State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 040014934

Date: 4/3/2019 12:00:00 AM

Type Of Visit:

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00613999

Licensee Name: Tjd, LLC

Address: 1685 SHAFFER RD. ATWATER, CA 95301

License Number: 040000070 Type of Ownership: Profit Corp

Facility Name: Anberry Nursing and Rehabilitation Center

Address: 1685 Shaffer Rd Atwater, CA 95301

Telephone : (209) 357-3420

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 040000225

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT	DEADLINE FOR COMPLIANCE
	CLASS: AA CITATION: Patient Care	100000.00	4/3/2019 4:30:00 PM

483.12

CLASS AA **CITATION --** Patient Care

Class AA Citation- Neglect

483.12 Freedom from Abuse, Neglect, and Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Title 22, 72315(g) Nursing Service- Patient Care

Each patient requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

Name Of Evaluator:
Iris DelRosario

Evaluator Signature:_____

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_____

Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

Title 22, 72335(a)(7)(b) Dietetic Service- Food Service

A current profile card shall be maintained for each patient, indicating diet order, likes, dislikes, allergies to foods, diagnosis and instructions or guidelines to be followed in the preparation and serving of food for the patient.

Title 22, 72523. Patient Care Policies and Procedures

(a)Written patient care policies and procedures shall be established and implemented to ensure that patient related goals and facility objectives are achieved.

On 12/5/18 an unannounced recertification survey was conducted. During the recertification survey, a Facility Reported Incident number CA00613999 was investigated regarding a resident that experienced a choking episode while eating his meal unsupervised in his room which resulted in Resident 56's death.

The facility failed to protect Resident 56 from neglect and provide services necessary for Resident 56 to reach his highest practicable physical well-being, when, the facility failed to:

1.Recognize the emergent situation and delayed calling emergency services or 911 when Resident 56 experienced a choking episode on 11/29/18.

2.Communicate Resident 56's new diagnosis of Progressive Supranuclear Palsy (PSP- a brain disorder that affects the ability to swallow and affects the ability to walk with a steady gait, balance and speech) on 4/18/18 to Resident 56's Primary Care Physician (PCP), Interdisciplinary Team (IDT- a group of healthcare professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient). Based on Resident 56's new diagnosis of PSP and high risk of choking, there was no updated care plan and no intervention in place.

3.Resident 56 had multiple teeth extractions and there was no documented assessment performed by Licensed Nurses after Resident 56 returned from his dental appointments. Resident 56's multiple teeth extractions placed the resident at a higher risk of choking affecting his chewing and swallowing ability. These facts were not communicated to the Speech Pathologist for a swallow evaluation to be done.

These failures resulted in Resident 56 not receiving the care needed for a diagnosis of PSP, such as swallow evaluation, possible supervision during meals, modified meals and other services required for PSP. The facility did not respond timely to an emergent situation and the delay in response led to Resident 56's death.

Resident 56's face sheet (a document containing resident profile information) indicated Resident 56 was 70 years of age, admitted to the facility on 4/7/17 with diagnoses which included dysphagia (difficulty in swallowing) and muscle weakness.

Resident 56's Minimum Data Set assessment (MDS) (a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 10/4/18 indicated the following for Resident 56: Brief Interview for Mental Status (BIMS- assessment of

cognitive status for memory and judgement) score of 9 of 15 points (moderate cognitive impairment) required supervision (oversight, encouragement or cueing) with setup assistance for meals and identified no problems or difficulty with swallowing.

On 12/5/18 at 8:30 a.m., during an interview, Certified Nursing Assistant (CNA) 1 stated, "I have been working in the facility for 17 years. I took care of [Resident 56] for 1 year. He eats breakfast in his room. I open the lid of his tray and he would feed himself. That's all I do for him and he will eat by himself, then I would get his tray back [once resident was finished with his meal]." CNA 1 stated on 11/29/18 while in the room giving Resident 56's roommate his breakfast tray, he heard Resident 56 cough. CNA 1 stated, "I went over [to Resident 56], he was sitting upright, he just nodded, he didn't say anything. I told the charge nurse [Resident 56] might be aspirating [breathing foreign objects into airways]. That was the only time I heard [Resident 56] cough like that."

On 12/5/18 at 9:16 a.m., during an interview, Licensed Nurse (LN) 2 stated, "A CNA came to me [on 11/29/18] and told me [Resident 56] might be aspirating. [Resident 56] didn't talk. I told him to lift up his head, I looked into his mouth and I saw a white drool mixed with food. I ran out to the nurses' station [calling out] that I need help [Resident 56] is choking. I called [Name of Ambulance Company] at around 7:25 a.m. [11/29/18] that I need an emergency transport, a resident is choking. I told them to send an ambulance with lights and sirens. I need emergency transfer now." LN 2 pointed at a paper written with the name and number of the ambulance company located at the nurse's station and stated that was the number she used to call for the ambulance. LN 2 stated, "I came back to the nurse's station and [the time] was 7:55 a.m. I was angry. Where are [the paramedics]. I see them out there parked at the front door [located across the street from the facility]. I asked them are you guys the lights and siren guys and he said yeah that's how busy we are. I told them I think our patient just passed away and they said what room... I don't understand what took them so long. They could have saved him. They are well equipped. They didn't even come with the lights and sirens on. I would have heard it but I didn't hear it. I never have to send a resident on a real emergency. Usually it's planned and [paramedics] respond right away but this time, I don't know why they didn't come right away."

The facility policy and procedure titled, "Change in Condition Assessment" dated 11/24/17, indicated, "Policy: It is the policy of this facility that residents who experience a change of condition will be assessed promptly and follow up action will be taken as indicated and in a timely manner ... Procedure ... 7. When emergency issues occur ... shortness of breath ... the physician will be called Stat [right away] ... b. If the resident deteriorates, the licensed nurse is to call 911 for transport to the hospital ... 12. The licensed nurse is to discuss the resident's change with the physician. Discussion should include interventions that can be carried out by the nursing staff in the facility. Every effort should be taken to treat the resident's condition in house before sending the resident to the acute hospital, if at all possible. All conversations with the physician are to be documented in the resident's medical record, in the nursing notes. 13. Treatments and interventions are to be carried out per the physician orders. 14. The licensed nurse who completed the resident assessment is to document the assessment in the nurse's note. An accurate assessment may require additional tools to be used to assist the licensed nurse. Tools available to the nurse include ... c. Pain assessment, f. SBAR [Situation, Background, Assessment and Recommendation- is a structured form of communication

that provides a systematic approach for nurses to assess and record change in a resident's status] Tool ... 15. Alert (72 Hour) Charting is to be initiated for any resident who experiences a change in condition. Documentation is to address the resident's status and effect of any new orders. Shift to shift reports should include the resident's change, current status and any new interventions started during a shift. It is important to communicate and document changes that occur from shift to shift ... 17. The Director of Nursing (DON) is to be notified of any resident experiencing changes in condition. The DON is to monitor the resident's changes and ensure that the attending physician is updated ..."

Review of Resident 56's progress note dated 11/29/18 indicated, "... This writer [LN 2] was notified at 0725 [a.m.] by CNA [1] that [Resident 56] may be possibly choking on breakfast, immediately went to assess resident and [Resident 56] was found sitting up in bed with a tray in front of him containing a freshly served breakfast that included a partially eaten tortilla. Resident pulse at 65, SpO2 sat (oxygen saturation- level of oxygen in the blood) is only 65% on RA [room air], asked resident if he was choking and no response was given, had resident sit more upright and looked in his mouth and could see nothing, immediately went to nurses station to get help from NOC [night nurse], returned to resident with NOC nurse and he [NOC nurse] immediately began to do abdominal thrusts after quick assessment and attempting a finger sweep with no success because resident would not open his mouth and partially clenching his teeth, after NOC nurse gave approximately 4 abd [abdomen] trust [thrusts]with no success [LN 1] ran back to nurses station to call for emergency assistance from [name of Ambulance Company]... dispatcher states that she will send ambulance with lights and sirens due to patient's inability to breathe... at 7:45 [LN 1] went back to desk and called resident's emergency contact ... and notified them of situation [choking] ... returned to resident's bedside, abd thrust still are ineffective ... however resident still has strong pulse 65-68 and Sp02 in 60's, resident suddenly went limp, cyanotic [turned blue in color] and without a pulse at [7:55 a.m.] ..."

Resident 56's progress note dated 11/29/18 at 8 a.m., indicated [name of Ambulance Company] arrived at [approximately] 0758 [a.m.] ... resident was no longer breathing ... time of death announced [sic] at [7:55 a.m., by [RN] ..."

The facility policy and procedure titled, "Life Threatening Medical Emergency Response" dated 11/24/17, indicated, "Purpose: To assure prompt response to a medical emergency... Policy: It is a policy of this facility to respond to any emergency which activates the facility's medical emergency response... 7. The emergency lead will communicate with the paramedics, update them on the resident's code status, diagnoses, recent medications administered..."

Review of the facility document titled, "Emergency Operations Plan" dated 11/17, indicated, "... Rapid Response Guides... Follow these steps if you recognize a potential or actual emergency that may threaten or impact the health and safety of occupants including residents... Step 1... Call 9-1-1 for emergency response..."

On 12/5/18 at 3:06 p.m., during an interview, Resident 17 stated she was Resident 56's sister. Resident 17 stated, "I just don't understand, they knew he had problems with swallowing. He needed to have supervision while eating. Somebody should have been there watching him. Nobody supervised him. They just put his tray and leave. My sister comes in on Monday, Wednesday and Friday. We eat lunch together. When we eat

together, he coughs a lot that's why he needed some supervision. My sister was not here every day to watch for him. Somebody with that problem shouldn't be left alone in the room while eating. We shouldn't have to be mourning his death if they would have supervised him."

On 12/5/18 at 3:46 p.m., during a concurrent interview and record review, the Speech Pathologist (SP) reviewed Resident 56's speech therapy notes and plan of care dated 4/10/17 which indicated the facility referred Resident 56 to SP for a swallow evaluation due to reports from caregivers of Resident 56 having swallowing difficulties during meals. The SP stated he performed the initial swallow evaluation on 4/10/17 and documented Resident 56 was having difficulty masticating [chewing] foods, and was observed with occasional coughing during meals. The SP stated Resident 56 and the family report intermittent [swallowing] difficulty. The SP stated Resident 56 was at risk for aspiration on liquids and required intermittent supervision. The SP stated, "He [Resident 56] was admitted on mechanical soft diet (is a diet that includes soft and easy to chew foods for people who have difficulty chewing and swallowing), honey thick liquids. When I discharged him [on 5/5/17], he did not require cueing and supervision with mechanical soft texture. He was safe to eat by himself. I told him to take small sips, small bites and he was able to demonstrate it safely." The SP note dated 5/8/17 indicated, "The [Resident 56] wishes to remain on current mechanical soft texture diet with nectar thick liquids to minimize risk of aspiration ... Precautions: ...Aspiration ... [Resident 56] and family report intermittent [swallowing] difficulty]. The SP stated it was a team effort that involved Licensed Nurses and CNA's to observe him and supervise him while eating. The SP stated, "[The facility] would have to let me know if [Resident 56] had any problems and would make a referral for me to do another swallow [evaluation]." SP stated the facility did not request a second referral for Resident 56 to receive a swallowing evaluation.

The facility policy and procedure titled, "Documentation, Nursing" dated 11/24/17, indicated, "... Purpose... To improve resident care by ensuring that nursing assessments, treatments and observations are documented in the medical record and easily accessible to all health care professionals involved in the resident's care... Policy... Documentation is to be clear, legible and reflect the plan of care..."

On 12/5/18 at 4:26 p.m., during a telephone interview, Family Member (FM) 1 stated she took Resident 56 to an appointment with Neurologist (Neuro- brain and spinal cord Medical Doctor [Neuro MD]) on 4/18/18 and Resident 56 was diagnosed with PSP. FM 1 stated she took Resident 56 to the neuro MD because Resident 56 began to have difficulty speaking and was falling frequently. FM 1 stated Resident 56's voice was, "Very soft spoken that you could hardly hear his voice or understand him." FM 1 stated she was concerned and wanted to know what was wrong with him. FM 1 stated she wanted to know if Resident 56 had Parkinson disease (a progressive disease of the nervous system marked by tremor, muscular stiffness, and slow, rough movement). FM 1 stated, "[Resident 56] got diagnosed last April [2018] with Progressive Supranuclear Palsy. It was paralysis in the muscles. It affected his speech, walking and swallowing. The [Neuro MD] told me it's a progressive disease." FM 1 stated she comes to the facility every Monday, Wednesday and Friday to visit Resident 56 and Resident 17 and they would have lunch together. FM 1 stated, "One time, we had lunch and something got stuck in his throat. I took [Resident 56] out to the nurses' station and told the nurse something got stuck in his throat. I told a [Licensed Nurse] and she just gave him a pudding. I cut [Resident 56's]

food in small pieces when I am there. He needs supervision while eating. He coughs up a lot ... I wouldn't want it to happen to anybody else."

Review of Resident 56's clinical record fax to physician dated 6/13/17, indicated, "[Attention] ... [Name of PCP] ... Problem, [Resident 56] and [FM] want [Resident 56] referred to Neurology. [FM] states [Resident 56] has slurred speech, swallowing problems (on thickened liquids) ... gait imbalance ..." The clinical record indicated Resident 56's PCP ordered a referral to a Neuro MD.

On 12/6/18 at 9:10 a.m., during an interview, CNA 2 stated she had been working in the facility for 26 years and took care of Resident 56. CNA 2 stated Resident 56 was observed to decline for the past months. CNA 2 stated Resident 56's voice changed to a very low tone and was at times difficult to understand. CNA 2 stated Resident 56 was becoming weaker and began to fall more often. CNA 2 stated she was unaware if he had swallowing issues because she would only set-up the meal tray for Resident 56 to eat his meal in his room and was not present while Resident 56 was eating. CNA 2 stated Resident 56 was not supervised during his meals.

On 12/6/18 at 9:47 a.m., during a concurrent interview and record review, LN 4 reviewed Resident 56's Neuro MD progress notes dated 4/18/18 indicating, "... Had PSP (Progressive Supranuclear Palsy) with degeneration... need to be monitored closely..." LN 4 stated she was the LN assigned to Resident 56 when he returned from his appointment with the Neuro MD. LN 4 stated Resident 56 returned with a doctor progress note indicating Resident 56 was newly diagnosed with PSP. LN 4 stated, "I just gave the document to medical records and it would be filed [away from the clinical record] by medical records." LN 4 stated she did not know what PSP meant for Resident 56's care and did not inform the Unit Manager (UM), Director of Nursing (DON) or the IDT team about the new diagnosis. LN 4 stated she should have informed the UM and DON in order to communicate and plan Resident 56's care and needs especially with a new diagnosis that she was not familiar with. LN 4 reviewed Resident 56's clinical record and was not able to find a care plan for his new diagnosis of PSP and how to address his care needs. LN 4 stated, "I have never done a care plan. It should be care planned so the nursing team would communicate and take care of his needs. It should also be [added] in his diagnosis but I don't see it included in his diagnoses. When I received the document after his appointment I should have documented it [in the clinical record]. I just wrote "no new orders" and no new diagnosis. I should not have done that. It made it look like I didn't do it. I didn't put it in the electronic health care record (EHR). I should have put it (in the EHR). That is what we were trained as nurses." LN 4 stated Resident 56's Primary Care Physician (PCP) should have been informed of his new diagnosis but she did not communicate this to him. LN 4 stated, "If we noticed that residents are having problems with swallowing we get a referral for a speech therapist [evaluation]. He had no problems with eating and swallowing. Sometimes I see him when I pass meds [medications] and he was okay."

The facility policy and procedure titled, "Documentation, Nursing" dated 11/24/17, indicated, "... Purpose... To improve resident care by ensuring that nursing assessments, treatments and observations are documented in the medical record and easily accessible to all health care professionals involved in the resident's care... Policy... Documentation is to be clear, legible and reflect the plan of care..."

The facility document titled, "Job Description LVN" undated, indicated, "... As LVN... you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties... Assist in developing methods for coordinating nursing services with other patient services to ensure the continuity of the patients' total regimen of care... Participate in the development of a written plan of care (preliminary and comprehensive) for each patient that identifies the problems/needs of the patient, indicates the care to be given, goals to be accomplished, and which professional service is responsible for each element of care..."

On 12/6/18 at 9:59 a.m., during a concurrent interview and record review, the UM reviewed Resident 56's Neuro MD progress notes dated 4/18/18 indicating, "... Had PSP (Progressive Supranuclear Palsy) with degeneration... need to be monitored closely..." The UM stated she was not aware of Resident 56's new diagnosis of PSP when he went to his Neuro appointment. The UM stated, "It should have been communicated with all staff. It was not care planned and it should have been care planned. If I was the one doing the care plan, I would put it under ADL's [Activities of Daily Living] and to monitor for decreased ADL functions such as difficulty in swallowing, to monitor how he eats, decreased in mobility function and to monitor for falls. [Resident 56] does not have a progressive disease like Parkinson's [progressive nervous system disorder that affects movement] before but now that he has a diagnosis of a progressive disease with degeneration, it should have been communicated with staff in order to plan care and anticipate the residents' needs." The UM stated the SP and PCP should have been notified about his newly diagnosed condition but was not informed by the nursing staff.

On 12/6/18 at 10:05 a.m., during a concurrent interview and record review, the DON reviewed Resident 56's Neuro MD progress notes dated 4/18/18 and indicated, "... Had PSP (Progressive Supranuclear Palsy) with degeneration... need to be monitored closely..." The DON stated she was not familiar with PSP or what it meant for Resident 56's care needs. The DON stated, "I did not know that [Resident 56] had that diagnosis. The healthcare team should have been notified about the diagnosis. If it got worst, we would have to send him back to the doctor. A referral to Speech [Pathologist] should have been made with the new diagnosis. It is important to monitor his swallowing if it got worse." The DON reviewed Resident 56's clinical record and was unable to find a care plan addressing his needs with his new diagnosed condition of PSP. The DON was unable to find Resident 56's PSP diagnosis added to his list of diagnoses. The DON stated, "It should be included in the diagnosis and it should be care planned to better plan for his care especially with a new diagnosis. The supervision [how he eats and level of assistance when eating] for [Resident 56] might have been different if the facility was aware of the new diagnosed condition." The DON reviewed the Neuro progress note with the PSP diagnosis and stated LN 4 was aware of the diagnosis and failed to communicate the condition to all facility team members.

On 12/6/18 at 11:44 a.m., during a telephone interview, the SP stated he was not aware of Resident 56's diagnosis of PSP. The SP stated, "That's the first time I've heard of that diagnosis. Unfortunately, I wasn't aware. It would have warranted a [speech therapy] screen..." The SP stated a speech therapy screening was not requested by the facility.

On 12/6/18 at 1:39 p.m., during a telephone interview, the PCP stated the new diagnosis

of PSP for Resident 56 was not communicated to him by the nursing staff. The PCP stated, "I'm looking at [internet search engine name] right now for the meaning of PSP. It means the resident will have swallowing problems... [The facility] has my direct number. They can call me anytime but I was not informed about the new diagnosis. It's a progressive disease so all the symptoms he was having will get worse over time [swallowing problems]. The nurses need to monitor his swallowing, the food and diet texture is a big thing..."

On 12/7/18 at 8:46 a.m., during a telephone interview, the Neuro MD stated, "I saw [Resident 56] last April 2018 and I diagnosed him with PSP. It means the patient cannot swallow, [he] will fall more. It's like a death sentence for the patient. With a swallow eval [evaluation] it may prolong his life... The facility should have known he had PSP. I wrote monitoring but [the facility] has their own speech therapist. They should have made a referral with the speech therapist when they saw the diagnosis that he had PSP. A speech evaluation should have been made. The resident needs supervision with eating and walking because [he] will have more difficulty with swallowing and walking as the disease progresses. It's a simple job they need to do. They need to look at the diagnosis and find out what the best care to give the patient. That's why nursing homes are there to provide the best care for the patient. They should not just file the paper with the diagnosis. They should read it and find out about it and what it means to the patient's care. That's what nursing care is for, to be able to provide a better care for the patient and their needs. [The facility] has a speech therapist that should work with him."

Professional reference titled, "Progressive Supranuclear Palsy (PSP) information" undated, (found at www.movementdisorders.ufhealth.org) indicated, "... Treating speech and swallow impairments is equally important... Choking or swallow difficulty is very common in PSP and another potential hazard. Aspiration of food, liquids or saliva can result in death. As such, formal swallow evaluation is strongly recommended and should include regular follow-up exams..."

On 12/7/18 at 9:14 a.m., during an interview, LN 5 stated she has been working in the facility for 6 years. LN 5 stated, "If [residents] are choking or having a stroke, I start the Heimlich maneuver... I would call 911 first because it's an emergency situation. I never had to send somebody out on an emergency. The most recent one I sent out was a resident had a [Urinary Tract Infection- infection of the bladder] so I called [Name of Ambulance Company] but if it's an emergency I would call 911.

On 12/7/18 at 9:25 a.m., during an interview, LN 1 stated she would call 911 in a life and death situation such as when a resident was choking. LN 1 stated she would call the [name of Ambulance Company] for non-threatening situations.

On 12/7/18 9:49 a.m., during an interview, CNA 3 stated, "I notify the nurse if I came across a resident that needs emergency attention, and after that the nurse takes over. I would call 911 for an emergency situation..."

On 12/7/18 10:04 a.m., during an interview, CNA 4 stated, "For emergency situation, I call code blue from the nurses' station. The nurses will do whatever they need to do for the resident and if delegated to me to call the ambulance, I will call 911. We have a different ambulance [phone number] for non-emergent situation. I will call 911 whether outside,

home or in the facility for emergency situation."

On 12/7/18 at 10:01 a.m., during a telephone interview, LN 2 stated, "We call [Name of Ambulance Company] for everything, for emergency and non-emergency... I will not call 911. That's what [licensed nurses] were trained when I got hired and that's what I did."

On 12/7/18 at 9:35 a.m., during an interview, the CNO stated, "For both emergency and non-emergency, nurses are supposed to call [Name of Ambulance Company]. If it is an emergency, we specify lights and sirens. It will not make any difference if we call 911 because there's only one Ambulance Company in this area." The CNO stated new hires and current staff are given in-service training for unusual occurrence such as fall prevention program, skin integrity and choking.

On 12/7/18 at 9:45 a.m., during an interview, the DON stated, "...If I am in that situation, I could have handled it differently. I would have called 911 directly since they will come immediately and 911 would have dispatched the fire department to respond competently in an emergency situation." The DON stated the facility does not have a specific policy for responding in an emergency situation. The DON stated it was included in the LN's Basic Life Support (BLS) training that they knew how to respond to an emergency like choking and how to perform the Heimlich maneuver.

On 12/7/18 9:55 a.m., during a concurrent interview and record review, the Director of Staff Development (DSD) stated the LN's are in-serviced annually on how to respond to an emergency situation like choking prevention. The DSD was not able to provide a specific policy on how the facility responds to an emergency situation like choking. The DSD stated the facility does not have a specific policy on how to respond when a resident was choking. The DSD stated LN's are supposed to call 911 for an emergency situation. The DSD provided a facility document titled, "CPR [Cardiopulmonary Resuscitation- an emergency life-saving procedure performed when someone's breathing or heartbeat has stopped]" undated, indicated "... First Aid for the Choking Victim: The Heimlich maneuver... [the manual application of sudden upward pressure on the upper abdomen of a choking victim to force a foreign object from the trachea] Choking is caused by an obstructed airway and is one of the leading causes of death. Everyone should know how to help a person who is choking, and as medical professionals, all CNAs are required to know how to assist someone with an obstructed airway caused by a foreign body... It is sensible to have someone call 911. The Heimlich maneuver may be successful. But it may not work and it is much, much better to have emergency personnel on the way then wait until the person loses consciousness and then call for help... Always call 911 or have someone call for help..." The DSD stated she goes over this document when she performs her annual in-service training on choking with the Licensed Nurses.

On 12/7/18 at 10:16 a.m., during an interview, LN 6 stated, "If it's an emergency, I would immediately call 911. If it's a non-emergency situation, I would assess the resident and I would call the PCP. If the PCP says to send resident out then I would call the ambulance which is [Name of Ambulance Company] but if they are having a heart attack or choking, I would definitely call 911 because it's an emergency. The nurses on the floor trained me what to do in case of an emergency situation and they told me to call 911."

On 12/7/18 at 10:43 a.m., during a telephone interview, [Ambulance Company]

representative stated, "[The facility] usually gets a hold of us through 911 or by calling us directly. Sometimes it depends on the situation... but I would think if it's a real emergency situation [staff] would call 911 as far as I know."

On 12/7/18 at 12:16 p.m., during a concurrent interview and record review, LN 7 opened a facility binder located at the nurse's station and pointed at the [Name of Ambulance Company] number and stated, "I would call [name of Ambulance Company] for any emergency situation. I was trained on orientation to call direct line [name of Ambulance Company] for all emergencies."

On 12/10/18 at 9:40 a.m., during an interview, the DSD stated she would call 911 for an emergency situation such as when a resident was choking. The DSD stated she would call [Name of Ambulance Company] for non-emergency situations such as when a resident will be transferred out of the facility to General Acute Care Hospital (GACH) for a procedure.

On 12/10/18 at 9:50 a.m., during an interview, LN 8 stated she would call 911 for every emergency situation such as when a resident was choking or having chest pain. LN 8 stated she would call [Name of Ambulance Company] for non-emergency situations and if residents were stable enough to be transferred to GACH for an evaluation. LN 8 stated, "The difference between calling 911 and the [name of Ambulance Company] is that, 911 can dispatch an ambulance that is available right away."

On 12/10/18 at 10:41 a.m., during an interview, LN 2 stated she was not sure if anybody checked to see if the ambulance arrived to the facility while Resident 56 was still choking. LN 2 stated she did not call the paramedics to ask if they were on the way to the facility.

On 12/10/18 at 10:53 a.m., during an interview, the DON stated nobody from the facility staff checked to see if the ambulance arrived at the facility while Resident 56 was still choking. The DON stated, "Someone should have called [the ambulance to [ask] when they are arriving to the facility]. The [facility staff] should call 911..."

On 12/27/18 at 9:17 a.m., during a telephone interview, [Ambulance Company] Compliance Officer stated, "If the facility needs emergency transport, they should call 911. They should not be calling for the ambulance number. The ambulance number is different from 911." The Ambulance Compliance Officer stated 911 was used for emergency situations and the ambulance direct phone number was used for non-emergency situations.

On 1/3/19 at 8:20 a.m., during a telephone interview, FM 1 stated, "[Resident 56] was having a lot of problems with speech, swallowing and walking. That's why I wanted him seen by a neurologist. [The facility staff] were saying [Resident 56] was high functioning. I was trying to get my brother more help." FM stated Resident 56 was admitted to the facility on April 2017 FM stated, "[Resident 56's] voice was not clear enough. I have to tell him to speak louder and he told me he couldn't. I requested another appointment to a neurologist and the reason for the referral was his speech problem so he could communicate better and other things that needs to be addressed like swallowing."

On 1/3/19 at 9:28 a.m., during a concurrent interview and record review at the nurse's

station, LN 4 reviewed the appointment calendar and stated Resident 56 went to dental appointments on 4/18/18, 5/4/18, 5/23/18, 6/5/18, 6/15/18, 7/19/18, 7/24/18, 9/17/18 and 11/21/18. LN 4 stated, "I don't know why [Resident 56] went to the dentist." LN 4 stated she was not aware Resident 56 had tooth extractions whenever he would go to his dental appointments or what procedure was performed by the dentist on Resident 56. LN 4 stated, "[Resident 56] has never had any tooth extractions, not that I am aware of." LN 4 reviewed Resident 56's progress notes in the computer and was unable to find documented assessment for the reason Resident 56 went to multiple dental appointments. LN 4 stated, "It should be documented in the progress notes. It should have been documented when the [dental] appointment was made so [Licensed Nurses] knew why [Resident 56] was going to the [dentist]. It should be documented in case it doesn't get passed on [to the next shift]." LN 4 stated it was important Licensed Nurses assessed and documented in the nurse's progress notes every time Resident 56 went to his dental appointment and after Resident 56 comes back from his dental appointment to ensure continuity of care and provide his care needs. LN 4 stated Resident 56 has a low tone voice and it was difficult for staff to understand him at times. LN 4 stated, " ... In the morning, [Resident 56's] voice would be louder, it varies, but that would be his usual [tone of voice]. LN 4 stated, the facility would call the PCP to get an order for a referral to SP but a referral to SP was not made. LN 4 stated, "It should have been referred to the [SP]. [Resident 56] should have been evaluated [by SP]." LN 4 stated she did not inform the PCP on Resident 56's change of voice. LN 4 stated, "For me [Resident 56] has always been that way [difficult to understand speech]."

On 1/3/19 at 10:24 a.m., during a telephone interview, FM stated Resident 56 was having dental pain and had tooth extractions. FM stated, "I do not know how many teeth [the dentist] pulled. He was complaining about tooth pain for about a year and the dentist was working with him for one year. I do not remember how many teeth [were extracted]. The facility should have notes from the dentist."

On 1/3/19 at 12:03 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 1/11/18, indicated, " ... Treatment (Tx) Recommendation ... # (number) 27 [tooth] sharp edge... # 27 painful- cuts tongue [with] sharp edge ..." The DON stated the dental consultation notes should have been given to the Licensed Nurse for a follow up after the dentist evaluated Resident 56. The DON was unable to find a documented nurse's assessment or follow up in Resident 56's clinical record. The DON stated, "It would be painful for a resident when they are eating. If you have a cut in the tongue, it makes [the resident] not want to eat. It will hurt more with spices [on the food] ..."

On 1/3/19 at 12:09 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 3/23/18, indicated, " ... Tx Recommendation ... [Extraction] # 21 [tooth] ..." The DON was unable to find documented nurse's assessment in Resident 56's clinical record, Licensed Nurses followed up after Resident 56 was evaluated by the dentist. The DON stated, "Social Service gets [the consultation notes] and files them away."

On 1/3/19 at 12:10 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 4/10/18, and indicated, " ... Referred for Extraction of Teeth ... [#] 6, [#] 21 ..." The DON stated, "For taking a tooth

out, [facility] would monitor [the resident] for 72 hours, every shift." The DON was unable to find documented nurse's notes, documentation the Licensed Nurses performed an assessment on Resident 56 after his dental appointment. The DON stated the facility reviewed all the residents medical records once a month. The DON stated when a resident goes out on an appointment, the facility does not verify if the consultation notes or referral was followed up by the Licensed Nurses or if a documentation or follow up assessment was completed.

On 1/3/19 at 12:12 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's x-ray results of the teeth dated 5/23/18 and stated she did not see a lot of teeth left. The DON stated, "I would have referred him to speech [pathologist]. As nurses, we can downgrade (a process when a SP changes a resident's diet to a consistency that is safe for residents to swallow) [a diet] but not upgrade [a diet]. Nurses are not getting the [dental consultation notes] so they will not be able to downgrade [Resident 56's diet]."

On 1/3/19 at 12:13 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 6/5/18, indicated, " ... MD Progress Note ... #6 [tooth], # 21 [tooth] extracted without complications ... MD New Orders ... Soft foods only for at least 3 days ..." The DON reviewed Resident 56's clinical record and was unable to find a documented assessment performed by Licensed Nurses after Resident 56's tooth extraction. The DON stated the facility should monitor Resident 56 and document every shift for 72 hours if there was any change in condition such as bleeding or pain.

On 1/3/19 at 12:14 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 5/23/18, indicated, " ... MD new orders ... [follow up] for extraction with [oral] sedation ... Date/Time of Next Appointment ... 6/15/18 [at] 9 a.m. ... procedure appointment ..." The DON reviewed Resident 56's nurse's progress notes dated 5/23/18 and stated the facility should document what the follow up dental appointment is for. The DON stated it was important to document in Resident 56's nurse's progress notes the reason why he went to the dentist and any procedures that would be done.

On 1/3/19 at 12:20 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 6/15/18, indicated, " ... Tooth # 7, 22, 14 ... Pain ... Please evaluate and render appropriate treatment ..." The DON reviewed Resident 56's clinical record and was unable to find documented assessment Licensed Nurses evaluated Resident 56 for pain after his dental appointment. The DON stated, "There should be a nurse's note. They should be putting [Resident 56] on documentation making sure [Licensed Nurses are] addressing the pain in his mouth and making sure he can eat his meals properly and safely or if it's too much pain to downgrade [Resident 56's diet] for the time being."

On 1/3/19 at 12:41 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 7/24/18, indicated, " ... MD Progress Note ... [Resident 56] has multiple missing Permanent teeth, needs replacement with upper and lower partial [dentures ... MD New Diagnosis: tooth # 14 has [dental] caries (tooth decay) ... MD New Orders ... filling [plus] partials [dentures] ..." The licensed nurse

did not note at the bottom of the dental consult note there was a new order from the dentist. The DON reviewed Resident 56's clinical record and was unable to find documentation of the new order after Resident 56 was seen by the dentist. The DON stated the Licensed Nurse did not document any new orders from the dentist. The DON stated, "It needs to be clarified as an actual order."

On 1/3/19 at 12:54 p.m., during a concurrent interview and record review, the DON reviewed Resident 56's dental consultation notes dated 11/21/18, indicated, " ... 2 x-rays taken for #7 [tooth], # 25 [tooth]. [Resident 56] is partially edentulous (lacking teeth), needs [Partial Upper Dentures] ..." The DON reviewed Resident 56's clinical record and was unable to find documentation Licensed Nurses referred Resident 56 to the SP to evaluate his swallowing abilities after the tooth extractions. The DON stated, "[Resident 56's] diet was not downgraded and remained the same diet after the tooth extraction." The DON stated Resident 56 should have been referred to the SP and the Licensed Nurses should have assessed and documented how Resident 56 tolerates the mechanical soft diet.

On 1/3/19 at 1:27 p.m., during an interview, the DON stated in the event of a life threatening emergency, the facility could call the main line of [name of Ambulance Company]. The DON stated, "Nurses can call that number [name of Ambulance Company] for emergency and non-emergency situations."

On 1/4/19 at 7:18 a.m., during a concurrent observation and interview, LN 3 demonstrated how he performed the Heimlich maneuver on Resident 56. LN 3 stated LN 2 went out of Resident 56's room on 11/29/18 and informed him Resident 56 was choking. LN 3 stated he went inside Resident 56's room, went to the right side of the bed and Resident 56's right side rail was up. LN 3 stated he did not put the right side rail down as he was preparing to perform the Heimlich maneuver. LN 3 stated he positioned Resident 56's on the left side of the bed. LN 3 stated he placed his hands on the xiphoid process (lower part of the breast bone) and began abdominal thrusts. LN 3 stated, the Heimlich maneuver was not working and Resident 56 was still choking. LN 3 stated, "The ambulance took a long time to arrive because we didn't call 9-1-1." LN 3 stated LN 2 should have not left Resident 56's room when she found him choking but should have started the Heimlich maneuver right away. LN 3 stated he performed a finger sweep (a technique for clearing a mechanical obstruction from the upper airway. The rescuer opens the victim's mouth by grasping the lower jaw and tongue between the thumb and fingers. The rescuer then attempts to sweep the foreign object out of the victim's mouth with a finger) on Resident 56 to clear his airway. LN 3 stated, "I saw something in his mouth. I tried to [perform a finger sweep] but he bit me so I don't want to make [Resident 56] more nervous. It might dislodge [the food bolus] further down if you do a finger sweep."

Professional reference titled, "Abdominal Thrusts" dated 12/17/18, (found at https://medlineplusgov/ency/article/000047.htm) indicated, " ... If the person is choking, perform abdominal thrusts as follows ... Place your fist, thumb side in, just above the person's navel (belly button), grasp the fist tightly with your other hand, make quick, upward and inward thrusts with your fist. If the person is lying on his or her back, straddle the person facing the head. Pushed your grasped fist upward and inward ... You may need to repeat the procedure several times before the object is dislodged. If repeated attempts do not free the airway, call 911 ..."

Name Of Evaluator:
Iris DelRosario

Evaluator
Signature:_____

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_____

Name:_____

Title:_____

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

On 1/4/19 at 9:22 a.m., during a telephone interview, the Registered Dietitian (RD) stated she was not informed by the facility that Resident 56 had tooth extractions and dental procedures. The RD stated, "I would refer [Resident 56] to speech [pathologist] or check with him how he is eating and doing on his current diet. We can do a downgrade [of Resident 56's diet] if needed. Downgrading [a diet] is easier and safer than upgrading [a diet]."

On 1/4/19 at 10:59 a.m., during an interview, LN 2 stated when Resident 56 started choking, she ran out to the nurse's station to ask for help. LN 2 stated there was a CNA in the room and at the time Resident 56 was choking, the CNA continued feeding Resident 56's roommate. LN 2 stated she found LN 3 at the nurse's station and asked for help to respond to Resident 56. LN 2 stated LN 3 performed four abdominal thrusts on Resident 56 and Resident 56 was still choking. LN 2 stated she went outside Resident 56's room to go to the nurse's station. LN 2 stated, "After four [abdominal thrusts], I'm going to call [Number and Name of Ambulance Company]." LN 2 stated after calling the Ambulance Company's main phone line, she went back to Resident 56's room and brought the emergency crash cart in case it was needed. LN 2 stated she was not aware that she needed to call 911 in an emergency life threatening situation. LN 2 stated, "I should have responded to [Resident 56] when he was choking. I was so scared ..." LN 2 stated she knew Resident 56 had missing teeth. LN 2 stated, "I think I remember, [Resident 56] was getting his tooth extracted to be fitted with partial [dentures]. I heard it from another nurse. I did not refer [Resident 56] to RD and SP." LN 2 stated it was important to assess Resident 56 after he came back from a dental procedure or when he had tooth extractions to monitor for pain, bleeding and assess if he could tolerate his current mechanical soft diet.

The facility policy and procedure titled, "Care Plans" dated 11/24/17, indicated, "... Purpose: To standardize the development and update of resident care plans that address the physical, mental and psychosocial needs of the resident... Policy... The care plan is to be updated when the resident experiences acute... changes in their medical... and functional condition... Procedure: Based on comprehensive assessment the interdisciplinary team (IDT) is to develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, as well as the resident's goals and preferences... The Interdisciplinary Team includes: Attending Physician, Licensed Nurse, Nursing Assistant, Resident, Resident's Representative, Dietitian and/or Food and Nutritional Service Director, Social Service Designee, Activities Designee... 3. The care plan is to be reviewed and revised by the IDT after the resident's initial assessment, quarterly and more often as warranted by the change in a resident's condition. 4. The resident's care plan is to be updated as changes occur... 6. The focus/problem list is to identify those areas that the resident has actual or potential risk for injury, illness or other impairments. 7. Each goal is to be realistic, measurable, directed towards the focus and individualized to the resident. The goal is to build upon the resident's strength... 8. Interventions are those services, items and approaches that specific staff is to carry out to aid the resident in attaining and maintaining their highest functional level and preventing further decline..."

Review of Resident 56's death certificate dated 11/29/18 obtained on [Name of County] on 1/3/19 indicated, " ... Cause of Death: Asphyxia (a condition arising when the body is

deprived of oxygen, causing unconsciousness or death, suffocation) by Choking on Food Bolus (Tortilla) ... Choked on Food Bolus (Tortilla) ..."

Therefore, the facility failed to protect Resident 56 from neglect when Resident 56's new diagnosis of PSP was not communicated by Licensed Nurses to Resident 56's Primary Care Physician and the Interdisciplinary Team. Resident 56 had multiple teeth extractions and there was no documented assessment performed by Licensed Nurses after Resident 56's teeth extractions. The Speech Pathologist was not informed of Resident 56's multiple teeth extractions for a swallow evaluation to be done and the need to possibly modify Resident 56's diet based on his chewing and swallowing ability. Resident 56 experienced a choking episode on 11/29/18 while eating a meal on his room unsupervised and staff did not recognize the emergent situation and delayed calling emergency services or 911. As a result of the delay in calling emergency services or 911, Resident 56 died.

These violations presented an imminent danger that death or serious harm would result or a substantial probability that death or serious harm would result and was direct proximate cause of Resident 56's death and constitutes a Class AA Citation.

Name Of Evaluator:
Iris DelRosario

Evaluator
Signature:_____

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature:_____

Name:_____

Title:_____

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