DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
Summary of Investigation
Community Provider

Case: E1104012-[redacted] **Waiver:** ICF/MR Private **DIDD Investigator:** Robin Bailey

Date: April 27, 2011

I. Initial Allegation(s):

On 4/3/11 at around 10:30 PM, the individual was getting his nightly snack for his diabetes which consists of a peanut butter sandwich and a glass of milk. The sandwich was broken up for him and he began to eat. The individual became choked and stood up with his hands to his throat. The DSP and nurse responded immediately and began the Heimlich maneuver. EMS was called as the individual became unresponsive. CPR was started by the two nurses in the home and he was transported to the ER. The conservator was contacted and the DNR was put into place. The individual passed at 3:50 AM. He was eighty three years old and had several medical conditions including heart disease, diabetes, angina and several psychosis diagnoses.

II. Conclusion(s):

"A preponderance of evidence does support the allegation of neglect in that staff neglected the individual by not properly monitoring him as he ate which resulted in a choking incident and eventual death. The authority for this determination is the ICF/MR Services Contract, between TN Department of Intellectual and Developmental Disabilities, the Bureau of TennCare and the private ICF/MR, which states that "the Facility Agrees: A.13. To comply with incident, abuse, injury and investigations documentation and reporting requirements developed by the State's Dept of Intellectual and Developmental Disabilities, which in this case is found in Chapter 18, 18.4.b., of the Community Provider Manual."

"A preponderance of evidence does support the allegation of neglect (training) in that Agency Management failed to ensure that staff were trained on the Diet Texture and what foods to avoid for the individual. The authority for this determination is the ICF/MR Services Contract, between TN Department of Intellectual and Developmental Disabilities, the Bureau of TennCare and the private ICF/MR, which states that "the Facility Agrees: A.13. To comply with incident, abuse, injury and investigations documentation and reporting requirements developed by the State's Dept of Intellectual and Developmental Disabilities, which in this case is found in Chapter 18, 18.4.b., of the Community Provider Manual."

III. Recommendation(s):

A. For **substantiated** investigations, it is recommended that Agency Management develop a response and plan of correction.

1. As relevant to the incident investigated, a plan of correction shall address the following:
    a. What has been done to safeguard the person (i.e. staff removed, equipment repaired, accounting procedures for property updated, etc);
    b. What procedures, if any, have been developed and implemented for protecting people from further abuse, neglect or exploitation; and
    c. If the incident was reported to DIDD in an untimely manner (as identified in this final investigation report, section IV.B.) what has been done to address late reporting.
2. The Agency Management response to substantiated investigations shall consist of:
    a. The Plan of Correction;
    b. Copies of disciplinary actions that were a result of the investigative findings; and
    c. Verification that the implicated staff person(s) were notified of the outcome of the investigation.
3. It is recommended Agency Management email the response and plan of correction to DMRSINVPOC.East@tn.gov within fourteen (14) calendar days from the release of this report. The release date is the day the Investigations Office forwarded the report to the Provider via email.

B. For **unsubstantiated** investigations, it is recommended that Agency Management develop a response (do not submit to DIDD) to include:

1. Verification that the implicated staff person(s) was notified of the outcome of the investigation;
2. If the incident was reported to DIDD in an untimely manner (as identified in this final investigation report, section IV.B.) what has been done to address late reporting; and
3. Verification that all incidental information was addressed.

NOTE: Incidental Information for Provider Follow-up

During the course of this investigation it was noted:

- None

Per the DIDD Provider Manual, Chapter 18, 18.3.d.4, for Community Providers, the summary of this investigation should be discussed with the involved service recipient(s) within five (5) business days of the receipt of the report. If a legal representative has been appointed, they should be invited to participate in this

discussion. The space below has been provided for your convenience as a means by which for you to document the fulfillment of this requirement.

Service Recipient or Legal Representative:

Signature	Date & Time
Printed Name	

Witness:

Signature	Date & Time
Printed Name	