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W 153	Continued From page 24 home." In review of a policy entitled "Incident Reports", it states, "A full written report of any serious incident or accident involving an individual will be placed in the individual's medical record. This report will include the date and time of each incident or accident and the action taken concerning it...The Regional Public Health will be notified by a phone call or by fax...within 24 hours of notification of the occurrence. A written copy of this report will be sent to Public Health within 7 days of such incident or accident."	W 153		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060e) 350.1610a) 350.1620d)12) 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 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized	W9999		

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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

Section 350.1610 Resident Record Requirements

a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

Section 350.1620 Content of Medical Records

d) In addition to the information that is specified above, each resident's medical record shall contain the following:
12) Records of significant behavior incidents, reactions to any family visits and contacts, attendance at programs, and leaves from the facility.

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:

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Based on interview, record review and observations, the facility failed to prevent neglect for 1 of 1 individual (R1) who has a diagnosis of Pica and required medical emergency treatment for removal of a jelly packet from his esophagus on 7/9/09, when the facility failed to:

1) Implement their own policy for neglect when they failed to provide an adequate level of supervision to ensure the physical safety of R1.

a) Ensure that direct care staff report R1's incidents of Pica and/or attempted Pica to administrative staff.

b) Ensure accurate tracking of trends and patterns regarding R1's Pica behavior.

c) Ensure that direct care staff implemented R1's level of supervision for meals on 7/9/09, as per his 6/29/09 Physician's orders and his 3/31/09 Individual Support Plan (ISP).

d) Ensure timely staff training for new employees that enables staff to complete his/her duties in a manner that provides for the health and safety of R1.

e) Ensure timely staff training across all environments (facility and day training site), after R1's 7/9/09 ingestion of a jelly packet.

In review of an undated facility roster, R1 functions in the profound range of mental retardation.

Physician's orders of 6/29/09 document medical diagnoses of Pica, Dysphagia, Manic with

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W9999	Continued From page 27 Psychotic Features, Insomnia and History of Seizures. R1 also has an order for a mechanical soft diet , with monitoring during meals due to his history of Dysphagia (difficulty with swallowing). R1's 7/10/03 psychological documents an intelligence quotient (IQ) of less than 20 on the Slosson Intelligence Test. His 3/31/09 Inventory for Client and Agency Planning (ICAP) documents an overall age level of 1 year and 3 months. R1 ambulates independently as per observations at the facility on 7/23/09 at 7:00 a.m. His 3/31/09 (ISP) documents that R1 was admitted to this facility on 3/27/03, has a state guardian, and is non-verbal. R1's meat should be cut into bite size pieces and his ISP states, "Recommend to monitor (R1) at all times while eating and prompt as needed...Pica: Staff to monitor for ingestion of foreign objects. Staff to insure small non-edible objects, lotions, etc. are kept away from individual...." Under the "Daily Living Skills Assessment" of his ISP, it states, "He needs to be verbally and occasionally prompted to take bite sized pieces...and to eat slowly rather than shovelling {shoveling}food...." R1 has a Behavior Support Program (BSP) dated 11/13/08, documenting his need for psychotropic medication to assist in behavior control. Behaviors addressed are: Inappropriate attention seeking behaviors, physical aggression, property destruction, being up and out of bed during the night and Pica.	W9999		

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His 4/7/09 vocational report states that R1 does not remove wrappers from candy, but puts them in his mouth without removing the wrapper.

A 7/11/2000 psychiatric evaluation documents prior ingestion of rubber gloves, nuts and bolts.

R1's pre-admission referral packet of 2/26/03 documents a history of Gastrointestinal Obstruction in 1998, requiring surgery for, "multiple ingested objects." A 5/1/02 Gastroenterology report documents the past surgery for, "multiple nuts and bolts...which were trapped at the ileocecal valve...."

In a 11:33 a.m., 7/27/09 phone interview with Z1, Z1 stated that she worked as a habilitation aide (HA), at this facility 5-6 years ago. Z1 stated that soon after her employment, R1 swallowed a syrup packet during the a.m. breakfast. Z1 could not recall the size and shape of this packet. Z1 stated that there were two other staff and herself on duty when this incident occurred. R1's lips turned blue and he stopped breathing. Z1 performed abdominal thrusts without success. Z1 then called 911. While Z1 was making the call, another staff performed abdominal thrusts and was successful in expelling the packet before the ambulance arrived. Z1 stated the facility took R1 to the emergency room to ensure no further treatment was necessary.

In an interview with E3 (Supervisor), on 7/9/09 at 3:10 p.m., E3 verified that Z1 was employed at the facility from 9/25/03-3/21/08.

An 7/9/09 incident investigation report from the facility documents that on this date, R1 was taken

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to the hospital by ambulance. R1 presented with signs/symptoms of a partial airway blockage after the breakfast meal. Staff suspected that R1 had swallowed a jelly packet, as he was coughing and attempting to clear his throat. The report states that R1 was breathing throughout the episode. R1 did not regurgitate any foreign object after abdominal thrusts by staff. At the hospital, a jelly packet was removed from R1's throat, from the top of R1's esophagus.

Per the facility's 7/9/09 investigation, E5 (Food Service Supervisor/Habilitation Aide - FSD/HA), E6 (HA), E4 (HA), and E7 (HA) were the staff on duty during the incident. By 7:15 a.m., all three dining tables (two in the north dining room and one in the south dining room), had been set by R4. "Setting the table did include condiment of jelly packets." At 7:20 a.m., E6 and E4 began supervising and assisting residents in the north dining room and E7 began supervising and assisting residents in the south dining room.

The investigation further states R1 was the last individual to be seated in the south dining room by E7. E7 then went to the kitchen to help get food for family style service. When E7 returned to the south dining room, she began to assist R2 in spreading jelly on his toast and then to R1 for the same. At this time, E7 noticed that R1 did not have a jelly packet, "as staff expected." E7 then asked E5 (in kitchen) to get another jelly packet for R1.

The facility concluded that R1 did receive a jelly packet during the table setting by R4. R1 placed the jelly packet into his mouth while E7 was in the kitchen getting food for the meal service. It is possible that he attempted to swallow it

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immediately, but based on staff observations of normal feeding patterns during the meal, it is more likely that R1 "pocketed" the jelly packet and swallowed it after finishing his meal and beginning to consume his fluids.

On 7/23/09, at 11:15 a.m., surveyor asked E5 if the facility had a jelly packet of the same type that R1 ingested on 7/9/09. E5 presented surveyor with a jelly packet and confirmed that this jelly packet is the type of container used by the facility and is the type that R1 ingested on 7/9/09.

This jelly packet measures 1& 1/2 inches by 1 & 14/16th inches; and is 11/16th inches thick. The jelly packet container is a plastic type substance and the pull away cover is an aluminum type cover.

a) The facility failed to ensure that direct care staff report R1's incidents of Pica and/or attempted Pica to administrative staff.

Per an undated facility staff roster, E4 has been employed as a HA since 12/27/07.

E4 was interviewed on 7/23/09, at 10:20 a.m.

E4 stated that on Mondays and Fridays he monitors the south dining room. E4 stated that R1 always eats in this dining room, that all individuals eat in the same room and place at their respective tables.

E4 stated that R1 tries to take the jelly packets. When he is helping R2 spread his jelly or butter on toast, R1 will reach for a jelly packet and palm

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it. R1 does this, "as a routine...(R1) is sneaky... (R1) cuffs it so you can't see it...." E4 further stated that R1 has been exhibiting this behavior since E4's employment. E4 stated that in order to keep R1 from going after the jelly packets, he would place everyone's jelly packet in his pocket, until it was time to use them.

When asked about other Pica attempts/ingestion incidents, E4 stated that on another occasion, R1 actually got a jelly packet into his mouth. E4 stated that he was able to retrieve the packet. E4 was not sure of the date, stating it was approximately 6 months ago. When asked, E4 stated that he did not document the incident and could not remember if he told anyone or not. He further stated that he probably should have reported this incident.

Per an undated facility staff roster, E5 has been employed as the FSD/HA since 3/24/08.

E5 was interviewed on 7/23/09 at 11:15 a.m.

When asked about other Pica attempts/ingestion incidents, E5 stated that after breakfast, empty plates are often placed on top of the chest freezer in the kitchen. One morning, R1 came into the kitchen after breakfast and took an empty jelly packet from one of the plates. R1 had the jelly packet part way in his mouth. E5 was able to intervene and retrieve the packet. E5 stated she could not remember the date of the occurrence. E5 stated that she did not report the incident to supervisory staff and did not document the incident.

Per an undated facility staff roster E6 has been employed as a HA since 6/18/07.

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E6 was interviewed on 7/23/09 at 11:00 a.m.

When asked about other Pica attempts/ingestion incidents, E6 stated that R1 took a syrup packet and tried to put it into his mouth. E6 stated that she was able to retrieve the packet before R1 got the packet to his mouth. E6 was not able to recall the date, but believed it was when she was first employed. E6 confirmed that she did not document the incident and did not report the incident to supervisory staff.

b) The facility failed to ensure accurate tracking of trends and patterns regarding R1's Pica behavior.

R1's behavioral data related to Pica was reviewed.

A document dated 1/23/09, entitled "QMRP/PSYCHIATRIC NOTES" documents in November/2008, R1 had 4 attempted Pica events, and no actual ingestions. In December/2008, R1 had 3 attempted Pica events, and no actual ingestions.

The 1/23/09 note does not document what the non-edibles objects were that R1 attempted to ingest.

In an interview with E1 (Residential Services Supervisor/Qualified Mental Retardation Professional - RSD/QMRP), on 7/23/09 at 12:30 p.m., E1 stated that this information would be on the behavior documentation sheet completed by direct care staff at the time of the behavior.

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E1 presented documents for October and November of 2008, entitled "Patterns and Trends Data Sheet."

E1 explained that four behaviors were tracked for R1: physical aggression, attention seeking/teasing, property destruction and Pica. A number system is utilized to plot the behavior: 1 for physical aggression; 2 for attention seeking; 3 for property destruction and 4 for Pica. When reviewing the documents with the surveyor, E1 confirmed that there was no information on these forms as to what non-edible object R1 attempted to ingest. When asked if it was important to know what the non-edible object was, E1 stated he was not worried about it until now. E1 further confirmed that the facility does not have a system in place to track trends and patterns relative to what non-edible objects R1 attempts to consume.

c) The facility failed to ensure that direct care staff implemented R1's level of supervision for meals on 7/9/09, as per his 6/29/09 Physician's orders and his 3/31/09 Individual Support Plan.

R1's 6/29/09 Physician's orders document his Pica and Dysphagia diagnosis. Diet orders from the physician are for mechanical soft diet, with monitoring during meals due to his history of Dysphagia.

R1's 3/31/09 ISP states, "Recommend to monitor (R1) at all times while eating and prompt as needed...Pica: Staff to monitor for ingestion of foreign objects. Staff to insure small non-edible objects, lotions, etc. are kept away from individual...."

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The ISP further states, "He needs to be verbally and occasionally prompted to take bite size pieces...and to eat slowly rather than shovelling {shoveling} food...."

The facility's 7/9/09 investigation regarding R1's jelly packet ingestion states, "The facility has concluded that (R1) did receive a jelly packet during table setting by CV (Countryview) resident (R4), and that he placed this jelly packet into his mouth whiles staff (E7) was in the kitchen getting food for meal service."

Under facility actions, the report states, "All Countryview staff will be retrained in order to ensure that they clearly understand that "Meal Service" begins as soon as there is any food on the table, including condiments and that (R1) cannot be left unsupervised even momentarily once Meal Service has begun."

d) The facility failed to ensure timely staff training for new employees that enables staff to complete his/her duties in a manner that provides for the health and safety of R1.

On 7/23/09, observations were conducted at the facility, beginning at 7:00 a.m. Staff on duty at this time were E4 and E6 (HA); E5 (FSD/HA), and E8 (Direct Care Staff).

After surveyor entry to the facility, E5 stated (7:05 a.m.) that they were contacting supervisory staff regarding the surveyor entry. E3 (Supervisor) arrived at approximately 7:15 a.m.

There are two dining rooms. The north dining room provides two dining tables. The south

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W9999	Continued From page 35 dining room provides one dining table. At 7:25 a.m., individuals were seated for the a.m. meal. In the south dining room, R1 and R4 were seated on one side of the table, R2 and R5 on the opposite side of the table. R3 was seated at one end of the table, and E8 at the opposite end of the table, between R1 and R2. E8 was monitoring the south dining room. E4 and E6 were monitoring the north dining room. At 7:40 a.m., E3 poured juices in the south dining room. At this time, E3 pushed the bowl of jelly packets farther away from R1's end of the table, and closer to the opposite end of the table where R3 was seated. E3 reminded E8 to place the jelly packets at that end of the table away from R1. E3 then left the south dining area. At 7:45 a.m., E8 was the only staff in the south dining room. R1 was scooping large amounts of oatmeal into his mouth, one after the other, with no pause to swallow. At this time E3 entered the south dining room again and told E8 that R1 should not put more than one bite in his mouth at once. E3 then went to R1 to physically assist him. E3 again left the south dining room. R1's toast had been cut into smaller pieces, but three pieces had not been totally cut through, and were sticking together. R1 began to place all three pieces of toast in his mouth. At this time E3 entered the room, and rushed to R1's side. E3 stated to E8 that they needed to cut the toast up into smaller bites and proceeded to do so for R1.	W9999		

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W9999	Continued From page 36 E3 further told E8 that she needs to remind R1 to put his utensil down after a bite, before obtaining another bite. E3 told E8 (and demonstrated at the same time), that she could gently place her had over R1's wrist area to assist him in putting his utensil down before obtaining another bite. E3 explained that this would help slow down R1's fast eating rate. E3 stated to E8, "It's a constant reminder for (R1)." E3 further explained to E8 that she should offer R1 drinks of his liquids between bites and physically demonstrated this for E8 as well. E3 further explained that this would also help R1 to slow down his eating rate and help keep him from choking. E8 stated to E3 that this is her first time to help with breakfast in the south dining room and that she usually works weekends. E8 further stated that she "pretty well" knew R1's dining needs, but was "still learning" about R1. E8 then told E3 that R1 likes jelly and staff have to watch him. E8 asked E3 if she had to sit with R1 all the way through the meal, to which E3 replied yes. During this time period R1 had coughed three times. E3 then demonstrated to E8 the procedure of turning R1's plate around and putting a limited number of bites in the front of the plate. E3 explained to E8 that this will also help R4 in controlling his large bites and rate of eating. During the entire observation period, E8 did not intervene to assist in R1's meal supervision until prompted by E3. A review of a facility document that validates staff names, titles and date of hire was reviewed. This	W9999		

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W9999	Continued From page 37 document validates that E8 was hired on 6/18/09. In an interview with E2 (Administrator), on 7/23/09, at 2:10 p.m., E2 confirmed that, as of this date, E8 has not completed Habilitation Aide training. In an interview with E3, on 7/23/09, at 2:30 p.m., E3 stated that new staff begin their dining training in the north dining room. E8 usually works weekends, when the routine is more relaxed. Weekdays, there is a "get it done now" atmosphere, as individuals are on a timeline to eat, receive medications and be ready for the day training bus. This was E8's first weekday morning in the south dining room. E3 further stated that staff are not assigned to a specific dining table, with one exception. (E6 is always assigned to the north room dining table, due to one individual who has uncontrolled seizures). E3 then stated that since E8 was a new staff, she assumed E8 would be assisting in the north dining room, and E4 would be in the south dining room. In the same interview, E3 confirmed (E2 - Administrator also present for this interview), that the facility does not have a procedure in place to ensure that newly hired staff have received adequate training regarding the special monitoring and supervision needs of individuals during meal times. E3 confirmed that E8 would have been the only staff monitoring the south dining room had she not received the phone call notifying her of surveyor entrance to the facility. e) The facility failed to ensure timely staff training	W9999		

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W9999	Continued From page 38	W9999		

across all environments (facility and day training site), after R1's 7/9/09 ingestion of a jelly packet. R1 required emergency room assistance to retrieve the packet.

In review of the facility's 7/9/09 investigation of R1's Pica incident, E1's report document states, "All Countryview staff will be retrained in order to ensure that they clearly understand that "Meal Service" begins as soon as there is any food on the table, including condiments, and that (R1) cannot be left unsupervised even momentarily once meal service has begun."

In an interview with E1, on 7/23/09 at 12:40 p.m., E1 was asked to describe how facility staff had been trained regarding R1's 7/9/09 Pica incident.

E1 presented a typed one page document entitled, "Staff Training in response to (R1) to ER (emergency room) this morning." This document is dated 7/9/09 and provides specific staff directions for meal service at the facility.

E1 stated that he posted the document on the office door next to the staff schedule. E1 further stated that staff were to initial the document as proof that they had read the in-service material. E1 stated that staff would also pass the information on to one another per word of mouth. E1 and E3 have been coming in to the facility some mornings to provide follow-up monitoring. When asked, E1 stated that there was no schedule for himself and E3 regarding the follow-up with the staff training.

In review of the staff training document with E1, there are thirteen (13) sets of initials on the original document.

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W9999	Continued From page 39 E1 was able to identify twelve (12) of the thirteen sets of initials (E's 5, 6, 7, 9, 10, 11, 12, 13, 14, 15 and 16), all of whom are Habilitation Aides or staff in training for Habilitation Aide certification. There was one set of initials that E1 could not identify. E9's initials appear on the document twice. In comparing the staff initials on the document with the facility staff roster, there are four (4) staff for whom there is no documentation that the in-service document had been read (E's 4, 8, 17 & 18). E4 and E8 were on duty in the a.m. of 7/23/09 at surveyor entry to the facility at 7:00 a.m. Additionally, there is no evidence for what date staff read and initialed the in-service information. In the same interview, E1 stated that a staff meeting was scheduled for 7/29/09, at which time R1's 7/9/09 Pica incident would again be covered. A review of 2009 facility menus documents that dressing and condiment packets are sent in the client's lunches to the day training site. This was further confirmed during an interview with Z3, on 7/24/09 at 12:50 p.m., who also confirmed that she assists R1 during his lunch time at the day training site. In an interview with Z2 on 7/24/09 at 1:00 p.m., Z2 stated that the facility did notify the day training site regarding R1's 7/9/09 Pica incident. Z2 stated that the facility has not met with the day training staff or provided any further documented training for day training staff since R1's incident.	W9999		

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Continued From page 40

This was further confirmed by E1 at the 7/24/09 Daily Status meeting at 3:10 p.m.

f) The facility failed to ensure a thorough investigation of R1's 7/9/09 jelly packet ingestion.

In review of the facility's 7/9/09 investigation for R1's Pica incident, four (4) facility staff (E's 4, 5, 6 & 7) were interviewed regarding R1's Pica incident. A facility staff schedule documents that these employees were the staff on duty during the 7/9/09 Pica incident.

In review of interview sheets for the above staff, E1 requests the following: "Please describe your objective observations of this morning's breakfast routine in as much detail as you can recall. Starting with the time that the tables were set (please note this time if possible) and ending with the moment that you became aware that (R1) required medical attention. As much as you can recall, please include specific times for your observations and activities. Please sign your statement."

In order to prevent further occurrences, facility staff were retrained to understand that "Meal Service" begins as soon as there is food on the table, including condiments, and that R1 cannot be left unsupervised even momentarily once meal service has begun.

The following new information was obtained during surveyor interviews with E's 4, 5 & 6, and shared with E1, E2 and E3 on 7/23/09 at the 4:30 p.m. Daily Status meeting.

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W9999	Continued From page 41 1 - E4 on 7/23/09 at 10:48 a.m. - R1 tries to take the jelly packets as a routine, "cuffing" them so staff do not see. Approximately 6 months ago, R1 successfully put a jelly packet in his mouth. E4 was able to retrieve it. E4 did not document this incident and did not relate the information to supervisory staff. 2 - E5 on 7/23/09 at 11:15 a.m. - After breakfast one morning (date not recalled), R1 came into the kitchen and took an empty jelly packet from a plate that was setting on the chest freezer. R1 had the jelly packet part way in his mouth. E5 was able to retrieve the packet. R5 did not report or document this incident. 3 - E6 on 7/23/09 at 11:00 a.m. - R1 (date not recalled), grabbed a syrup packet and tried to put it in his mouth. E6 was able to retrieve the packet before R1 actually got the packet to his mouth. E6 stated the syrup packets are about twice the size as the jelly packets. E6 did not document or report this incident. On 7/23/09 at 3:10 p.m., surveyor observed a number of pieces of chalk in R1's nightstand drawer. There was also a clear plastic storage bag in the drawer, which contained numerous small stringing beads, approximately 1/4-3/8ths inch in diameter and length. In review of the facility's 7/9/09 investigation, there is no evidence of checking R1's room, regarding possible Pica hazards. It was not until after an Immediate Jeopardy was called in 7/24/09 at 3:10 p.m., that the facility enacted a plan to provide for the immediate	W9999		

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disposal of used jelly packets and daily room checks for R1.

The facility policy for abuse and neglect was reviewed.

"Neglect means a failure on a long term care 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."

Physical neglect is defined as, "The deprivation of goods and services necessary to maintain physical or mental health. Withholding....safety...or other essentials including in an implied or contractual agreement of responsibility to an individual receiving services."

Self-neglect is defined as, "The behavior or an individual that threatens his/her own safety. Refusal to provide...safety precautions."

"The agency monitors the care and services of the residents to prevent abuse and neglect by the following methods...Staff competency...Incident reporting and analysis of all incidents to determine if possible abuse or neglect exists and to identify patterns and trends...."

"On-going training is routinely scheduled and given to each staff member to reinforce learned competencies. The agency recognizes that on-going training in all areas of the habilitation curriculum is vital in preventing incidents of abuse and neglect...In addition, topics of training are conducted as a result of changes in resident

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W9999	Continued From page 43 health or behavior status...." Under the "Behavior" policy it states, "All maladaptive behavioral incidents must be documented and reported to the facility QMRP/RSD." Under "Individual and Facility Records," it states, "Records are maintained for each individual that are adequate for: Planning and continuous evaluation of the individual's habilitation program...Records of significant behavior incidents...." Under "Incident Reports," it states, "A full written report of any serious incident or accident involving an individual will be placed in the individual's medical record. This report will include the date and time of each incident or accident and the action taken concerning it." (A)	W9999		