OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator**
1218-0186	March 13, 2019	XXXXXXXXXXXXXX
Facility/Agency Name		
Achievement Unlimited, Inc.		
Facility/Agency Address		**Incident Location**
285 S. Farnham Galesburg, Illinois 61401		XXXXX X XXXX XXXXXXXXXXXXX

Allegation

On October 5, 2017, the Office of the Inspector General (OIG) received a notice of death from the agency. It was reported that XX XXXXXX XXXXXXX was eating breakfast and got up and ran to the bathroom. Staff followed him and noticed he was foaming at the mouth and turning blue. Staff performed the Heimlich, called 911 and initiated CPR. XX XXXXXXXX was transported to XXXXX in XXXXXXXX, XXXXX. When an attempt was being initiated to suction XX XXXXXXXX, he had already passed away. Upon reviewing records related to XX XXXXXXXX's death, the XXXXX found that the record had evidence of possible failures by the agency to provide adequate care. The XXXXX recommended the case undergo full investigation to rule out the possibility that neglect occurred in his care at the CILA, prior to his death.

Synopsis

XX XXXXXXXX had a history of choking. XX XXXXXXXX's ISP states that he tends to eat too rapidly and should be monitored while he is eating. He tends to steal and stash food, and then eats it rapidly. His ISP states there are no medical problems, except for XX XXXXXXXX's rapid intake of food. His supervision level was visual line-of-sight and he was on a general diet. The ISP states he needs verbal prompts during meals to help slow his rate of eating. It is not mentioned in his ISP that he is at moderate risk of choking, even though XXXXX, on April 8, 2017, gave him a score of eight on the Choking Risk Assessment Tool. On October 5, 2017, XXXXX was working in the kitchen preparing and serving breakfast to eight individuals, including XX XXXXXXXX. She was the only staff present in the kitchen to prepare, serve, and monitor mealtime. She said she was unaware of XX XXXXXXXX's need for special supervision and received no specific training on XX XXXXXXXX's needs. At approximately 7:15 a.m., XX XXXXXXXX and other CILA residents were having breakfast. XXXXX was cooking hash browns with sausage. She stated she was probably preparing plates and knows she had her face towards the stove. XXXXX said she heard someone coughing so she turned around and saw it was XX XXXXXXXX. XXXXX said he was known to regurgitate food after eating so she asked him to go to the bathroom which he did. She then continued cooking and she heard a chair being pushed so she turned around and saw it was

XX XXXXXXXX standing up and coughing again. She again asked him to go to the bathroom. XXXXX said he took off running down the hall. Then, XXXXX heard XXXXX yell "call 911". XXXXX began to perform the Heimlich maneuver. 911 was called and EMT's arrived promptly around 7:20 a.m. XX XXXXXXXX was transported to XXXXX where he later expired.

XXXXXX had the responsibility to ensure staff was trained on XX XXXXXXXX's ISP as required per 59 Illinois Administrative Code, Chapter 1, Part 115 but failed to do so. There is no evidence XXXXX received formal training on XX XXXXXXXX's ISP, or that she read his ISP. XXXXX acknowledged he was unsure of any training given on the various levels of supervision and there was no formal training regarding XX XXXXXXXX's mealtime supervision. The agency failed to have written policies assigning specific staff to ensure line of sight supervision during meal preparation, failed to have adequate staff during mealtime and failed to provide adequate supervision of staff to ensure line of sight supervision was provided to XX XXXXXXXX. Furthermore, there was evidence that the mealtime safety of XX XXXXXXXX was placed secondary to having the house tour ready by 9:00 a.m. And finally, because of XX XXXXXXXX's history of choking on food, staff should have been trained to call 911 immediately at any time XX XXXXXXXX was observed to have signs of choking.

Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXX. The allegation of neglect is substantiated against Achievement Unlimited, Inc.

Recommendations

The Office of the Inspector General recommends the agency:

1. Provides clear and concise training on each individual's ISP and supervision requirements.

2. Develops clear definitions of various levels of supervision and ensure all staff are trained appropriately.

3. Ensures the morning duties of the direct care staff are clearly communicated to the direct care staff and documented.