STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G058	A. BUILDING _____ B. WING _____	01/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILBERTSON LODGE	301 BOWMAN LANE NEWPORT NEWS, VA 23606

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 01/16/18 through 01/17/18. The facility was in substantial compliance with 42 CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Disabilities (ICF/ID) Federal Regulations. The census in this four (4) bed facility at the time of the survey was 4. The survey sample consisted of 1 current Individual record (Individual #1) and one closed record (Individual #2).	E 000		
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid survey survey was conducted on 01/16/18 through 01/17/18. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities (ICF/ID) Federal Regulations. No complaints were investigated during the survey. The Life Safety Code report will follow. The census in this four (4) bed facility at the time of the survey was 4. The survey sample consisted of 1 current Individual record (Individual #1) and one closed record (Individual #2).	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) 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 record review and staff interview, the	W 149	The facility conducted an investigation which resulted in a finding of neglect towards Individual #2 as a result of failure to follow Individual #2's Individualized Program Plan (IPP.) It was determined that staff left their personal food out within reach of Individual #2 and left him unsupervised although his IPP required that he be supervised during meals. All program staff present at the time the incident occurred were terminated	2/6/2017

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

Daphne Cunningham, Director of Residential Services 2/21/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 facility staff failed to implement policies and procedures that prohibit neglect for one individual (Individual #2 a closed record), in the survey sample of two individuals. The findings included: The facility staff failed to provide Individual #2 with supervision to prevent choking while consuming a muffin where he later died. Individual #2 was admitted to the facility on 5/22/13 with diagnoses of moderate intellectual disability, Type II diabetes, hypertension, gastroesophageal reflux disease (GERD), hypothyroidism, hyperlipidemia, sleep apnea, seizures and paranoid schizophrenia. An Annual Nutritional Assessment dated 5/10/16 indicated: "Medical Problems: Type II diabetes, hypertension, GERD, Hypothyroidism, Paranoid Schizophrenia, hyperlipidemia, sleep apnea, seizure disorder. Current Diet: 1800 calorie low fat, low cholesterol. Consistency: bite size, ground meats. Needs: No chicken on bone and cubed bread only to be mixed with meats, ten 8 ounce cups of fluids daily. For hospitalizations, a pureed-consistency diet is recommended." A Behavioral Support Plan dated 5/6/16 indicated: "Target Behavior: Disruptive Behavior - Shouting, throwing his walker or other objects, making statements of wanting to harm himself or others, making verbally abusive statements towards others." An Individual Service Plan (ISP) dated 5/24/16 indicated: "Individual #2 receives and responds to At-table staff supervision during meal and snack	W 149	QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertson Lodge staff on January 24, 2017 to review the incident involving Individual #2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provided instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.) QIDP/Residential Supervisor implemented the use of cue cards that include the instructions for supporting all Individuals during meal time in accordance with their Nutritional Management Plan (see Attachment J.) The cue cards are utilized by staff during meal preparation and while supporting Individuals during meals	1/24/2017 5/31/2017 And ongoing

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W 149	Continued From page 2 time. During all meals and snack time, Individual #2 will accept staff supervision and redirection to eat at an acceptable pace for his safety and to prevent episodes of choking for 4 consecutive months. It is recommended that Individual #2 maintain a diet consisting of bite-sized portions with ground meats and liquids. In order to avoid load cramming and rapid rate of eating and possible choking, the following steps are recommended and suggested: 1. Presentation of small, single solid bites before liquid drink. 2. Provide continuous monitoring of food ingestion. For example: Individual #2's plate may need to be removed after each small bite in order to prevent food cramming and possible choking/aspiration. 3. Liquid wash (including applesauce) following each bite sized solid. 4. Verbal/visual directions provided for Individual #2 while eating. For example: verbally instruct Individual #2 to ingest one bite-size piece at a time before drinking liquids." An Incident and Accident Report dated 1/21/17 at 4:59 P.M. indicated: "QIDP (Qualified Intellectual Disability Professional) was notified and it was reported to QIDP that while staff were in the back of the house toileting two individuals, Individual #2 was on the couch sleep. QIDP was informed by staff that when they walked back into the common area, they noticed Individual #2 was not on the couch anymore but was at the dining table with a snack. Staff asked the other staff members did they give Individual #2 a snack. The two staff members responded no. Staff approached Individual #2 and asked him to hand the snack to her. He responded by stuffing the snack in his mouth and ambulating back to the couch. Staff	W 149	Consulting Dietitian provides training to Gilbertson Lodge Staff on food consistency preparation and observes meal preparation during monthly reviews. Dietitian will include observation specific to each Individual in her monthly review notes. QIDP/Residential Supervisor will review the meal protocols for all Individuals at the monthly staff meeting after each Individual's annual meeting in order to ensure that staff understand the significance of the plan and the importance of following the individualized protocol QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A.)	3/1/2018 3/1/2018 and ongoing 1/24/2017

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W 149	Continued From page 3 took the bag that Individual #2 had on the table back into the kitchen and poured a cup of water for individual #2. Staff heard another staff member asked (sic) Individual #2 was he choking and was he okay. That staff stated to another staff that Individual #2 was turning blue in the face. Staff ran into the kitchen and picked up the kitchen phone to call 911. The staff noticed that the phone was not ringing or had a dial tone. That staff went into QIDP's office to get the cordless phone to dial 911. Staff ran back into the common area with Individual #2 and began to transfer him on the floor. While on the phone with 911, staff proceeded to inform the dispatcher that Individual #2 was choking and that she was going to perform CPR (carido resuscitation). The staff started to perform CPR as she was communicating with dispatcher. Dispatcher asked her to count compressions aloud as she was doing them. The staff checked for Individual #2's pulse and noticed that he did not have one. Staff informed dispatcher that he did not have a pulse. At the time, dispatcher stated that she could not hear the staff's voice anymore thereby staff passed the phone to another staff member to talk to the dispatcher as she continued another set of compressions. Another staff member checked Individual #2's pulse again as EMT arrived. EMT asked staff to continue CPR and observed as she was performing compressions on Individual #2. Another set of EMT arrived shortly after the first EMT. Staff switched off with another staff member to step outside. Staff called QIDP and nurse on call to notify of the incident. Nurse informed staff that she was on her way. QIDP informed staff that she was on her way to the home to assess the situation. Staff went back into the house and EMT were performing CPR on Individual #2 and were using AED to find pulse as	W 149	QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertson Lodge staff on January 24, 2017 to review the incident involving Individual # 2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provided instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.) Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.) This training included the addition of "Choking Charlie," a mannequin used to instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth.	1/24/2017 2/28/2017 2/28/2017

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W 149	Continued From page 4 well as trying to clear Individual #2's airway. EMT asked staff for Individual #2's medical information. Staff informed EMT of all Individual #2's medical conditions. Nurse arrived and introduced herself to EMT. EMT was able to find a pulse for Individual #2 after 15 minutes of performing CPR. EMT placed Individual #2 on a breathing machine then proceeded to inform staff of his transfer to hospital. EMT stated that his condition was stable. Nurse inquired about Individual, #2's condition from EMT but was not able to get any accurate information about his condition. Individual #2 was transferred to hospital with one staff and nurse following. At the end of the shift, Individual #2 remained at the hospital." A Facility Human Rights Investigation (Potential Neglect) dated February 6, 2017 indicated: Overview - "On January 22, 2017, this investigator's office received an incident report, dated January 21, 2017. The report noted Individual #2 received services at the residential facility, choked while consuming a muffin. Per the incident information reported. Individual #2 obtained a muffin that belonged to staff, which was on the dining room table. The individual consumed the muffin, which resulted in him choking and being transported to the hospital, where he later died. This investigator contacted the local Adult Protective Services on January 23, 2017 at 2:04 p.m. to make a report of the incident (potential neglect). The call was taken by Adult Protective Services who indicated that this was not a reportable incident due to the individual expiring. Given the nature of the allegation, the three staff members on duty at the time of the incident (DSP	W 149	Residential Services Manager and Registered Nurse have enhanced staff training to add the DBHDS Health Safety and Quality Alerts to the existing Fatal Five training conducted for Gilbertson Lodge with special focus on Choking/Aspiration, Pneumonia, and Dysphagia. This training, provided by the Residential Services Manager and Registered Nurse, is required of all current and new staff on an annual basis. Gilbertson Lodge staff received the training on March 6, 2017 (see attachment E.) This training is offered at least quarterly in order to train oncoming staff and provide refresher training. The facility conducted an investigation which resulted in a finding of neglect towards Individual #2 as a result of failure to follow Individual #2's Individualized Program Plan (IPP.) It was determined that staff left their personal food out within reach of Individual #2 and left him unsupervised although his IPP required that he be supervised during meals. All program staff present at the time the incident occurred were terminated.	3/6/2017 3/6/2017 And ongoing 2/6/2017

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W 149	Continued From page 5 #2, DSP #3, and DSP #1) were instructed not to return to work for the duration of the investigation." Investigation Summary "The incident report, completed by (QIDP), dated January 21, 2017, provided the following information: QIDP was notified and it was reported to QIDP that while staff were in the back of the house toileting two individuals, [Individual #2] was on the couch asleep. QIDP was informed by staff that when they walked back into the common area, they noticed [Individual #2] was not on the couch anymore but was at the dining table with a snack. Staff asked the other staff members did they give [Individual #2] a snack. The two staff members responded no. Staff approached [Individual #2] and asked him to hand the snack to her. He responded by stuffing the snack in his mouth and ambulating back to the couch. Staff took the bag the [Individual #2 had on the table back into the kitchen and poured a cup of water for [Individual #2]. Staff heard another staff member asked (sic) [Individual #2] was he choking and if he was okay. That staff stated to another staff that [Individual #2] was turning blue in the face. Staff ran into the kitchen and picked up the kitchen phone to call 911. Staff ran back into the common area with [Individual #2] and began to transfer him on the floor. While on the phone with 911, staff proceeded to inform the dispatcher that [Individual #2] was choking and that she was going to perform CPR. The staff started to perform CPR as she was communicating with dispatcher. Dispatcher asked her to count compressions aloud as she was doing them. The staff checked for [Individual #2] pulse and noticed	W 149	QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertson Lodge staff on January 24, 2017 to review the incident involving Individual # 2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provided instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.) QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertson Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff on the placement of their personal food items in order to prevent staff from leaving their food sitting out in an area that is accessible to the Individuals. At no time will staff food items be left within reach of the Individuals. A refrigerator was purchased and placed in the staff office which is specifically for staff food.	1/24/2017 2/28/2017 2/28/2017

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W 149	Continued From page 6 that he did not have one. Staff informed dispatcher that he did not have a pulse. At the time, dispatcher stated that she could not hear the staff's voice anymore thereby staff passed the phone to another staff member to talk to the dispatcher as she continued another set of compressions. Another staff member checked [Individual #2's] pulse again as EMT arrived. EMT asked staff to continue CPR and observed as she was performing compressions on [Individual #2]. Another set of EMT's arrived shortly after the first EMT. Staff switched off with another staff member to step outside. Staff called QIDP and nurse on call to notify of the incident. Nurse informed staff that she was on her way. QIDP informed staff that she was on her way to the home to assess the situation. Staff went back into the house and EMT were performing CPR on [Individual #2] and using AED to find pulse as well as trying to clear [Individual #2's] airway. EMT asked staff for [Individual #2's] medical conditions. Nurse arrived and introduced herself to EMT. EMT was able to find a pulse for [Individual #2] after 15 minutes of performing CPR. EMT placed [Individual #2] on a breathing machine then proceeded to inform staff of his transfer to hospital. EMT stated that his condition was stable. Nurse inquired about [Individual #2's] condition from EMT but was not able to get any accurate information about [Individual #2] condition. [Individual #2] was transferred to hospital with one staff and nurse following. At the end of the shift, [Individual #2] remained at hospital." "At the time of transport to hospital [Individual #2] had a pulse and his o2 was 83%. Writer, staff and program (sic) went to the hospital with EMS. Once at ER writer nor staff was allowed to go	W 149	Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.) This training included the addition of "Choking Charlie," a mannequin used to instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth. Training Services Administrator has added the Choking Charlie module to the CPR course. All Residential Services staff are required to demonstrate this skill during initial and recertification CPR training.	2/28/2017 2/28/2017 2/28/2017 And ongoing

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W 149	Continued From page 7 back in the room as hospital staff was working on him. ER Physician came out and stated that he been working on [Individual #2], he had given him IV fluids and epinephrine and he had established an airway with a fiber optic invasion procedure because EMS was unable to establish airway in the field due to the stuff being stuck in his throat so he is now intubated. Per ER Physician, [Individual #2] had been down for 1 hour and 20 minutes out in the field because EMS was unable to establish an airway. Which cause him to be hypoxia which resulted in injury to the brain that he is not going to be able to overcome. ER physician stated that all things was (sic) done for [Individual #2] that they would do for someone on cardiac arrest. As far as neurology that was shot per the ER Physician. In the ER he currently have pulses due to the vasopressors that was given. [Individual #2's] sister was contacted by ER Physician at 1203 P.M. to discuss code status and it was explain to her about the brain injury and it would not be beneficial to continue to do CPR. ER Physician explained [Individual #2's] that everything would be taken off him. [Individual #2's] sister made him a DNR. Back in the ER [Individual #2] was able to maintain his pulse and breathing on his own so he was transferred to ICU. In the evening at around 5:30 P.M. pulse, HR, and BP started dropping as the medication that was given was wearing off. Around 6:15 P.M. [Individual #2] expired and he was peaceful." Review of the Video Surveillance Footage (January 24, 2017) After a review of the video surveillance footage, this investigator noted the following: "1. There were three staff present and five	W 149	QIDP/Residential Supervisor and Residential Services Manager have added Choking Education Posters to the Kitchen, +Staff Office, Activity Room, and Hallway where all Individuals bedrooms are located in order to provide an ongoing reminder and quick reference to staff concerning responding during a choking incident. Training materials remain onsite for staff reference (see attachment I.) An AED has been purchased for the home. All staff are trained on the use of the AED during their initial and bi-annual CPR recertification by the Training Services Department QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A.)	2/28/2017 5/31/2017 And ongoing 1/24/2017

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W 149	Continued From page 8 individuals in the home at the time of the incident. 2. A muffin was present on the dining room table as [Individual #2] was walking out of the kitchen. A staff member walked from the kitchen through the dining room towards the back of the house. One individual was asleep in a chair in the living area. 3. [Individual #2] sat at the table and proceeded to open the muffin. The first bite was taken at approximately 10:13 am. He consumed four bites of the muffin while unattended for approximately two minutes. 4. Direct Service Staff #1 (DSP #1) appeared from the hallway and walked to the dining table at approximately 10:15 am. DSP #1 approached [Individual #2] to retrieve the muffin. [Individual #2] stood up and walked to the couch using his walker, as DSP #2 and DSP #3 entered the room. 5. [Individual #2] sits on the couch and begins to put his left fingers into his mouth. DSP #2 approaches him and pats him on the back. [Individual #2] continued to dig into his mouth. [Individual #2] eventually sits back on the the couch and his head slumps backwards. DSP #1 and DSP #3 rush into the kitchen and return with a cup of water. The three approach [Individual #2]. 6. DSP #1 directed colleagues to initiate CPR and she ran to the kitchen to call 911. DSP #3 and DSP #2 appear to panic and walk out of the room, and [Individual #2] is left unattended for approximately 10 seconds while they scramble around.	W 149	QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A.) Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.) This training included the addition of "Choking Charlie," a mannequin used to instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth.	1/24/2017 2/28/2017 2/28/2017

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W 149	Continued From page 9 7. Video surveillance demonstrated DSP #1 running from the kitchen to the back office in a fast pace and coming out of the back office on a cell phone. DSP #1 approached [Individual #2] and began to move him to the floor to begin CPR. At this time DSP #2 assisted with moving [Individual #2] to the floor. 8. DSP #1 initiated chest compression without breaths. DSP #1 eventually handed the phone to DSP #3. 9. DSP #2 assumed chest compressions upon arrival of the EMT." During Investigative Interviews DSP #2 acknowledged she was the staff who brought in the muffins. That's what I usually bring in for breakfast. "I get one for me and one for DSP #1, but that wasn't my muffin on the dining table." DSP #2 also acknowledged [Individual #2] should never consume food unsupervised. When asked if the individual was ever left alone when he was unconscious, she replied, "NO". During Investigative Interviews DSP #3 acknowledged DSP #1 and DSP #2 were eating breakfast at the dining table. After we ate, I had another client in the med room and I ended up taking him back to his room because he was falling asleep. I then took another Individual to her room and when I was done, I called [Individual #2] to come to the med room for his eye drops. I then told him to go sit on the couch, and I went to attend to another individual in her room. I hear DSP #1 or DSP #2 asking about who gave [Individual #2] food, so I moved up front. During the interview, DSP #3 expressed, "He	W 149	QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertson Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff on the placement of their personal food items in order to prevent staff from leaving their food sitting out in an area that is accessible to the Individuals. At no time will staff food items be left within reach of the Individuals. QIDP/Residential Supervisor and Residential Services Manager provided staff training on the updated policy and procedures on February 28, 2017 (see attachment C.) A refrigerator was purchased and placed in the staff office which is specifically for staff food. QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A.)	2/28/2017 2/28/2017 2/28/2017 1/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G058	A. BUILDING _____ B. WING _____	01/17/2018

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W 149	Continued From page 10 should have been supervised, but wasn't." When asked what could have been done differently to prevent this incident, DSP #3 replied, "I feel we should have tried the Heimlich...I regret not doing that first." During Investigative Interviews DSP #1 stated, we had just completed the morning hygiene after breakfast. I then walked into the common area and saw [Individual #2] sitting at the dining table eating. I asked if anyone gave him a snack because he was eating and it wasn't snack time yet. I went to him and asked him what he was eating...that's when he shoved some of the food in his mouth. I removed the food from his hand and told him to go to the couch. I put the food in the kitchen and then went to get water to help him support is food to go down. DSP #1 indicated that the muffin was brought into the home by DSP #2. When asked what could have been done differently to prevent this incident, DSP #1 stated, "monitor him more closely. Someone should have started the Heimlich immediately...checked his mouth...something besides just standing there. I just remembered in the moment that compressions were more important than giving him breaths...I tried to help as best as I could...but I felt like I was doing everything alone." A Time Line dated 1/21/17 indicated the following: "At 10:09 A.M. Individual #2 went into med room with DSP #3 At 10:12:27 A.M. Individual #2 sat at dining room table and began unwrapping muffin, staff DSP #3 passed through living room going toward back of house	W 149	QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertson Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff on the placement of their personal food items in order to prevent staff from leaving their food sitting out in an area that is accessible to the Individuals. At no time will staff food items be left within reach of the Individuals. A refrigerator was purchased and placed in the staff office which is specifically for staff food. QIDP/Residential Supervisor and Residential Services Manager provided staff training on the updated policy and procedures on February 28, 2017 (see attachment C.) QIDP/Residential Supervisor and Residential Services Manager have added Choking Education Posters to the Kitchen, Staff Office, Activity Room, and Hallway where all Individuals bedrooms are located in order to provide an ongoing reminder and quick reference to staff concerning responding during a choking incident. Training materials remain onsite for staff reference (see attachment I.)	2/28/2017 2/28/2017 2/28/2017 2/28/2017

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W 149	Continued From page 11 At 10:13 :08 A.M. Individual #2 took first bite of muffin At 10:14:11 A.M. Individual #2 had what looks (appears) to be the 7th bite of the muffin and DSP #1 took it from him, he got up and left the table (Individual #2 was alone from about 10:12:47 to 10:14:11 when eating the muffin) At 10:14:33 A.M. Individual #2 sat down on the sofa/3 staff were in the room At 10:14:47 A.M. Individual #2 sat up on the sofa appears to be in discomfort/3 staff in room At 10:15:01 A.M. DSP #2 was at his side and patting his back, Individual #2 motioned toward his mouth four times that is seen At 10:15:18 A.M. DSP #1 went to kitchen to call 911 At 10:15:25 A.M. Individual #2 leaned back on sofa, staff DSP #2 was at his side, he was moving At 10:15:42 A.M. DSP #2 left the room, individual was moving, leaned back on sofa, but was turning blue At 10:15:49 A.M. DSP #2 returned to room, appeared to be in panic (Individual #2 left alone for 7 seconds At 10:16:01 A.M. DSP #2 left the room, Individual #2 was moving At 10:16:11 A.M. DSP #1 returned still on phone with 911, both other staff joined her (Individual #2 was alone for about 10 seconds) At 10:16:14 A.M. Individual #2 was no longer moving, staff drag him to the floor At 10:16:23 A.M. Compressions began, performed by DSP #1 At 10:19:20 A.M. EMT arrived and called for back-up, staff DSP #2 assumes compressions At 10:21:22 A.M. Five additional EMT's arrive At 10:21:37 A.M. EMT's began compressions, EMT's observed attempting to intubate Individual	W 149	Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.) This training included the addition of "Choking Charlie," a mannequin used to instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth. Training Services Administrator has added the Choking Charlie module to the CPR course. All Residential Services staff are required to demonstrate this skill during initial and recertification CPR training.	2/28/2017 2/28/2017 2/28/2017 And ongoing

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W 149	Continued From page 12 #2 At 10:38:50 A.M. EMT's stop compressions, have breathing apparatus attached At 10:39:20 A.M. EMT went out of home At 10:39:49 A.M. Program nurse arrives, states that EMT's were not able to intubate individual and she questioned why individual was not yet transferred At 10:41:20 A.M. EMT returns with stretcher At 10:45:38 A.M. EMT exit home with Individual #2 on stretcher At 10: 59 A.M. Individual #2 arrives at ER At 11:02 A.M. Individual #2 is triaged Death Summary: "Finial diagnosis: Cardiac arrest (primary), Respiratory arrest (additional) In the morning of admission, patient was eating a muffin, where he subsequently choked on it, causing respiratory arrest with subsequent followed by cardiac arrest. Patient's downtime is 25 minutes prior to arrival of the EMS Patient had a total resuscitation time of 54 minutes in the ER, but finally circulation was returned spontaneously and decided to admit the patient to ICU On physical exam though the patient does not have any neurological reflex, including corneal reflex, gag reflex Sister has decided not to resuscitate and patient eventually passed away, and patient was pronounced dead, January 21, 2017 at 5:26 PM". A review of Employee Counseling Record for the three staff members involved indicated: "You are receiving a Second Group Offense written warning for Abuse/Neglect of an individual in your care. ICF/ID Personnel Policy #16 - Abuse and neglect, states that 'it is the policy of the	W 149	QIDP/Residential Supervisor and Residential Services Manager have added Choking Education Posters to the Kitchen, Staff Office, Activity Room, and Hallway where all Individuals bedrooms are located in order to provide an ongoing reminder and quick reference to staff concerning responding during a choking incident. Training materials remain onsite for staff reference (see attachment I.) An AED has been purchased for the home. All staff are trained on the use of the AED during their initial and bi-annual CPR recertification by the Training Services Department	2/28/2017 5/31/2017 And ongoing

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W 149	Continued From page 13 facility/agency to ensure that all individuals are free from verbal, physical abuse or punishment." Furthermore the agency's Human Rights Policies identify abuse as "any act or failure to act by an employee or other person responsible for the care of an individual" and neglect as "failure by a person or program or facility to (sic) responsible for providing services to do so including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment." "On 1/21/17, you were on duty working, when an individual receiving services at the facility, choked while consuming a muffin. Per the incident information reporter, the individual obtained a muffin that belonged to staff, which was on the dinning room table. The individual consumed the muffin, which resulted in him choking and being transported to the hospital, where he later died." "On January 22, 2017, the Quality Management office received the incident report, dated January 21, 2017 noting that the individual (Individual #2) choked while consuming a muffin. Per agency policy, a formal investigation was implemented and you were placed on administrative leave pending the findings of the investigation. During the course of the investigation, it was noted that at the time of the incident, Individual #2 had an Individualized Program Plan (IPP) that included at table supervision during all meals and snacks. Specifically, the plan stated: In order to avoid cramming and rapid rate of eating and possible choking, the following steps are recommended and suggested: Presention of small. single solid bites before liquid drink. Provide continuous monitoring of food ingestion.	W 149	The facility conducted an investigation which resulted in a finding of neglect towards Individual #2 as a result of failure to follow Individual #2's Individualized Program Plan (IPP.) It was determined that staff left their personal food out within reach of Individual #2 and left him unsupervised although his IPP required that he be supervised during meals. All program staff present at the time the incident occurred were terminated QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertson Lodge staff on January 24, 2017 to review the incident involving Individual #2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provided instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.)	2/6/2017 1/24/2017

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W 149	Continued From page 14 Liquid wash following each bite sized solid. Verbal/visual directions provided for Individual #2 while eating." "It was further determined that the individual was left unattended with food in his reach, which he consumed unsupervised. Failure to keep food out of the reach of the individual/provide supervision while he was eating led to the individual choking." "Based on the information obtained during the investigation, there was a preponderance of information to support a finding of abuse (neglect) towards the individual. As such, the finding of neglect was substantiated." Correction Action Plan: "Due to the severity of the incident, you will be terminated from your position (s) effective immediately, signed and dated 2/7/17." During an interview on 1/17/18 at 10:15 A.M. with the Residential Service Director, she stated, the facility failed to provide Individual #2 with supervision to prevent, "Neglect." The facility staff failed to provide supervision to prevent neglect.	W 149	QIDP/Residential Supervisor will review the meal protocols for all Individuals at the monthly staff meeting after each Individual's annual meeting in order to ensure that staff understand the significance of the plan and the importance of following the individualized protocol	3/1/2018 and ongoing
			Consulting Dietitian provides training to Gilbertson Lodge Staff on food consistency preparation and observes meal preparation during monthly reviews. Dietitian will include observation specific to each Individual in her monthly review notes.	3/1/2018
			QIDP/Residential Supervisor implemented the use of cue cards that include the instructions for supporting all Individuals during meal time in accordance with their Nutritional Management Plan (see Attachment J.) The cue cards are utilized by staff during meal preparation and while supporting Individuals during meals	5/31/2017 And ongoing
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated	W 242		

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W 242	Continued From page 15 that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to implement the individual program plan for one individual (Individual #2), in the survey sample of two individuals. The findings included: The facility staff failed to provide Individual #2 with supervision to prevent choking while consuming a muffin where he later died. Individual #2 was admitted to the facility on 5/22/13 with diagnoses of moderate intellectual disability, Type II diabetes, hypertension, gastroesophageal reflux didease (GERD), hypothyroidism, hyperlipidemia, sleep apnea, seizures and paranoid schizophrenia. An Annual Nutritional Assessment dated 5/10/16 indicated: "Medical Problems: Type II diabetes, hypertension, GERD, Hypothyroidism, paranoid Schizophrenia, hyperlipidemia, sleep apnea, seizure disorder. Current Diet: 1800 calorie low fat, low cholesterol. Consistency: bite size, ground meats. Needs: No chicken on bone and cubed bread only to be mixed with meats, ten 8 ounce cups of fluids daily. For hospitalizations, a pureed-consistency diet is recommended." A Behavioral Support Plan dated 5/6/16 indicated: "Target Behavior: Disruptive Behavior - Shouting, throwing his walker or other objects, making statements of wanting to harm himself or others, making verbally abusive statements towards	W 242	QIDP/Residential Supervisor, Residential Nurses, and Residential Services Manager met with Gilbertson Lodge staff on January 24, 2017 to review the incident involving Individual #2 with all program staff. QIDP/Residential Supervisor and Residential Services Manager provided instruction for monitoring the eating area and storing staff food. Residential Nurses provided an in-service training on the administration of the Heimlich Maneuver. (See Attachment A.) QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A.) Consulting Dietitian provides training to Gilbertson Lodge Staff on food consistency preparation and observes meal preparation during monthly reviews. Dietitian will include observation specific to each Individual in her monthly review notes.	1/24/2017 1/24/2017 3/1/2018

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W 242	Continued From page 16 others." An Individual Service Plan (ISP) dated 5/24/16 indicated: "Individual #2 receives and responds to At-table staff supervision during meal and snack time. During all meals and snack time, Individual #2 will accept staff supervision and redirection to eat at an acceptable pace for his safety and to prevent episodes of choking for 4 consecutive months. It is recommended that Individual #2 maintain a diet consisting of bite-sized portions with ground meats and liquids. In order to avoid load cramming and rapid rate of eating and possible choking, the following steps are recommended and suggested: 1. Presentation of small, single solid bites before liquid drink. 2. Provide continuous monitoring of food ingestion. For example: Individual #2's plate may need to be removed after each small bite in order to prevent food cramming and possible choking/aspiration. 3. Liquid wash (including applesauce) following each bite sized solid. 4. Verbal/visual directions provided for Individual #2 while eating. For example: verbally instruct Individual #2 to ingest one bite-size piece at a time before drinking liquids." An Incident and Accident Report dated 1/21/17 at 4:59 P.M. indicated: "QIDP (Qualified Intellectual Disability Professional was notified and it was reported to QIDP that while staff were in the back of the house toileting two individuals, Individual #2 was on the couch asleep. QIDP was informed by staff that when they walked back into the common area, they noticed Individual #2 was not on the couch anymore but was at the dining table	W 242	Residential Services Manager and Registered Nurse have enhanced staff training to add the DBHDS Health Safety and Quality Alerts to the existing Fatal Five training conducted for Gilbertson Lodge with special focus on Choking/Aspiration, Pneumonia, and Dysphagia. This training, provided by the Residential Services Manager and Registered Nurse, is required of all current and new staff on an annual basis. Gilbertson Lodge staff received the training on March 6, 2017 (see attachment E.) This training is offered at least quarterly in order to train oncoming staff and provide refresher training. QIDP/Residential Supervisor will review the meal protocols for all Individuals at the monthly staff meeting after each Individual's annual meeting in order to ensure that staff understand the significance of the plan and the importance of following the individualized protocol	3/6/2017 And ongoing 3/6/2017 And Ongoing 3/1/2018 and ongoing

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W 242	Continued From page 17 with a snack. Staff asked the other staff members did they give Individual #2 a snack. The two staff members responded no. Staff approached Individual #2 and asked him to hand the snack to her. He responded by stuffing the snack in his mouth and ambulating back to the couch. Staff took the bag that Individual #2 had on the table back into the kitchen a poured a cup of water for individual #2. Staff heard another staff member asked (sic) Individual #2 was he choking and was he okay. That staff stated to another staff that Individual #2 was turning blue in the face. Staff ran into the kitchen and picked up the kitchen phone to call 911. The staff noticed that the phone was not ringing or had a dial tone. That staff went into QIDP's office to get the cordless phone to dial 911. Staff ran back into the common area with Individual #2 and began to transfer him on the floor. While on the phone with 911, staff proceeded to inform the dispatcher that Individual #2 was choking and that she was going to perform CPR (carido resuscitation) The staff started to perform CPR as she was communicating with dispatcher. Dispatcher asked her to count compressions aloud as she was doing them. The staff checked for Individual #2's pulse and noticed that he did not have one. Staff informed dispatcher that he did not have a pulse. At the time, dispatcher stated that she could not hear the staff's voice anymore thereby staff passed the phone to another staff member to talk to the dispatcher as she continued another set of compressions. Another staff member checked Individual #2's pulse again as EMT arrived. EMT asked staff to continue CPR and observed as she was performing compressions on Individual #2. Another set of EMT arrived shortly after the first EMT. Staff switched off with another staff member to step outside. Staff called QIDP and	W 242	QIDP/Residential Supervisor, Residential Services Manager and Director of Residential Services revised Gilbertson Lodge's Staff Rest Breaks and Meal Breaks Policy (see attachment B, #5) to instruct staff on the placement of their personal food items in order to prevent staff from leaving their food sitting out in an area that is accessible to the Individuals. At no time will staff food items be left within reach of the Individuals. Training Services Administrator provided specific, hands-on training to program staff in order to assess performance of the Heimlich Maneuver on February 28, 2017 (see Attachment C.) This training included the addition of "Choking Charlie," a mannequin used to instruct staff on properly performing the procedure (see Attachment D.) The training requires that staff perform the Heimlich Maneuver until the item is dislodged. In addition, the trainer discussed barriers to staff performing the Heimlich Maneuver upon the first indication that someone is choking and reiterated the universal sign of choking to include clutching the neck and/or pointing toward the neck or mouth.	2/28/2017 2/28/2017 2/28/2017

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W 242 Continued From page 18

nurse on call to notify of the incident. Nurse informed staff that she was on her way. QIDP informed staff that she was on her way to the home to assess the situation. Staff went back into the house and EMT were performing CPR on Individual #2 and were using AED to find pulse as well as trying to clear Individual #2's airway. EMT asked staff for Individual #2's medical information. Staff informed EMT of all Individual #2's medical conditions. Nurse arrived and introduced herself to EMT. EMT was able to find a pulse for Individual #2 after 15 minutes of performing CPR. EMT placed Individual #2 on a breathing machine then proceeded to inform staff of his transfer to hospital. EMT stated that his condition was stable. Nurse inquired about Individual, #2's condition from EMT but was not able to get any accurate information about his condition. Individual #2 was transferred to hospital with one staff and nurse following. At the end of the shift, Individual #2 remained at the hospital."

During an interview on 1/17/18 at 10:15 A.M. with the Residential Service Director, she stated, the facility failed to implement Individual #2's program plan to provide Individual #2 with supervision when eating to prevent choking.

The facility staff failed to implement Individual #2's program plan supervision to prevent choking when eating.

W 242

Training Services Administrator has added the Choking Charlie module to the CPR course. All Residential Services staff are required to demonstrate this skill during initial and recertification CPR training.	2/28/2017 And ongoing
QIDP/Residential Supervisor will review the meal protocols for all Individuals at the monthly staff meeting after each Individual's annual meeting in order to ensure that staff understand the significance of the plan and the importance of following the individualized protocol	3/1/2018 and ongoing
QIDP/Residential Supervisor implemented the use of cue cards that include the instructions for supporting all Individuals during meal time in accordance with their Nutritional Management Plan (see Attachment J.) The cue cards are utilized by staff during meal preparation and while supporting Individuals during meals	5/31/2017 And ongoing
QIDP/Residential Supervisor posted signage in the kitchen and dining areas instructing staff that the area is to be monitored at all times (see Attachment F.) This requirement was reviewed with staff by QIDP and Residential Services Manager on January 24, 2017 (see attachment A)	1/24/2017