STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G636	A. BUILDING 00 B. WING	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORVILLA INC	3202 S FELLOWS SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00359014. Complaint #IN00359014: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149 and W157. This visit was done in conjunction with a predetermined full recertification and state licensure survey and the COVID-19 focused infection control survey. Dates of Survey: September 1, 2, 7, 8, and 9, 2021. Facility Number: 001212 Provider Number: 15G636 Aims Number: 100240190 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/30/21.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 sample clients (A and C), the facility failed to implement its written policies and procedures to prevent abuse and neglect of client A and neglect for client C. Findings include:	W 0149	Staff will be retrained on all high risk plans for all clients, including dining risk plans. Staff will attend a training with the dietician which includes how to properly serve pureed vs mechanical soft consistencies. Staff will be retrained on how to effectively	10/08/2021

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

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	The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 9/1/21 at 1:06 pm. 1. A BDDS report dated 1/7/21 indicated the following: "On 1/7/21, staff went into the kitchen who in (sic) non verbal with bread in her mouth when staff got closer to [client A] staff noted that [client A] was choking on the bread that was in her mouth and her lips had started turning blue. Staff immediately alerted other staff for help and followed the choking protocol per our agency. Staff immediately started with back blows, the back blows were unable to dislodge the bread [client A] was choking on. Staff then started the Heimlich Maneuver (abdominal thrusts), the bread became dislodged and staff were able to sweep the rest of the bread out of her mouth without issue. [Client A's] color came back to her lips and [client A] did not appear to be distressed from the choking incident. [Client A] was then sent out to the ER (emergency room) with a staff member to be further evaluated. [Client A's] current diet is mechanical soft ground texture per her guardian's request and current doctor's order from 3/20/20, she had previously been on a pureed diet per recommendations of her last swallow, dietician evaluation, and doctor's order." An investigation dated 1/8/21 indicated the following: "Conclusion: Staff present followed training they received in their CPR (cardiopulmonary resuscitation)/First Aid course and acted appropriately for the emergency. Staff and nurse will monitor [client A] for any effects from this		follow a dining plan, which would include sitting with an individual until they have finished eating. All ANE reports, including reports of choking, will be investigated by the Director of Corporate Compliance. Risk plans will be revised if necessary, and corrective action will take place after choking incidents. Human Rights Restrictions will be completed with guardian approval if necessary. Staff will be retrained on diet plans and appropriately surveying meal times when individuals have a choking plan, which would include sitting with the individual and observing signs of choking until they have completed their meal. The Director of Corporate compliance will ensure that investigations will be completed. The QIDP and company nurse will ensure that staff are being retrained and that revisions are being made to the choking plans if applicable. This applies to all group homes. The Director of Corporate compliance will ensure that investigations will be completed. The QIDP and company nurse will ensure that staff are being retrained and that revisions are being made to the choking plans if applicable.	

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	incident and follow-up with PCP (primary care physician) if needed. Recommendations: It was determined that the bread in the home needs to be locked up. This has been on (sic) ongoing issue with [client A] as she attempts to eat bread not prepared properly on a regular basis as well as other foods. However, bread is the main item [client A] seeks, and this restriction will reduce any future choking incidents. This needs the approval of all guardians in the home since it is a restriction for everyone living in the home and needs approval then through Corvilla's Human Rights Committee (HRC)." 2. A BDDS report dated 1/28/21 indicated the following: "On 1/27/21 when staff was helping another client (sic) heard [client A] in the kitchen they went into the kitchen and found [client A], who is non-verbal, with leftover pizza (from the day prior's meal) in her mouth and realized that [client A] was choking on the pizza. Staff immediately alerted other staff for help and followed the choking protocol per our agency. Staff immediately started with back blows, the back blows were unable to dislodge the bread [client A] was choking on. Staff then started the Heimlich Maneuver, the pizza was then able to be dislodged and swept out of the mouth without issues. [Client A] did not appear to be distressed from the choking incident. Due to our agency protocol, [client A] was sent out to the ER with a staff member to be further evaluated. While at the hospital, a chest x-ray was completed and [client A] had no signs of aspiration and was discharged back to (sic) group home with the following discharge instructions: 'Follow up with PCP within 7-10 days from ER visit. [Client A's]			

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	current diet is mechanical soft ground beef texture per her guardian's request and current doctor's order from 3/20/20, she had previously been on a pureed diet per recommendations of her last swallow, dietician evaluation and doctor's order. [Client A] is allowed to have pizza at meal times with supervision as long as it's cut up into small, bite size pieces with extra sauce." An investigation dated 1/28/21 indicated the following: "Conclusion: Staff present followed training they received in their CPR/First Aid course and acted appropriately for the emergency. Staff and nurse will monitor [client A] for any effects from this incident and follow-up with PCP if needed. Recommendations: It was determined that the bread in the home needs to be locked up. This was approved through Human Rights Committee on 1/7/21. This has been on (sic) ongoing issue with [client A] as she attempts to eat bread or bread items not prepared properly on a regular basis as well as other foods. Any leftovers need to be made to the proper consistency of everyone in the home or just not saved and thrown away." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 9/2/21 at 12:22 pm and stated, "Staff should keep the bread locked in the office refrigerator and should observe [client A] at all times. The previous QIDP (Qualified Intellectual Disabilities Professional) was supposed to retrain the staff. That was my recommendation. I don't know if she actually did it or not." 3. A BDDS report dated 4/7/21 indicated the following:			

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	"On 4/6/21 at around 1:15 pm, it was reported to the Residential Director and CCQA (Corporate Compliance and Quality Assurance) Director, about an incident that occurred on 4/2/21 at lunchtime. Staff reported that another [Direct Support Professional (DSP) #9] was eating her lunch. [Client A] was standing beside [DSP #9] and trying to get her lunch. [DSP #9] was eating sushi with wasabi sauce. [DSP #9] gave [client A] some of the wasabi sauce. [Client A] cannot determine if something is hot or spicy prior to eating it. [Client A] immediately drank a glass of water and went running out of the kitchen. [DSP #9] said that maybe next time [client A] will not bother her for her food. [DSP #9] was laughing after the incident. Once notified on 4/6/21, [DSP #9] was suspended pending investigation. Two other staff were present in addition to [DSP #9] and the reporting staff. The other two staff confirmed the incident when interviewed. [DSP #9] was also interviewed and confirmed that this is an accurate account of the incident. It was determined through the witnesses and the staff's account that [DSP #9] willfully inflicted pain on [client A] which is abuse. [DSP #9] was also emotionally abusive by laughing at [client A] after the incident. The staff was also using this as a punishment for attempting to eat the food. Corvilla does not tolerate abuse of and any use of aversive techniques. Therefore, [DSP #9] was terminated." CCQAD #1 was interviewed on 9/2/21 at 12:22 pm and stated, "Staff should report to administration immediately when they suspect abuse or neglect. We retrained all of the staff on abuse and neglect." CCQAD #1 stated, "There was an investigation. I think it just wasn't written down. We terminated the staff."			

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	4. A BDDS report dated 6/17/21 indicated the following: "On 6/16/21, SGL (supported group living) staff had prepared another client's medication and had left the door open while she went to get the client for his 4 pm medication. In that short period of time, [client A] went into the medication room and swiped the client's medication from the cup and ate the tablet before staff was able to get the tablet out of her mouth. [Client A] had swallowed 1 tablet of Carbamazepine (used to treat seizures, nerve pain, and bipolar disorder), 200 mg (milligrams). SGL staff called the agency nurse immediately. SGL staff were given side effects to watch for and if any abnormal findings were noted, SGL staff were to call the agency nurse back for further instructions. Doctor has been notified and no new instructions were given. [Client A] has had no ill side effects from taking 1 tablet of this medication." CCQAD #1 was interviewed on 9/2/21 at 12:22 pm and stated, "The client should be in the medication room with the door shut for privacy. The wheelchairs fit in there. We built that room specifically so clients could get in and out easily. Staff should not be passing medications outside of the medication room. The room should be locked when staff are not inside." CCQAD #1 indicated there was no investigation for client A taking unattended medications. 5. A BDDS report dated 7/26/21 indicated the following: "Staff were prepping lunches at day program when [client A] grabbed another client's sandwich and stuffed it in her mouth. [Client A] is currently on a mechanical soft diet in which food is prepared in a ground beef texture. [Client A]			

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	then ran from staff laughing as they were trying to stop her. [Client A] then started choking on the sandwich and staff followed the choking protocol and started back blows and were able to sweep the large chunk of sandwich out of [client A's] mouth. [Client A] did not appear to be in distress from this incident but per protocol was sent out to urgent care via staff to be further evaluated." A related investigation dated 7/27/21 indicated the following: "Conclusion: It appears staff followed appropriate care protocols when [client A] began choking. Based on the staff's comments, staff are not sitting with the individuals while they are eating all the time. Recommendations: Going forward, after talking to [day program staff #1, #2, and #3] this will be enforced at all locations. Staff will be sitting or standing by each table to assist anyone in the future. It was further discussed; all staff need to be in the dining area during all meals, including snacks, unless they are passing medications. [Client A] will be monitored by a designated staff if she finishes her meal before others and begins walking around the area." 6. A BDDS report dated 7/29/21 indicated the following: "Staff were preparing lunches in Day Program when [client C] grabbed another client's fish and stuffed it in her mouth. She is currently on mechanical soft diet. Staff then had to give her back blows and were able to sweep the fish out of her mouth. [DSP C] did not appear to be in distress from this, but, per protocol, was sent out to urgent care via staff to be further evaluated."			

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	An investigation dated 7/29/21 indicated the following: "Conclusion: Proper care for choking was followed. However, staff are still not monitoring the food and tables with persons at an appropriate level. Recommendations: On 8/2/21, [Licensed Practical Nurse (LPN) #1) and [Day Program Staff #1, #2, and #3], all from day services, met and discussed the need for monitoring lunches better. It was discussed to have a staff at all tables at all times during any eating times." 7. A BDDS report dated 8/7/21 indicated the following: "At 10:00 pm on 8/6/21, it was reported by staff to the Compliance Officer that earlier on 8/6/21, at around 8:00 am [Direct Support Professional (DSP) #8] was verbally abusive toward [client A]. The reporting staff stated that [DSP #8] said to [client A], 'Come over here and see what happens to you.' Upon hearing this, [DSP #8] was immediately suspended pending further investigation." A related investigation dated 8/9/21 indicated the following: "Conclusion: It is believed, based on [DSP #2's] statement that [DSP #8] did threaten [client A]. This is considered verbal abuse. Abuse of any kind violates Corvilla's policy and violates the rights of the persons served. Therefore, [DSP #8] was terminated from Corvilla on 8/9/21 for substantiated verbal abuse. Recommendations: Staff was terminated for verbal abuse specifically a verbal threat against [client A]."			

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Client A's record was reviewed on 9/1/21 at 2:11 pm.
Client A's Risk Management Plan/Dining dated 6/2020 indicated the following:
"1. Risk Involved
a. Choking
b. Aspiration....
2. Diet Instructions
a. Mechanical soft diet (per family request).
3. Staff Guidelines
a. Thin liquids.
b. Medication whole with a drink.
c. 1 on 1 supervision required for all meals.
d. Allow extra time to swallow.
e. Sit upright for all oral intake.
f. Remain in upright position for at least 30 min (minutes) after eating or drinking.
g. Remind client to slow down while eating.
h. Small bites at a time.
i. Anytime [client A] eats or swallows something that is not within diet plan, staff must do a GER (general event report) and start an aspiration sheet."

Client C's record was reviewed on 9/1/21 at 2:24 pm.
Client C's Risk Management Plan/Dining dated 6/2021 indicated the following:
"1. Risk Involved
a. Choking
b. Aspiration....
2. Diet Instructions
a. Mechanical soft, ground beef texture.
b. Medication whole with liquid.
c. Staff to ensure that [client C] receives 1/4 c (cup) of BAP (bran flakes, applesauce, and prune juice) 2 x daily.
c. (sic) Supervision during all meals.
d. Thin liquids (staff to ensure [client C] drinks

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	6-8 oz (ounces) of water with each meal). e. Remain at upright position 90%, 30 min after a meal. f. Oral hygiene after each meal. g. Notify nurse of any and all choking incident immediately. h. Anytime [client C] eats or swallows something that is not within diet plan, staff must do a GER and start an aspiration sheet." Day service staff #1 was interviewed on 9/2/21 at 11:25 am and stated, "I was trained on [client A's] plans a long time ago. I haven't been retrained since [client A's] last choking incident." Day service staff #1 stated, "We feed [client A] later than everyone else, so she doesn't run around and grab their food when she is finished." Day service staff #1 stated, "[Client A] is supposed to have her food served in mechanical soft texture. We make sure to watch her. Her eating is fine. The only problem is when she grabs other people's food." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 9/2/21 at 12:01 pm and stated, "Day service staff should have been trained on [clients A and C's] plans. We requested training on their high risk plans for choking and dining." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 9/2/21 at 12:22 pm and stated, "Staff needed to be retrained on the dining plans. We talked to them about a staff being at each table within arms reach. We also talked about everyone at a table having similar textures." CCQAD #1 stated, "I think staff were retrained. I don't know for sure if they were or not." CCQAD #1 indicated there was no documentation of training of staff for			

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	clients A and C's dining plans. The facility's Incident Reporting and Management Policy dated August 2018 was reviewed on 9/1/21 at 2:00 pm and indicated the following: "It is the policy of Corvilla, Inc. to: - Ensure the health and safety of all its clients. - Regard a reportable incident as any event or occurrence characterized by risk or uncertainty, resulting in or having the potential to result in significant harm or injury to an individual or death of an individual. - Not tolerate abuse, neglect, or exploitation of clients by staff members, clients, or persons in the community. - Maintain and train its staff as well as implement all current state agency/authority incident reporting requirements. - Protect the confidentiality of all persons involved in an investigation. - Continually assess the agency's internal investigation system and make adjustments as needed to improve its effectiveness. I. Definition of Reportable Incidents Reportable incidents include but are not limited to: 1. Alleged, suspected, or actual abuse, (which must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) as indicated) which includes but is not limited to: a. physical abuse, including but not limited to: i. intentionally touching another person in a rude, insolent or angry manner; ii. willful infliction of injury; iii. unauthorized restraint or confinement resulting from physical or chemical intervention; iv. rape;....			

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	2. Alleged, suspected, or actual neglect (which must also be reported to [APS] or [CPS] as indicated) which includes but is not limited to: a. failure to provide appropriate supervision, care, or training;... 3. Alleged, suspected, or actual exploitation (which must also be reported to [APS] or [CPS] as indicated) which includes but is not limited to: a. unauthorized use of the:... ii. personal property or finances; or.... 8. Elopement of an individual that results in evasion of required supervision as described in the ISP as necessary for the individuals health and welfare.... 15. A fall resulting in injury, regardless of the severity of the injury.... III. Investigations of Allegations (Internal): When action by a Corvilla employee or client are alleged to be abusive, neglectful, or exploitative or to involve criminal activity, the Human Right Officer, hereafter called the investigator, will within 48 hours after the receipt of the verbal report or such other time frame as may be determined appropriate, conduct an investigation and complete a written investigation report. A. The investigation will include the following procedures: 1.) an interview with the reporting staff member. 2.) An interview with any other witnesses including clients. 3.) An interview with the client in the presence of his or her program manager. 4.) An interview with the accused. 5.) Every attempt will be made to conduct interviews in the primary language of the individual being interviewed. B. The report shall include: 1.) A statement of the incident. 2.) A statement regarding information gained			

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	from interviews. 3.) findings of substantiation or unsubstantiation of allegation(s), and intent. 4.) Input into a recommendation for resolution. Disciplinary action, if warranted will be determined by the division management staff in conjunction with the Chief Human Resources Officer. 5.) An assessment of the agency incident reporting and investigation process.... B. If abuse, neglect, or financial exploitation has occurred, sanction may be invoked by the Management Staff in conjunction with the Chief Human Resources Officer. The accused, the reporting staff member, the client, the guardian, the CEO (Chief Executive Officer), and Chief Human Resources Officer are notified that allegation has been substantiated and appropriate action has been taken. The confidentiality of all involved parties shall be maintained in the resolution. When sanction of written warning, suspension, or dismissal has been invoked, it shall be recorded in the employee's personnel file with his or her knowledge and any written statement he or she may care to submit." This federal tag relates to complaint #IN00359014. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview for 4 of 7 allegations of abuse, neglect, and exploitation reviewed, the facility failed to effectively implement corrective action to prevent choking for client A.	W 0157	All ANE reports, including reports of choking, will be investigated by the Director of Corporate Compliance. Risk plans will be revised if necessary, and	10/07/2021

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	Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 9/1/21 at 1:06 pm. 1. A BDDS report dated 1/7/21 indicated the following: "On 1/7/21, staff went into the kitchen who in (sic) non verbal with bread in her mouth when staff got closer to [client A] staff noted that [client A] was choking on the bread that was in her mouth and her lips had started turning blue. Staff immediately alerted other staff for help and followed the choking protocol per our agency. Staff immediately started with back blows, the back blows were unable to dislodge the bread [client A] was choking on. Staff then started the Heimlich Maneuver (abdominal thrusts), the bread became dislodged and staff were able to sweep the rest of the bread out of her mouth without issue. [Client A's] color came back to her lips and [client A] did not appear to be distressed from the choking incident. [Client A] was then sent out to the ER (emergency room) with a staff member to be further evaluated. [Client A's] current diet is mechanical soft ground texture per her guardian's request and current doctor's order from 3/20/20, she had previously been on a pureed diet per recommendations of her last swallow, dietician evaluation, and doctor's order." An investigation dated 1/8/21 indicated the following: "Conclusion: Staff present followed training they received in their CPR (cardiopulmonary resuscitation)/First Aid course and acted		corrective action will take place after choking incidents. Human Rights Restrictions will be completed with guardian approval if necessary. Staff will be retrained on diet plans and appropriately surveying meal times when individuals have a choking plan, which would include sitting with the individual and observing signs of choking until they have completed their meal. This applies to all group homes. The Director of Corporate compliance will ensure that investigations will be completed. The QIDP and company nurse will ensure that staff are being retrained and that revisions are being made to the choking plans if applicable. This applies to all group homes. All staff were retained on correct diet consistencies with a dietician during the week of 10/7/2021.	

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appropriately for the emergency. Staff and nurse will monitor [client A] for any effects from this incident and follow-up with PCP (primary care physician) if needed.

Recommendations:
It was determined that the bread in the home needs to be locked up. This has been on (sic) ongoing issue with [client A] as she attempts to eat bread not prepared properly on a regular basis as well as other foods. However, bread is the main item [client A] seeks, and this restriction will reduce any future choking incidents. This needs the approval of all guardians in the home since it is a restriction for everyone living in the home and needs approval then through Corvilla's Human Rights Committee (HRC)."

2. A BDDS report dated 1/28/21 indicated the following:
"On 1/27/21 when staff was helping another client (sic) heard [client A] in the kitchen they went into the kitchen and found [client A], who is non-verbal, with leftover pizza (from the day prior's meal) in her mouth and realized that [client A] was choking on the pizza. Staff immediately alerted other staff for help and followed the choking protocol per our agency. Staff immediately started with back blows, the back blows were unable to dislodge the bread [client A] was choking on. Staff then started the Heimlich Maneuver, the pizza was then able to be dislodged and swept out of the mouth without issues. [Client A] did not appear to be distressed from the choking incident. Due to our agency protocol, [client A] was sent out to the ER with a staff member to be further evaluated. While at the hospital, a chest x-ray was completed and [client A] had no signs of aspiration and was discharged back to (sic) group home with the

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	following discharge instructions: 'Follow up with PCP within 7-10 days from ER visit. [Client A's] current diet is mechanical soft ground beef texture per her guardian's request and current doctor's order from 3/20/20, she had previously been on a pureed diet per recommendations of her last swallow, dietician evaluation and doctor's order. [Client A] is allowed to have pizza at meal times with supervision as long as it's cut up into small, bite size pieces with extra sauce." An investigation dated 1/28/21 indicated the following: "Conclusion: Staff present followed training they received in their CPR/First Aid course and acted appropriately for the emergency. Staff and nurse will monitor [client A] for any effects from this incident and follow-up with PCP if needed. Recommendations: It was determined that the bread in the home needs to be locked up. This was approved through Human Rights Committee on 1/7/21. This has been on (sic) ongoing issue with [client A] as she attempts to eat bread or bread items not prepared properly on a regular basis as well as other foods. Any leftovers needs to be made to the proper consistency of everyone in the home or just not saved and thrown away." 3. A BDDS report dated 7/26/21 indicated the following: "Staff were prepping lunches at day program when [client A] grabbed another client's sandwich and stuffed it in her mouth. [Client A] is currently on a mechanical soft diet in which food is prepared in a ground beef texture. [Client A] then ran from staff laughing as they were trying to stop her. [Client A] then started choking on the sandwich and staff followed the choking			

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	protocol and started back blows and were able to sweep the large chunk of sandwich out of [client A's] mouth. [Client A] did not appear to be in distress from this incident but per protocol was sent out to urgent care via staff to be further evaluated." A related investigation dated 7/27/21 indicated the following: "Conclusion: It appears staff followed appropriate care protocols when [client A] began choking. Based on the staff's comments, staff are not sitting with the individuals while they are eating all the time. Recommendations: Going forward, after talking to [day program staff #1, #2, and #3] this will be enforced at all locations. Staff will be sitting or standing by each table to assist anyone in the future. It was further discussed; all staff need to be in the dining area during all meals, including snacks, unless they are passing medications. [Client A] will be monitored by a designated staff if she finishes her meal before others and begins walking around the area." 4. A BDDS report dated 7/29/21 indicated the following: "Staff were preparing lunches in Day Program when [client C] grabbed another client's fish and stuffed it in her mouth. She is currently on mechanical soft diet. Staff then had to give her back blows and were able to sweep the fish out of her mouth. [DSP C] did not appear to be in distress from this, but, per protocol, was sent out to urgent care via staff to be further evaluated." An investigation dated 7/29/21 indicated the following:			

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	"Conclusion: Proper care for choking was followed. However, staff are still not monitoring the food and tables with persons at an appropriate level. Recommendations: On 8/2/21, [Licensed Practical Nurse (LPN) #1) and [Day Program Staff #1, #2, and #3], all from day services, met and discussed the need for monitoring lunches better. It was discussed to have a staff at all tables at all times during any eating times." Observations were conducted at the facility owned and operated day service on 9/2/21 from 11:00 am until 12:00 pm. Clients A and C were present throughout the observation period. On 9/2/21 at 11:09 am, client C was served a chopped hot dog, chopped bread, and apple sauce. Client C ate independently with a spoon. At 11:13 am, client C got up from the table and dumped her food into the garbage. Day Service Staff #2 stated, "Are you all done, [client C]?" - Day service staff did not sit at a table with client C or observe her while she ate. Day service staff #1 was interviewed on 9/2/21 at 11:25 am and stated, "[Client C] chokes when she grabs other people's food. We rearranged the seating, so [client C] is closer to where staff are." Day service staff #1 indicated she had not been trained on client C's dining plan since her most recent choking incident. On 9/2/21 at 11:00 am, client A was seated at a table with 3 other clients. Day service staff #1 gave client A hand sanitizer and provided verbal and visual prompts for client A to sanitize her hands. At 11:09 am, client A's table mates were served their lunches. Day service staff #1			

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	assisted client A's table mates with their meals. At 11:17 am, client A's table mates began finishing their meals. Client A had not received her lunch. At 11:20 am, client A's table mates finished their meals and their places were cleared. Day service staff #3 gave client A a plate with a chopped hot dog and chopped bread and walked away. Client A began eating her meal independently. Client A was not supervised by staff while she ate. At 11:23 am, day service staff #1 was standing with her back to client A. Day service staff turned around and looked at client A then turned her back to client A. At 11:25 am, day service staff #1 looked at client A then turned away. Day service staff #1 was interviewed on 9/2/21 at 11:25 am and stated, "I was trained on [client A's] plans a long time ago. I haven't been retrained since [client A's] last choking incident." Day service staff #1 stated, "We feed [client A] later than everyone else, so she doesn't run around and grab their food when she is finished." Day service staff #1 stated, "[Client A] is supposed to have her food served in mechanical soft texture. We make sure to watch her. Her eating is fine. The only problem is when she grabs other people's food." Client A's record was reviewed on 9/1/21 at 2:11 pm. Client A's Risk Management Plan/Dining dated 6/2020 indicated the following: "1. Risk Involved a. Choking b. Aspiration.... 2. Diet Instructions a. Mechanical soft diet (per family request). 3. Staff Guidelines a. Thin liquids.			

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	b. Medication whole with a drink. c. 1 on 1 supervision required for all meals. d. Allow extra time to swallow. e. Sit upright for all oral intake. f. Remain in upright position for at least 30 min (minutes) after eating or drinking. g. Remind client to slow down while eating. h. Small bites at a time. i. Anytime [client A] eats or swallows something that is not within diet plan, staff must do a GER (general event report) and start an aspiration sheet." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 9/2/21 at 12:01 pm and stated, "Day service staff should have been trained on [clients A and C's] plans. We requested training on their high risk plans for choking and dining." Corporate Compliance and Quality Assurance Director (CCQAD) #1 was interviewed on 9/2/21 at 12:22 pm and stated, "Staff needed to be retrained on the dining plans. We talked them about a staff being at each table within arms reach. We also talked about everyone at a table having similar textures." CCQAD #1 stated, "I think staff were retrained. I don't know for sure if they were or not." CCQAD #1 indicated there was no documentation of training of staff for clients A and C's dining plans. This federal tag relates to complaint #IN00359014. 9-3-2(a)			