1's adaptive plate (scoop plate with non skid bottom) and adaptive utensils have never been available for R1 to use.
E4 stated that he poured R1's apple juice into a cup and mixed it with 1 packet of thickener.
E4 stated R1 started eating his food. E4 was asked if he cut R1's sandwich into small pieces as per his prescribed diet. E4 stated he cut R1's sandwich into 1/4's. E4 was asked if he monitored R1 to ensure he alternated food and drink and stopped cleared his throat and swallowed. E4 stated that he did monitor R1 during the meal. E4 stated he cleaned off the tables, went to the bathroom and then went outside to smoke. E4 stated when he was outside E8 came out and told him that R1 was choking. E4 stated he went back inside and saw R1 choking and attempted the Heimlich. E8 and E6 performed CPR on R1.

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W 149	Continued From page 19 E4 was asked if he has receive any training since R1 choked on 9/2/16. E4 stated that he was off work for a few days when staff were trained. E4 stated that when he returned to work E6 read some papers to him and gave him some papers for his binder. E4 stated that he was told if a client gets sent with the wrong food they are supposed to throw that food away. E4 stated that peanut butter and jelly sandwiches and grapes are not be served to any clients. E4 stated that he was also given vital information about the clients that he works with. E1 (Administrator) was interviewed on 9/16/16 at approximately 11:40am. E1 stated that R1 choked during lunch on 9/2/16 at his day training program. E1 stated that R1 was given a peanut butter and jelly sandwich for lunch. E1 was asked if a peanut butter and jelly sandwich should have been served to R1 since he has orders for a mechanical soft diet. E1 stated that R1 had previously been served peanut butter and jelly and he had no history of choking. E1 stated that peanut butter and jelly sandwiches are ok to be served to a person on a mechanical soft diet. E1 stated the facility's investigation showed that staff did not supervise R1 during lunch as required. Staff did not cut R1's sandwich into small bites and staff did not provide R1 with his needed adaptive equipment. E1 was asked if R1 had any previous history of choking. E1 stated that R1 has no history of choking and had been receiving a mechanical soft diet for years. E2 was interviewed on 9/20/16 at 11:03am. E2 was asked if R1 should have been served a peanut butter and jelly sandwich due to his	W 149		

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W 149	Continued From page 20 prescribed diet of a mechanical soft diet. E2 stated that based on talking to E9 (cook), E1 (Administrator) and E10 (Day Training Director) it is ok for clients on a mechanical soft diet to receive peanut butter and jelly sandwiches. E2 was asked to provide a copy of R1's most recent Videofluroscopic Swallowing Study(VFSS). E2 provided a copy of a VFSS for R1, dated 7/25/13. The VFSS was reviewed and included the following: Purpose of Study - Aspiration risk Physician order to determine safe diet and "choking on mechanical soft and nectar thick." Results - diagnosis Dysphagia. Otherwise no abnormality noted. R1's Physician's notes dated 6/25/13 note - Continuing choking episodes on mech. soft and nectar thick liqs - VFSS. There are no physician note regarding a follow up to the VFSS that was completed. R1's nursing notes were reviewed. On 7/25/13 nursing staff documented - Results of video swallow. No abnormality demonstrated. E1 was interviewed on 9/20/16 at 12:52am. E1 stated that she reviewed R1's clinical record and there is no documentation of any IDT (Inter Disciplinary Team) team meeting that documented R1 had previous choking incidents. E1 stated she did not know why R1's physician documented that R1 had "continuing choking episodes". On 9/16/16 E1 provided a document that defines a Mechanical Soft Diet. E1 stated the document is from a food handler class and the material is	W 149		

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used for staff training.
The Mechanical Soft Diet is defined as - Mechanically Altered (chopped) (staff or kitchen prepared) - Individuals who receive mechanically - altered / chopped diet will need staff, either in the kitchen or in the dining area, to cut their food into very small pieces. Often this is done in the kitchen with a blender or food processor. However, you should be prepared to chop the food as directed or prescribed by the individual's diet plan if a blender or food processor is not available.

Z1 (Speech Language Pathologist) was interviewed on 9/20/16 at 11:50am. Z1 was asked if R1, who has a prescribed mechanical soft diet, should have received a peanut butter and jelly sandwich on 9/2/16.
Z1 stated before this incident (R1 choking on 9/2/16 on a peanut butter and jelly sandwich) the organization started to re-evaluate all of their policies. A new policy was developed in mid August 2016 that addresses choking prevention. Z1 stated the policy was not fully implemented and staff were not completely trained on this new policy.
Z1 was asked if R1 should ever have received a peanut butter and jelly sandwich. Z1 first stated that R1 should not have been served a peanut butter and jelly sandwich. Then Z1 explained the policy on choking prevention is new and staff had not been trained. Z1 was again asked if R1 should have received a peanut butter and jelly sandwich. Z1 stated, "Probably not." Z1 was asked why this type of sandwich should probably not have been served to R1. Z1 stated peanut butter is too sticky, it is to hard to clear.

The facility's policy titled "Choking Prevention

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W 149	Continued From page 22 Policy and Procedure" dated August 2016 was reviewed. The policy includes the following: "Factors that Increase the Risk of Choking: Individual with Intellectual / Developmental Disabilities may have a number of factors that increase the risk of choking, including but not limited to: - Neurological and muscular disorders such as Cerebral Palsy and Seizure Disorders - Dysphagia (difficulty swallowing) ... - Incorrect diet texture - liquids or food items not prepared in accordance with prescribed diet ... Common Foods Identified as "High Risk" for Choking - Hot dogs served whole - Chicken on the bone - Grapes - Peanut butter - Peanut butter sandwiches on soft bread ... Awareness is the First Step of Prevention - Because of the risk factors associated with choking, it is critical that care givers ensure adequate supervision of persons served, and are trained and familiar with individual's: - Prescribed diets - Meal time or Pica precautions - History of previous choking incidents or difficulty swallowing - Properly assisted eating techniques - Positioning during and after meal time - Required supervision during meals ..."	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 23 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate 1 incident of neglect involving 1 of 1 client in the sample (R1) who choked on 9/2/16 and expired on 9/3/16 after receiving food that was not on his specially prescribed diet. Findings include: A facility investigative summary completed on 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator) and reviewed by E1 (Administrator). The investigation includes the following: Summary of the Incident: On September 2nd 2016, R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital (on 9/3/16). The facility's investigation noted the following: - R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder, Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease). - According to his Physician Order Sheet (charting from 9/2/16 - 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again. - According is his Occupational Therapy Evaluation dated 7/30/15: R1's current equipment needs included a scoop plate with non-skid bottom, built up handled spoon and fork curved to the left for right hand use (not needed for finger foods).	W 154		

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W 154	Continued From page 24 - According to his ICF-IID Family Style Dining Assessment dated 9/30/15: The form indicates that R1 needs hand over hand assistance for cutting his food, he can independently scoop his food, independently pierce his food, independently bring a utensil to his mouth independently able to hold a cup and independently able to use a napkin. The facility's investigation concluded that on September 2nd 2016 while R1 was eating lunch at his day program he began to choke. Staff responded and performed abdominal thrusts and finger sweeps but could not completely dislodge the food item. The QIDP was informed and the paramedics were quickly notified by calling 911. The paramedics instructed staff to transfer R1 to the floor and to initiate CPR. The instructions were followed by staff. The paramedics obtained a pulse and R1 was transported to a local hospital. On September 3rd 2016, R1 was pronounced deceased at the hospital. The cause of death is listed as Asphyxia and Choking on Food. The investigation found conflicting statements regarding what R1 had for lunch. He was sent from the residence with a mechanical soft turkey sandwich but staff substituted this with a peanut butter and jelly sandwich due to his food preference. A staff member reported seeing him eating a hotdog but no one observed anyone actually giving him a hotdog. According to staff, R1 refused his juice drink. As mentioned, R1 was provided with a substitute peanut butter and jelly sandwich due to his food preference. According to the Physician's Order Sheet, R1 was on a mechanical soft diet with nectar thick liquids, no ice cream, no sherbet, no	W 154		

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jello, small bites, alternate food and drink, have resident to stop clear throat and swallow again. Based on staff statements, it does not appear that the food was cut into small pieces nor was R1 reminded to stop, clear throat, and swallow again.

It is our conclusion that R1 choke on a piece of a peanut butter and jelly sandwich despite staff immediate intervention and paramedics intervention to remove the food.

E9 (cook) was interviewed on 9/20/16 at 12:35pm. E9 was asked if R1 was to be served a peanut butter and jelly sandwich as he is on a mechanical soft diet. E9 stated that R1 has previously been served peanut butter and jelly sandwiches because it is on the menu.
E9 provided a copy of the facility's menu for Week 2 Thursday. The menu notes peanut butter and jelly sandwiches for lunch for regular diets. Mechanical soft diets notes cheese sandwich with ground turkey is to be served. E9 stated that she did not realize peanut butter and jelly sandwiches should not be served to persons on mechanical soft diets.

E1 (Administrator) was interviewed on 9/16/16 at approximately 11:40am. E1 stated that R1 choked during lunch on 9/2/16 at his day training program. E1 stated that R1 was given a peanut butter and jelly sandwich for lunch. E1 was asked if a peanut butter and jelly sandwich should have been served to R1 since he has orders for a mechanical soft diet. E1 stated that R1 had previously been served peanut butter and jelly and he had no history of choking. E1 stated that peanut butter and jelly sandwiches are ok to be served to a person on a mechanical soft diet.

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E1 stated the facility's investigation showed that staff did not supervise R1 during lunch as required. Staff did not cut R1's sandwich into small bites and staff did not provide R1 with his needed adaptive equipment.
E1 was asked if R1 had any previous history of choking. E1 stated that R1 has no history of choking and had been receiving a mechanical soft diet for years.

E2 was interviewed on 9/20/16 at 11:03am. E2 was asked if R1 should have been served a peanut butter and jelly sandwich due to his prescribed diet of a mechanical soft diet. E2 stated that based on talking to E9 (cook), E1 (Administrator) and E10 (Day Training Director) it is ok for clients on a mechanical soft diet to receive peanut butter and jelly sandwiches. E2 was asked to provide a copy of R1's most recent Videofluroscopic Swallowing Study(VFSS).
E2 provided a copy of a VFSS for R1, dated 7/25/13.
E2 was asked if he interviewed the Speech Language Therapist (who assesses R1's oral motor needs and identified and recommends special diets). E2 stated he did not interview the Speech Language Therapist.
E2 was asked if he interviewed the physician (who ordered R1's special diet). E2 stated that he did not interview the physician.
E2 was asked if he determined how R1's beverage (apple juice) was prepared to ensure nectar thick consistency. E2 stated that he did not ask how R1's beverage was prepared.

R1's VFSS was reviewed and included the following:
Purpose of Study - Aspiration risk Physician order to determine safe diet and "choking on

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W 154	Continued From page 27 mechanical soft and nectar thick." Results - diagnosis Dysphagia. Otherwise no abnormality noted. R1's Physician's notes dated 6/25/13 note - Continuing choking episodes on mech. soft and nectar thick liqs - VFSS. There are no physician note regarding a follow up to the VFSS that was completed. R1's nursing notes were reviewed. On 7/25/13 nursing staff documented - Results of video swallow. No abnormality demonstrated. E1 was interviewed on 9/20/16 at 12:52am. E1 stated that she reviewed R1's clinical record and there is no documentation of any IDT (Inter Disciplinary Team) team meeting that documented R1 had previous choking incidents. E1 stated she did not know why R1's physician documented that R1 had "continuing choking episodes". On 9/16/16 E1 provided a document that defines a Mechanical Soft Diet. E1 stated the document is from a food handler class and the material is used for staff training. The Mechanical Soft Diet is defined as - Mechanically Altered (chopped) (staff or kitchen prepared) - Individuals who receive mechanically - altered / chopped diet will need staff, either in the kitchen or in the dining area, to cut their food into very small pieces. Often this is done in the kitchen with a blender or food processor. However, you should be prepared to chop the food as directed or prescribed by the individual's diet plan if a blender or food processor is not available. Z1 (Speech Language Pathologist) was	W 154		

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W 154	Continued From page 28 interviewed on 9/20/16 at 11:50am. Z1 was asked if R1, who has a prescribed mechanical soft diet, should have received a peanut butter and jelly sandwich on 9/2/16. Z1 stated before this incident (R1 choking on 9/2/16 on a peanut butter and jelly sandwich) the organization started to re-evaluate all of their policies. A new policy was developed in mid August 2016 that addresses choking prevention. Z1 stated the policy was not fully implemented and staff were not completely trained on this new policy. Z1 was asked if R1 should ever have received a peanut butter and jelly sandwich. Z1 first stated that R1 should not have been served a peanut butter and jelly sandwich. Then Z1 explained the policy on choking prevention is new and staff had not been trained. Z1 was again asked if R1 should have received a peanut butter and jelly sandwich. Z1 stated, "Probably not." Z1 was asked why this type of sandwich should probably not have been served to R1. Z1 stated peanut butter is too sticky, it is to hard to clear.	W 154		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 1 client in the sample (R1) received his specially prescribed mecahnical soft diet with nectar thick liquids. Findings include:	W 460		

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W 460	Continued From page 29 A facility investigative summary dated 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator) and reviewed by E1 (Administrator). The investigation includes the following: Summary of the Incident: On September 2nd 2016, R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital (on 9/3/16). The facility's investigation noted the following: - R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder, Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease). - According to his Physician Order Sheet (charting from 9/2/16 - 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again. The facility's investigation concluded that on September 2nd 2016 while R1 was eating lunch at his day program he began to choke. Staff responded and performed abdominal thrusts and finger sweeps but could not completely dislodge the food item. The QIDP was informed and the paramedics were quickly notified by calling 911. The paramedics instructed staff to transfer R1 to the floor and to initiate CPR. The instructions were followed by staff. The paramedics obtained a pulse and R1 was transported to a local hospital. On September 3rd 2016, R1 was pronounced deceased at the hospital. The cause of death is listed as Asphyxia and Choking on	W 460		

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W 460	Continued From page 30 Food. It is our conclusion that R1 choke on a piece of a peanut butter and jelly sandwich despite staff immediate intervention and paramedics intervention to remove the food. E9 (cook) was interviewed on 9/16/16 at 12:50pm. E9 stated that she made R1's lunch for 9/2/16. E9 stated that R1's lunch consisted of a ground turkey sandwich on soft wheat bread, a soft nutri-grain bar, applesauce and apple juice. E9 stated R1's day program has packets of thickening agent to add to R1's juice to make it nectar thick. E9 was asked to provide a copy of the menu for 9/2/16 for lunch. The menu for lunch for 9/2/16 was reviewed and notes a bologna sandwich for regular diets. Mechanical soft diets note tuna salad is supposed to be served with 1/2 Cup of 3 bean salad and 1/2 Cup of applesauce and milk. E9 was asked why the menu was not followed for 9/2/16. E9 stated that bologna is not available so turkey was substituted. Ground turkey was used for the mechanical soft diets. E9 stated that a nutri-grain bar was substituted for the 3 bean salad. E9 stated that R1 was given apple juice for his beverage. E9 was asked how staff ensure that R1's juice is made to nectar thick consistency. E9 stated that staff are to pour the juice into a cup and mix it with 1 packet of thickener. E9 showed surveyor the packet of thickener and the apple juice that R1 should have received. The apple juice is identified as 6.75 fluid ounces. The packet of thickener notes that 1 packet of thickener should be mixed with 4 ounces of liquid to ensure nectar thick consistency. E9 observed the apple juice container (6.75 ounces) and 1 packet of thickener	W 460		

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W 460	Continued From page 31 (for 4 ounces of liquid) and verified that 1 packet would not ensure nectar thick consistency when mixed with 6.75 ounces of apple juice. E9 was again interviewed on 9/20/16 at 12:35pm. E9 was asked if R1 was to be served a peanut butter and jelly sandwich as he is on a mechanical soft diet. E9 stated that R1 has previously been served peanut butter and jelly sandwiches because it is on the menu. E9 provided a copy of the facility's menu for Week 2 Thursday. The menu notes peanut butter and jelly sandwiches for lunch for regular diets. Mechanical soft diets notes cheese sandwich with ground turkey is to be served. E9 stated that she did not realize peanut butter and jelly sandwiches should not be served to persons on mechanical soft diets.	W 460		
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure adaptive eating utensils and dishes are provided to 1 of 1 client in the sample (R1) identified whose IPP (Individual Program Plan) identifies a need. Findings include: A facility investigative summary completed on 9/14/16 was reviewed. The investigation was completed by E2 (Quality Assurance Facilitator)	W 484		

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W 484	Continued From page 32	W 484		

and reviewed by E1 (Administrator). The investigation includes the following:
Summary of the Incident:
On September 2nd 2016, R1 was observed to be choking during lunch while at his day program. The day program staff responded and the paramedics were called. R1 was transported to the hospital by ambulance and R1 passed while at the hospital (on 9/3/16).
The facility's investigation noted the following:
- R1 was a 54 year old male living with Moderate Intellectual Disability, Major Depressive Disorder, Cerebral Palsy, Rhinitis and GERD (Gastro Esophageal Reflux Disease).
- According to his Physician Order Sheet (charting from 9/2/16 - 10/1/16): R1's diet order was mechanical soft with nectar thick liquids, no ice cream, no sherbet, no jello, small bites, alternate food and drink, have resident stop to clear throat and swallow again.
- According is his Occupational Therapy Evaluation dated 7/30/15: R1's current equipment needs included a scoop plate with non-skid bottom, built up handled spoon and fork curved to the left for right hand use (not needed for finger foods).

E2 documented that E9 (cook) was interviewed on 9/8/16 regarding R1's lunch for 9/2/16. E9 noted that R1's lunch consisted of a turkey mechanically soft blended sandwich. Apple sauce, nutri-grain (soft baked) bar and juice (day program has the thickening packets.).

E4 was interviewed on 9/16/16 at 1:50pm. E4 stated that on 9/2/16 he obtained R1's sack lunch from the cooler in the kitchen area. E4 stated he opened up R1's sack lunch bag and saw that it was a meat sandwich. E4 stated that R1 does

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W 484	Continued From page 33 not like the mechanical soft sandwich so he switched it with a peanut butter and jelly sandwich that he took from another client. E4 stated that he cut the sandwich into 1/4's and then put it on a styrofoam plate. E4 stated that R1's adaptive plate (scoop plate with non skid bottom) and adaptive utensils have never been available to use. E1 (Administrator) was interviewed on 9/16/16 at approximately 11:40am. E1 stated that R1 choked during lunch on 9/2/16 at his day training program. E1 stated the facility's investigation showed that staff did not supervise R1 during lunch as required. Staff did not cut R1's sandwich into small bites and staff did not provide R1 with his needed adaptive equipment.	W 484		