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W 000	INITIAL COMMENTS The investigation of #95256-I resulted in determination of Immediate Jeopardy (IJ). On 5/25/21 at 2:46 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff took the actions necessary to consistently keep clients safe. The facility was notified on 5/25/21 at 3:15 p.m. The facility developed a plan to remove the IJ, which included the retraining staff of staff on policies/procedures and reporting behaviors to nursing/management to ensure client safety. The IJ was removed on 6/1/21 at 12:35 p.m. The facility was found to be out of compliance with the Condition of Participation (COP) Facility Staffing. Deficiencies were cited at W189 and W191. The onsite infection control survey was completed at the same time and the facility was found to be in compliance with federal standards.	W 000	See Attached POC 7/26/21	
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to comply with the Condition of Participation (CoP) Facility Staffing. The facility failed to ensure staff were adequately trained on agency policies and procedures to competently and consistently respond to client medical situations and communicate clients needs to appropriate medical personnel.	W 158		

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

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W 158	Continued From page 1 Cross-reference W189: Based on interview and record review, the facility failed to consistently ensure staff followed agency policies regarding incident reporting for major incidents (choking) as defined by the facility. Cross-reference W191: Based on interview and record review, the facility failed to ensure staff were adequately trained to communicate client behaviors to the personnel responsible for the development of behavioral programming. On 5/25/21 at 2:46 p.m., Immediate Jeopardy (IJ) was determined based on the facility's failure to ensure staff competency to keep clients safe. The facility was notified on 5/25/21 at 3:15 p.m. The facility developed a plan to remove the IJ, which included the retraining staff of staff on policies/procedures and reporting behaviors to nursing/management to ensure client safety. The IJ was removed on 6/1/21 at 12:35 p.m.	W 158		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently ensure staff followed agency policies regarding incident reporting for major incidents (choking) as defined by the facility. This affected 1 of 1 client (Client #1) involved in investigation 95256-I.	W 189		

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Findings follow:

Record review revealed a facility investigation for an incident on 1/19/21 where Client #1 was taken to the emergency room around noon after staff reported the client was unable to swallow food and water without coughing at both snack and lunch that morning. The report indicated once at the hospital the client had an x-ray which revealed an unidentified item was in the client's esophagus and the client was admitted. The investigation report revealed the next day on 1/20/21 the client's oxygen dropped while at the hospital which required him to be intubated after a sausage was removed from his esophagus.

Record review of a consumer information document revealed Client #1 was 59 years old and admitted to the facility 4/5/97. The client was diagnosed with Profound Intellectual Disability, anxiety disorder, conduct disorder, seizures, no functional speech and PICA. The client had a dysphagia evaluation, completed 12/2019, which indicated food needed to be cut into dime size pieces with "close supervision" during intake while being prompted with cues for slow rate and sips of liquids due to impulse control. The client also had a staff service plan, dated 6/2020, which indicated if choking occurred the nurse needed to be contacted.

Further review of the facility investigation revealed during the afternoon on 1/19/21 (after Client #1 was at the hospital) Developmental Specialist (DS) A reported she thought the client choked earlier in the morning during snack at 10:40 a.m. and she performed the Heimlich Maneuver on Client #1. The investigation further

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revealed the next day on 1/20/21 DS B indicated shortly after breakfast around 7:30 a.m. on 1/19/21 he witnessed the client seated in the living room coughing excessively and was informed by DS A Client #1 just consumed several sausages in the kitchen before staff could stop him. DS B reported he tried to give the client some water before he took him to the restroom and performed the Heimlich maneuver. DS B reported nothing came out during the Heimlich. The investigation conclusion indicated neither DS A nor DS B reported the sausage being stolen by Client #1 on the morning of 1/19/21 or the use of the Heimlich maneuver before the client was taken to the hospital despite knowing they were to report the information to nursing. The report further indicated "for his health and safety, this was important information the hospital should have been informed of when he went to the ER on 1/19/21.

Record review revealed an agency policy for reporting injuries. The policy listed categories of "Major Incidents," one of which was choking incidents. The policy revealed "the staff member who witnesses the incident, or the first to become aware of the incident, must immediately notify their group home Program Coordinator, and/or Manager on Call and/or the Director of ICF/ID services." The policy further indicated "the staff member who witnesses the incident, or the first to become aware of the incident, must also immediately notify the Nurse on Call."

When interviewed on 5/24/21 at 2:05 p.m. DS A confirmed she witnessed Client #1 take the sausage from the kitchen on 1/19/21 around 7:30 a.m. She remembered the client coughed several times right after he ate the sausage, but

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seemed better shortly after. At 10:40 a.m. during snack DS A remembered she observed the client coughed significantly after every bite/drink of soup and she eventually performed the Heimlich maneuver on him. After this, she took away his soup due to being concerned with his ability to swallow. She and other staff decided to wait until lunch to see if the client's swallowing improved. At approximately 11:15 a.m. during lunch, the client again started to cough after every bite and shortly after this she called the nurse and reported the client struggled and coughed during both snack and lunch. DS A admitted she failed to tell the nurse about the sausage or about performing the Heimlich during the phone call.

When interviewed on 5/25/21 at 8:20 a.m. DS B confirmed he worked an overnight shift and stayed on duty until 9:00 a.m. on 1/19/21. DS B remembered about 7:30 a.m. DS C told him Client #1 had eaten some of the sausages from the pan in the kitchen. He looked in the pan where 8 sausages were and found only 2 left. At that time he noticed the client coughing significantly and told the other staff to call the nurse while he took the client into the restroom to do the Heimlich. DS B stated he did 5 or 6 Heimlich thrusts but nothing came out, however, Client #1 stopped coughing. He reported the client drank half a cup of water and was returned to a chair in the living room. DS B indicated he knew a nurse needed to be called but admitted no one called.

When interviewed on 5/25/21 at 10:30 a.m. the Registered Nurse (RN) confirmed she took the call on 1/19/21 at 11:31 a.m. from DS A regarding Client #1's trouble swallowing snack and lunch. The RN also stated she called the house at 9:26

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a.m. that morning to ask about each client as part of her daily routine and was told there were no concerns regarding Client #1 and his temperature was 96.8. She confirmed she received the call at 11:31 a.m. from DS A where she reported only that the client coughed when he attempted to swallow, but was not told about the sausages or Heimlich use. After she talked with DS A she conferred with the ICF/ID Director and they decided to have him checked at the Lutheran Hospital ER. The RN confirmed the hospital performed an x-ray and reported a mass or unidentified object in the client's esophagus on the afternoon of 1/19/21. She also confirmed it wasn't until 9:24 a.m. the next morning (1/20/21) when she was informed by the owner of Behavioral Technologies (BT) Client #1 had consumed a bunch of sausages a few hours before the choking was reported on 1/19/21 at 11:30 a.m. The RN reported she immediately called the hospital and told them about the sausages and a few hours later the hospital did an emergency removal of the sausage and intubated the client who had stopped breathing. The RN also confirmed the client then spent 17 days in the hospital and was weak upon return to the home.

When interviewed on 5/25/21 at 1:20 p.m. the Director of ICF/ID Services confirmed staff failed to report Client #1's choking incidents for several hours on 1/9/21, even after the client was taken to the emergency room. She also confirmed when staff finally reported a concern, they only reported the client had trouble swallowing and failed to pass on the vital information that the client had potentially choked at least twice earlier in the morning after stealing and eating several sausages. She confirmed their policy required

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W 189	Continued From page 6 staff to report any incident of choking immediately and when staff failed to do so for several hours it placed the client at additional risk. The Director confirmed the client stopped breathing at the hospital and spent 17 days there before he returned home.	W 189		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff was adequately trained to communicate client behaviors to personnel responsible for the development of programming for behavioral problems. This affected 1 of 1 client (Client #1) involved in investigation 95256-I. Findings follow: Record review revealed a facility investigation for an incident on 1/19/21 where Client #1 was taken to Lutheran Hospital ER around noon after staff reported the client was unable to swallow food and water without coughing at both morning snack and lunch. The report also indicated staff performed the Heimlich maneuver on the client at least twice that morning. The report further revealed once at the hospital an x-ray revealed an unidentified item was in the client's esophagus and the client was admitted. The investigation report revealed the next day on 1/20/21 the client's oxygen dropped while at the hospital which required him to be intubated after a sausage was removed from his esophagus. Further review of the facility investigation	W 191		

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revealed several staff was aware the client stuffed at least two whole sausages in his mouth around 7:30 a.m. on 1/19/21 and swallowed them before staff could stop him. The investigation conclusion confirmed none of the staff on duty reported the stolen sausages until the next day on 1/20/21 and indicated "for his health and safety, this was important information the hospital should have been informed of when he went to the ER on 1/19/21." The investigation also stated there was no programming in place for Client #1 stealing food because there was no history of the client stealing food.

Record review revealed a document regarding documentation of client behaviors. The document instructed staff to document behaviors they were aware of and behaviors identified as "unusual" for the client on a form called a "Behavior Incident Report" (BIR) and turn them in for the program writer to review.

Additional record review of Client #1's Comprehensive Functional Assessment (CFA) last updated 3/8/21 revealed the client did not exhibit the behavior of taking food that does not belong to him. The document further noted the client could get food from the kitchen, eat finger foods, and had a Dysphagia evaluation due to difficulty swallowing. The program also indicated the client had a history of PICA.

Record review of Client #1's Behavior Support Plan (BSP) in place at the time of the incident confirmed no programming related to stealing food but did note the client needed to be monitored continuously when eating and when he was around materials he could ingest (items in the size of 4 inches by 4 inches or smaller).

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When interviewed on 5/24/21 at 2:05 p.m. Developmental Specialist (DS) A confirmed she witnessed Client #1 walk into the kitchen unsupervised on the morning of 1/19/21 at around 7:30 a.m. and eat at least two sausages from a pan before she could stop him. She stated she tried to get them out of his mouth, but he swallowed them too quickly. She indicated DS C was assigned to the client, but was working with other clients in the dining room and didn't see him walk into the kitchen so she followed him in. DS A confirmed she followed Client #1 into the kitchen and stated she did so as she knew he would steal food if given the opportunity. She stated he didn't steal food often, only because they didn't let him in the kitchen alone. The DS confirmed she failed to report the stolen sausages until the next day on 1/20/21 despite calling the Registered Nurse (RN) at 11:31 a.m. to report the client's swallowing difficulties. She also confirmed several other staff in the house were aware the client stole the sausages, had the Heimlich done, and was coughing excessively that morning. DS A stated she never filled out a BIR because she thought his assigned staff would do it.

When interviewed on 5/24/21 at 3:40 p.m. DS C confirmed she was assigned to Client #1. She also confirmed DS A told her early in the morning Client #1 had stolen and eaten several sausages on the morning of 1/19/21. She admitted a BIR should have been done for the stealing of food and was not sure why no one did it. She thought DS A would have done one since she saw him steal the food.

When interviewed on 5/25/21 at 8:20 a.m. DS B

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confirmed he was told by DS A about the client stealing sausages around 7:30 a.m. DS B indicated he believed the client may have eaten up to six sausages due to the amount left when he checked the pan. DS B confirmed he worked the overnight shift and got off at 9:00 a.m. on 1/19/21. He confirmed he did the Heimlich on Client #1 around 7:30 a.m. after the client coughed repeatedly and appeared in distress. He stated he told DS A and/or DS C to call nursing when he gave the client the Heimlich but no one did. He also stated everyone knows Client #1 would steal food if given the opportunity, but they don't usually give him the opportunity.

When interviewed on 5/25/21 at 9:10 a.m. the Developmental Supervisor confirmed the client would steal food if given the opportunity, so they don't let him into the kitchen alone. When asked if this was part of programming he stated he thought so, but wasn't sure. He also confirmed staff should have communicated the stolen sausages and the choking incidents to the nurse immediately on the morning of 1/19/21.

When interviewed on 5/25/21 at 10:30 a.m. the Registered Nurse (RN) confirmed she received the call from DS A around 11:31 a.m. which reported Client #1 had difficulty swallowing at snack and lunch on 1/19/21. She indicated she conferred with the ICF/ID Director and they decided to have him assessed at the hospital. She stated she was not told about the Heimlich being done until later that day and was not told about the stolen sausages until the next morning at 9:24 a.m. She confirmed both of these pieces of information were very important and not having them could have been catastrophic for the client. She confirmed the client was intubated on

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W 191	Continued From page 10 1/20/21 after the emergency removal of the sausage and stayed in the hospital for 17 days. When interviewed on 5/25/21 at 1:20 p.m. the ICF/ID Director confirmed staff should have filled out a BIR on the stolen sausages on the morning of 5/19/21. She also confirmed she wrote the Behavior Support Plan (BSP) for Client #1 and the BSP had not addressed stealing food until after the incident. When asked why there was no programming for stealing food the director indicated she did not know there was an issue with stealing food. When told several staff, as well as the supervisor all, indicated the client would steal food if given the opportunity she stated no one ever informed her of that and she never received a BIR about the behavior. She confirmed staff needed to fill out BIRs for programmatic behaviors as well as "unusual" or non-programmatic behaviors to let her know about the need for programming.	W 191		

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Delta 98256 – I POC

W 158; W159; W 191

1. BT Developmental Specialists will be retrained on BT “Major Incidents” policy and reporting of these incidents.

   The Director ICF/ID Services will develop the training and the house Program Coordinators will complete the training with the Developmental Specialists. The Program Coordinators, Program Coordinator Supervisor, QIDP, Director ICF/ID Services and Nursing staff will be responsible for monitoring reporting of ‘Major Incidents.”

2. BT Developmental Specialists will be retrained on how and when to fill out a Behavior Incident Report.

   Director ICF/ID Services will develop the training and the house Program Coordinators will train Developmental Specialists. Monitoring of completion of Behavior Incident Reports will be completed by follow up when the Program Coordinators are at the house. Monitoring and follow up will also be completed by the Program Coordinator Supervisor, QIDP and Director ICF/ID Services.

   Completion Date: 7/26/21