



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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January 4, 2017

Richard Strong, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Strong:

On **December 16, 2016**, a survey was conducted at Meridian Center Genesis Healthcare by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be a **WIDESPREAD PATTERN** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situation(s) in writing on **December 16, 2016**.

On **December 19, 2016**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, an onsite revisit was completed on **December 21, 2016** and it was determined that the immediate jeopardy to the residents had been removed effective **December 20, 2016**. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged

compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 16, 2017**. Failure to submit an acceptable PoC by **January 16, 2017**., may result in the imposition of additional civil monetary penalties by **February 6, 2017**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy cited during this survey:

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F0323 -- S/S: K -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil Monetary Penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 16, 2017**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0323 -- S/S: K -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#1** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder

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Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **January 16, 2017**.. If your request for informal dispute resolution is received after **January 16, 2017**., the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



David Scott, RN, Supervisor
Long Term Care

DS/lj

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cc: Chairman, Board of Examiners - Nursing Home Administrators

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/16/2016
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
(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	
F 000	INITIAL COMMENTS A Complaint Investigation survey was conducted at the facility on December 16, 2016. Immediate Jeopardy was identified at: *42 CFR 483.25(d) - F323 The Immediate Jeopardy was not removed prior to the exit conference. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Nina Sanderson, LSW Edith Cecil, RN Acronyms include: CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation DNR = Do Not Resuscitate DNS = Director of Nursing Services HS = At Bedtime LPN = Licensed Practical Nurse RN = Registered Nurse SLP = Speech Language Pathologist	F 000			
F 323 SS=K	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		1/11/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/13/2017

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

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F 323	<p>Continued From page 1</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the facility's investigations and policies, it was determined the facility failed to ensure residents were provided with the level of supervision necessary for safety and staff were competent to perform life-saving interventions for residents who experienced choking episodes. This was true for 1 or 4 sampled residents (Resident #1). The failure to provide lifesaving interventions contributed to, or resulted in, the death of Resident #1, and placed all residents who consumed food orally, in Immediate Jeopardy of brain, tissue, and/or organ damage, and coma, due to severe hypoxia, or death due to asphyxiation. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 5/2/16, with diagnoses which included Parkinson's disease and dementia.</p>	F 323	<p>Resident affected: Resident #1 discharged from Genesis Meridian Center on 12/02/2016.</p> <p>Other Residents with the potential to be affected: On December 19th, 20th, or before next scheduled shift the Nursing Staff were reeducated by a CPR certified instructor on the Obstructed Airway Intervention Procedure with correlating return demonstration to validate competency testing.</p> <p>Licensed Nurses and Certified Nursing Assistant staff were reeducated by a CPR certified instructor on recognition of airway emergencies.</p> <p>Staff daily assignments sheets were</p>		

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F 323	<p>Continued From page 2</p> <p>Resident #1's Nutrition Care Plan, revised 12/8/16, documented interventions including:</p> <ul style="list-style-type: none"> * Provide Resident #1's diet as ordered by the physician, revised 12/8/16. * Honor Resident #1's food preferences within his meal plan, revised 12/8/16. * Staff to encourage Resident #1 to chew and swallow each bite, revised 12/8/16. <p>Resident #1's December 2016 physicians' orders documented:</p> <ul style="list-style-type: none"> * Resident #1 was to receive a regular/liberalized diet, initiated on 5/2/16. * Resident #1 had a DNR order, initiated on 5/2/16. * Speech Therapy was to evaluate and treat Resident #1 for increased swallowing difficulties, ordered on 11/29/16. <p>On 12/9/16, the facility submitted a self-reported Summary of Investigation to the State Agency [SA] which documented Resident #1 choked during the evening meal on 12/2/16, and died of asphyxia. The investigation did not include a review of staff's compliance with facility policies and procedures or if staff's actions in response to the choking were consistent with current standards of practice. The SA contacted the facility on 12/12/16 and requested further information.</p> <p>On 12/14/16 the facility provided the following additional information to the SA:</p> <ul style="list-style-type: none"> * An undated Investigation Report - The Report documented that on 12/2/16 at 5:20 pm, CNA #6 	F 323	<p>updated to include CNA, and licensed nursing dining room assignments to ensure adequate dining room supervision.</p> <p>Licensed nurses were educated that they cannot leave the dining room while residents are eating until they are relieved by another licensed staff member to ensure licensed nurse supervision in the dining room during meal times by the Executive Director or designee.</p> <p>Any Nursing Staff that were not available for education and training on December 19th or 20th will not work until the above actions are completed (including education completed by a CPR certified instructor) and competency is demonstrated.</p> <p>Systemic Change: A review of the centers policy for managing an obstructed airway, and CPR were reviewed by the Center Nurse Executive on 12/17/2016. The Center policy for obstructed airway was updated by Sr. Director, Clinical Operations and Corporate Policies and Procedures Genesis HealthCare to reflect current standards of practice by the center IDT on 12/19/2016.</p> <p>On or before 12/20/2016 Licensed nurses and CNA's were re-educated by a CPR certified instructor on managing an obstructed airway intervention Procedure (policy updated 12/19/2016) and emergency recognition with correlating</p>		

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F 323	<p>Continued From page 3</p> <p>provided a dinner tray to Resident #1 which contained chicken, potatoes, squash, and a biscuit, and offered to cut up the chicken.</p> <p>* An undated Incident Report Witness Statement from CNA #7 - CNA #7 documented Resident #1 received his dinner meal at approximately 5:15 pm. CNA #7 stated she heard someone coughing and turned and saw Resident #1 touching his throat and struggling to breathe. CNA #7 went to Resident #1's side and tapped him on the back to make sure he was sitting in an upright position. CNA #7 encouraged Resident #1 to cough and noticed Resident #1's face had turned red from trying to cough and expel the food. CNA #7 asked CNA #6 for assistance in locating a nurse. CNA #6 stated the RN had stepped out of the dining room. CNA #7 asked CNA #6 to take Resident #1 from the dining room to find an RN.</p> <p>* An undated Incident Report Witness Statement from CNA #6 - The statement documented CNA #6 "rushed" Resident #1 to LPN #2 who was in the hall. LPN #2 instructed CNA #6 to take Resident #1 to his room and LPN #2 would be there quickly with a suction machine. The statement documented LPN #2 tried using the suction machine and when it was not successful the nursing staff started the Heimlich maneuver. In addition, the statement documented the two CNAs stood Resident #1 up while LPN #2 performed the Heimlich maneuver. The statement documented Resident #1 had to be lowered to the floor and abdominal thrusts were attempted.</p> <p>* An undated Incident Report Witness Statement from CNA #8 - The statement documented CNA</p>	F 323	<p>return demonstration to validate competency testing.</p> <p>A review of new orders including but not limited therapy evaluations will be reviewed during the morning clinical meetings with Director of Rehab or designee present to validate acknowledgement of orders and evaluations schedule.</p> <p>Obstructed Airway and emergency recognition training will be completed at time of new hire skilled training and annually thereafter.</p> <p>Audit Beginning 12/19/2016 weekly dining room assignment audits will be completed by Center Executive Director or designee to validate Licensed Nurse supervision in dining room schedule as assigned.</p> <p>Beginning the week of 12/19/2016, weekly audits of newly hired direct care staff will be completed Center Nurse Executive or Designee to validate that Obstructed Airway and Emergency Recognition was completed during skills portion of orientation.</p> <p>The results of these audits will be compiled by the Center Nurse Executive and reported to the QAPI committee for review monthly X3 months or until substantial compliance is sustained. The Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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F 323	<p>Continued From page 4</p> <p>#8 went to assist CNA #6 when she heard her calling for help in the hallway. The statement documented Resident #1 was red in color and was coughing hard and CNA #8 encouraged Resident #1 to continue coughing. CNA #8 continued to wheel Resident #1 down to towards the nurses' station where LPN #2 was located. CNA #8 documented Resident #1's face turned a dusky/gray color. LPN #2 instructed CNA #8 to take Resident #1 to his room while he grabbed the suction machine. While LPN #2 suctioned Resident #1's mouth, he was able to dislodge small pieces of chicken. CNA #8 documented Resident #1 was stood up and the Heimlich maneuver was performed. She described Resident #1 as taking raspy breaths. Staff sat Resident #1 in his wheelchair and the nursing staff attempted to suction him again. The nurses stood him up again and tried the Heimlich maneuver. CNA #8 documented Resident #1 was losing his color after another unsuccessful attempt with the Heimlich maneuver. After the failed attempt they laid him on the floor and initiated abdominal thrusts. She documented Resident #1 passed away.</p> <p>* An undated Incident Report Witness Statement from LPN #2 - The report documented that on 12/2/16 at 5:25 pm, LPN #2 stated he was heading to the dining room, when CNA #6 met him in the hall and told him Resident #1 was choking. LPN #2 instructed one of the CNAs to get the RN, and directed the other to take Resident #1 to his room. LPN #2 stated he got a suction machine and tried to suction and clear Resident #1's airway. After a bit, RN #2 entered the room and the nurses started to perform the Heimlich maneuver. LPN #2 was able to get</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>some food particles out, however Resident #1 remained cyanotic and did not respond to verbal stimuli. The statement documented LPN #2 continued to perform the Heimlich maneuver and RN #2 called Resident #1's physician. The physician instructed the staff to call 911. RN #2 took over performing the Heimlich maneuver while LPN #2 left the room and called 911. When LPN #2 returned to the room, Resident #1 was on the floor and non-responsive. The paramedics declared Resident #1 dead when they arrived.</p> <p>* Summary of an interview facility staff completed with LPN #2 - The summary documented LPN #2 as stating Resident #1's room was approximately 125 feet from the dining room and when he went to grab the suction machine he was "...only away [from Resident #1] maybe two minutes while I got the equipment."</p> <p>* Copy of RN #2's 12/2/16 Nurses' Note as an Incident Report Witness Statement from RN #2 - Resident #1's Nurses' Note, dated 12/2/16, documented RN #2 was notified at 5:30 pm, that Resident #1 was possibly choking on food. Another LN had taken Resident #1 to his room and begun an assessment. The note documented Resident #1's face was dusky and he presented with "taking gasping respirations with mucus heard in [his] airway." In addition, it documented Resident #1 did not respond to verbal stimuli. The note documented the Heimlich maneuver was performed by LPN #2 and several small food particles were expelled. RN #2 took over the thrusts and more food particles were expelled. Resident #1's facial color was turning pink and Resident #1 clamped his mouth shut when the nurses attempted to suction him again.</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>Nursing staff stood Resident #1 up again and provided him additional abdominal thrusts. The note documented at 5:43 pm, Resident #1's physician was called and gave orders for the RN to call 911. The note documented Resident #1 coughed, lost consciousness, and was dusky. He was placed on the floor and abdominal thrusts were performed. In addition, the note documented, at 5:50 pm, Resident #1 had no heartbeat or respirations and when the emergency medical crew arrived, Resident #1 was declared dead.</p> <p>* An undated Summary of Investigation: Accidental Death Report - The report documented an initial coroner's report determined the cause of death for Resident #1 was mechanical asphyxia [airway obstruction or choking on a foreign object] from a food bolus in the trachea.</p> <p>An on-site visit was made to the facility on 12/16/16.</p> <p>Resident #1's Nurses' Note, dated 11/29/16, documented he had increased coughing after taking his bedtime medications and an order for a Speech Therapy evaluation and treatment was requested from the physician. Resident #1's December 2016 physicians' orders included an order, dated 11/29/16, for ST to evaluate and treat him.</p> <p>On 12/16/16 at 2:00 pm, the Therapy Director stated Resident #1 was served by a different SLP in the past. She said Resident #1 was discharged from services on 11/13/15, with SLP recommendations for a regular textured food diet</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>and for staff to refer him to speech therapy if his swallowing function declined. She stated she received an email, on 11/29/16, from RN #3 requesting speech therapy to evaluate and treat Resident #1 for increased coughing after taking medications. The Therapy Director stated her staff was waiting for a physician order before proceeding with an evaluation.</p> <p>On 11/29/16, the physician ordered ST to evaluate Resident #1's swallowing difficulties and initiate treatment. An evaluation was not initiated prior to his death on 12/2/16.</p> <p>During an interview on 12/16/16 at 11:45 am, LPN #2 stated he was assigned to start his shift in the dining room at 5:15 pm; however he was assisting another resident with his/her needs and was walking to the dining room at 5:20 pm. As he was walking to the dining room CNA #6 was pushing Resident #1 down the hall in his wheelchair towards him. LPN #2 stated Resident #1 was cyanotic and could not speak. However, Resident #1 could look at him and did respond to verbal commands to cough. LPN #2 stated he encouraged Resident #1 to cough, only Resident #1 was unable to cough with much force. LPN #2 stated when Resident #1 could not cough or clear his airway he instructed a CNA to take him to his room and another CNA to find the RN. LPN #2 stated he ran to get a suction machine from an O2 storage closet because it was close to his approximate location. He stated the crash cart was down in the dining room and the O2 storage closet was closer. LPN #2 met CNA #6 and Resident #1 in his room where he initiated suctioning of the food. LPN #2 stated the suction was able to get some small food particles out and</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>LPN #2 instructed Resident #2 to try and cough between suctioning. LPN #2 stated RN #2 entered Resident #1's room, and when Resident #1 was unable to cough at all the nurses started to perform the Heimlich maneuver. CNA #6 and #8 picked Resident #1 up into a standing position and LPN #2 performed 6-8 thrusts. He stated some food particles did come out. RN #2 was standing in front of Resident #1 and assessing him. LPN #2 stated RN #2 said Resident #1's airway was not clear and she would do thrusts. RN #2 performed 6 thrusts on Resident #1. LPN #2 stated he attempted to suction Resident #1 again and he clamped his mouth shut. LPN #2 stated he asked RN #2 to call Resident #1's physician while he took over the abdominal thrusts. LPN #2 stated he performed 6-10 thrusts with more pressure and Resident #1 was able to expel more food particles. LPN #2 stated at the 10th thrust Resident #1's physician told RN #2 to call 911. LPN #2 stated RN #2 took over performing thrusts and instructed him to go call 911. He stated he left the room and made the phone call to 911. In addition, LPN #2 stated he initially chose to use the suction machine on Resident #1 because he had a history of coughing often with meals and when staff tapped him on the back, Resident #1 would get upset; swat at their hands; and tell staff to not hit him because it hurt. LPN #2 stated he chose the suction because it was "less invasive."</p> <p>On 12/16/16 at 3:30 pm, CNA #6 stated she was called to assist another CNA in the dining room with a resident that appeared to be choking. CNA #6 stated Resident #1 was coughing when she approached him at approximately 5:25 pm [on 12/2/16]. CNA #6 stated Resident #6 did not say</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>anything, when asked if he was choking Resident #1 nodded his head. CNA #6 assisted with transporting Resident #1 from the dining room. She stated he continued coughing until they reached the nursing station. She stated he made eye contact but did not follow simple directions. CNA #6 stated when they reached Resident #1's room he was blue.</p> <p>The website mayoclinic.org states, the universal sign for choking is hands clutched to the throat. If the person does not give the signal, to look for these indications:</p> <ul style="list-style-type: none"> * Inability to talk * Difficulty breathing or noisy breathing * Inability to cough forcefully * Skin, lips and nails turning blue or dusky * Loss of consciousness <p>The facility's 6/20/16 policy, Obstructed Airway Intervention, instructed staff that if a resident was choking and could not speak, cough, or breathe, emergency medical services [EMS] was to be activated and subdiaphragmatic thrusts began [Heimlich maneuver].</p> <p>The undated Investigation Report received in the SA on 12/14/16, included an approximate time line of events. Key points included:</p> <ul style="list-style-type: none"> * 5:25 pm - A CNA noticed Resident #1 coughing, stating with difficulty, "I can't breathe." One CNA instructed another CNA to take Resident #1 from the dining room and find an LN. * 5:26 pm - The CNA took Resident to LPN #2 who was in the hall walking toward the dining room. LPN #2 assessed Resident #1 and 	F 323			

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F 323	<p>Continued From page 10</p> <p>described his skin as dusky in color. LPN #2 directed the CNA to pushed Resident #1 to his room while he got a suction machine.</p> <p>* 5:28 pm - Resident #1 was in his room, appeared "gurgley, and gasping for breath."</p> <p>* 5:29 pm - Resident #1 appeared dusky, non-verbal, and his eyes were open and pupils dilated. Resident #1's mouth was checked and no food observed. An unsuccessful suction attempt was completed with a small amount of food expelled.</p> <p>* 5:30 pm - Resident #1's skin was dusky and he appeared to be gasping for air. The Heimlich maneuver was attempted and some food was dislodged. Resident #1's skin appeared pinker. Suction was again attempted, however, Resident #1 clenched his teeth shut and suctioning could not be performed.</p> <p>* 5:43 pm - The Heimlich maneuver was attempted again without success. Resident #1's physician was called and the physician directed staff to call 911.</p> <p>* 5:44 pm - 911 was called.</p> <p>* 5:45 pm - Resident #1 was coughing and lost consciousness. Abdominal thrusts were continued without response.</p> <p>* 5:50 pm - Resident #1 was without a pulse and respirations.</p> <p>* 5:50 pm - Paramedics arrived [within 6 minutes of 911 call] and did not attempt further interventions.</p> <p>The first lifesaving intervention [suctioning] was initiated 4 minutes after Resident #1 began choking and stated he could not breathe. There was no further documentation of words spoken by Resident #1. The Heimlich maneuver was first attempted 5 minutes after the incident began. 911</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>was called 19 minutes after Resident #1 began choking and paramedics arrived 6 minutes later. The website BrainInjuryFoundation.org, states that without oxygen reaching the brain, irreversible brain damage starts to occur within 5 minutes. The facility failed to initiate appropriate, timely lifesaving measures necessary to sustain Resident #1's life.</p> <p>2. Professional standards of practice review and policy review included:</p> <p>a. The American Red Cross: Basic Life support for Healthcare Providers Handbook 2015, documented the practice to follow for individuals who are choking is:</p> <ul style="list-style-type: none"> * Ask the individual if s/he is choking and would the individual like assistance. * Notify the individual that you are trained to assist him/her. * If the individual cannot breathe or has a weak or ineffective cough, initiation of the Heimlich maneuver is required. * Emergency response [EMS] should be called if the individual was identified as requiring the Heimlich maneuver. * Deliver "abdominal thrusts until the object is forced out; the person can cough, speak or breathe; or the patient becomes unconscious." * If an individual has lost consciousness, immediately initiate CPR, starting with chest compressions. <p>In addition, the handbook documented a blind finger sweep [when an object is not observed in the mouth] was not to be performed and to continue CPR. The handbook documented</p>	F 323			

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F 323	<p>Continued From page 12 further to "never try more than 2 ventilations during one cycle of CPR, even if the chest doesn't rise."</p> <p>b. The facility's Obstructed Airway Interventions Policy and Procedure, revised 6/20/16, documented if a resident was choking EMS was to be activated, and if the resident was conscious, the Heimlich maneuver initiated. If the resident became unconscious staff was to open the resident's mouth and look for the object. If they saw the object they were instructed to remove it with their finger. If objects were not visualized, staff was to open the resident's airway by tilting the head and attempting two rescue breaths. If the chest did not "clearly" rise, staff was instructed to re-tilt the head and perform another rescue breath. If the chest continued to not rise, staff was instructed to begin CPR.</p> <p>Facility staff failed to promptly initiate the Heimlich maneuver while Resident #1 was conscious, as instructed in the facility's policy. Additionally, the facility's Policy and Procedure for Obstructed Airway Interventions was inconsistent with the standards of practice described in the American Red Cross: Basic Life support for Healthcare Providers Handbook 2015. The facility's policy did not instruct staff to immediately initiate CPR if the choking resident became unconscious.</p> <p>c. The facility's Cardiac and/or Respiratory Arrest Policy and Procedure, revised 11/30/15, documented if a resident had a DNR order, CPR and ALS would not be initiated. However, under certain emergency circumstances, a resident who had a DNR order would be provided</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>lifesaving treatment; for example if they were choking, staff would initiate obstructed airway interventions.</p> <p>On 12/16/16 at 2:50 pm, the DNS stated that the nursing staff watched videos for training on CPR and choking. He stated there was information in a book on the crash cart regarding how to manage choking. The DNS stated that in the case of Resident #1, the staff did not use the crash cart and probably did not look at the book. The DNS stated rescue breathing was not initiated by the staff, and they did not check the heart rate. The DNS stated the reason the rescue breaths and heart rates were not check was because Resident #1 was alert, his eyes were open, and he was coughing. They did not check for pulse. The DNS stated the RN checked Resident #1's airway but Resident #1 went quickly from staff completing abdominal thrusts to loss of consciousness. The DNS was asked if the staff recognized the signs of an occluded airway vs a restricted airway. The DNS stated Resident #1 was coughing and talking. He stated his staff would not initiate the Heimlich maneuver due to trauma, which may cause the foreign object to become lodged. The DNS stated Resident #1's cough was hard and forceful, and then became weak. The DNS was unable "to speculate why the resident's cough weakened." He stated the initiation of the Heimlich, when someone was choking, was when there was no airway; no talking; and no coughing.</p> <p>On 12/16/16 at 3:00 pm, the Administrator and DNS stated the facility's corporate office required CNAs to be CPR certified. The DNS stated he initiated an "After-Action Assessment review,"</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>spoke with staff regarding the event. The DNS stated each licensed nurse should be familiar with how to respond in accordance with the facility's policy and procedure and CNAs need to be able to recognize and identify episode of choking. CNAs were considered to be first responders. The DNS stated CNAs Scope of Practice "does not include assessment."</p> <p>The American Red Cross: Basic Life Support for Healthcare Providers Handbook, 2015, documented a definition for Scope of Practice as being: "The range of duties and skills you acquire in training that authorizes you to perform by your certification to practice."</p> <p>3. Interviews with staff on how they would respond to residents who were choking:</p> <p>* On 12/16/16 at 7:30 am, CNA #1 was in the dining room preparing to serve residents breakfast. She stated several residents had difficulty with swallowing and, "They sit in the back. More will be coming that [area] will be full." She stated she received her CPR certification a year and a half ago and commented, "I have been trained." She stated that if she encountered a resident choking she would take care of them the best she could. She said she would have someone run for help and check to see if the resident was breathing. She said nurse should come soon and by then she would put the resident on the floor and help the resident clear the food from the his/her airway. She further stated, "I might have to do the Heimlich, it is so hard, I have not had to do it. Both CNAs and nurses are usually always close. Have the resident take a drink if they are talking to me to</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>try to clear it." Asked if she had read the facility's Policy and Procedure for obstructed airway, CNA #1 stated, "I imagine so, I am not positive. I know they are always having us read."</p> <p>* On 12/16/16 at 7:48 am, LPN #2 stated he would recognize a choking victim when they used the "universal sign of choking," of placing hands to the throat; were unable to talk; had changes to their skin color; and had a panicked look on their faces. He stated he would initiate the Heimlich maneuver if he came across someone choking. LPN #2 stated his most recent CPR training had been before he started working at the facility and he had been there for 11 months. He stated the facility had provided an in-service on managing choking incidences earlier that week.</p> <p>* On 12/16/16 at 7:50 am, Unit Manager LPN #1 was assigned to the medication cart which was positioned just outside the dining room. She stated she was still in orientation and was currently reviewing the Policy and Procedures in the training. She stated she received her CPR certification in July 2015. She stated that if she encountered a resident choking, she would assess them and encourage them to cough for about a minute. LPN #1 further stated, "I would provide privacy; probably take them to their room." Unit Manager LPN #1 stated if a resident was unconscious she would start the Heimlich and if not breathing she would begin compressions and suction if indicated to dislodge the piece of food.</p> <p>* On 12/16/16 at 7:50 am, CNA #10 stated she would recognize choking if the resident started to cough. She stated if the resident was obviously</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>not breathing, she would probably do the Heimlich. She would have to decide whether to do it in the dining room or not, depending on how the resident looked due to the potential for it being traumatic for other residents to see. CNA #10, employed in her position for the last 3-4 months, stated the decision would be made based on color. If the resident was blue she would initiate the Heimlich maneuver in the dining room; if not blue, take them out to do it. CNA #10 said she was trained on the Heimlich maneuver 1-2 months ago as part of CPR training. She stated she had no training on the Heimlich/choking response since that time.</p> <p>* On 12/16/16 at 8:00 am, CNA #9 stated she would recognize that a resident was choking by their facial expression and coughing. CNA #9 stated she would encourage the resident to cough and send another CNA to get a nurse. If the resident was not breathing, she would lift the resident's arms over his/her head. If the resident was still not breathing, she would do CPR but would first check the facial expression to see if the resident's color was purple or blue. When asked if she had been trained in the Heimlich maneuver, CNA #9 asked "What is the Heimlich maneuver? I don't know this, should I have been to a class?"</p> <p>* On 12/16/16 at 8:12 am, Activities Assistant #1 stated she would recognize a choking victim if they were not coughing and turning gray. She stated she would tell a RN or CNA and let them handle the situation if she came upon someone choking; she would not intervene.</p> <p>* On 12/16/16 at 8:15 am, CNA #2 stated there</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>were usually 3 CNAs present in the dining room for breakfast, 4 for lunch, and 3 for dinner. She stated there was usually a nurse there. CNA #2 stated she received CPR certification 11/2015. She stated if she encountered a resident choking, she would either encourage them to cough or start the Heimlich, mostly keep encouraging them to cough it up. She stated she would not pat them on the back. She stated she would start CPR (chest compressions and breathing). CNA #2 had been employed in her position for a year. She stated she had not seen mock codes for choking used for training.</p> <p>* On 12/16/16 at 8:22 am, the Activities Director stated she would recognize a choking victim if they were coughing. She stated she would put the person's hands up above the head if they were coughing and get an RN or CNA to assist. When asked if there was any immediate action she would take, she stated she would start by checking if an object was in the mouth and remove the object if seen. If she could not see the object she would initiate CPR. The Activities Director stated she had CPR training in the past.</p> <p>* On 12/16/16 at 8:31 am, CNA #4 stated she would recognize a choking victim when the resident used the "universal sign of choking," of placing hands to the throat; were unable to talk; and turned red. She stated she would ask the resident if s/he was ok, and pat the resident on the back. If the resident did not respond she would get an RN. CNA #4 stated she had CPR training recently and the facility had done an in-service earlier that week as a refresher. In addition, she stated someone had choked last week and had passed away.</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>* On 12/16/16 at 8:40 am, CNA #3 stated assignments for the dining room were communicated on Hall assignments. She stated they rotate but are very clear. CNA #3 has been in her position for approximately 2 and ½ years with her current CPR certification valid until sometime in 2018. She stated she has not participated in mock codes as continued training during her employment. CNA #3 stated that if she encountered a resident choking, she would assess them, encourage them to breathe and cough. "If the airway was blocked, I would call for help and start the Heimlich maneuver. I would visually check the airway before performing the Heimlich, finger sweep if they could not open their mouth on their own. I would begin the process of CPR on the ground, chest compressions and rescue breathing." CNA #3 stated she would do this where the resident was because it was an emergency. CNA #3 stated she had read the policy and procedure on obstructed airway but could not remember the date.</p> <p>* On 12/16/16 at 8:42 am, CNA #5 stated she would recognize a choking victim if they were coughing and turned blue. She stated she would ask the resident if s/he were ok, have them try to cough harder, and see if the person could talk. If the resident did not respond she would get an RN. CNA #5 stated she would initiate the Heimlich maneuver when they stopped coughing. CNA #5 stated she had CPR training recently and the facility had done an in-service earlier that week, which she was unable to attend. She did not know when the next in-service was scheduled. In addition, she stated someone had</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>choked last week and they had passed away.</p> <p>* On 12/16/16 at 8:50 am, LPN #3 stated she would recognize a choking victim when the person used the "universal sign of choking," of placing hands to the throat and were unable to speak. She stated she would initiate the Heimlich maneuver in the dining room, to try and clear the airway as fast as possible, if she came across someone choking. In addition, she stated she would perform finger sweeps to try and get the food out. She stated she was current on her CPR and the facility had done an in-service earlier that week because there was a resident who had died a couple weeks ago from choking.</p> <p>4. Interview with the DNS:</p> <p>On 12/16/16 at 2:50 pm, the DNS stated staff interviews were completed following the event. He stated LPN #2 was a newer nurse, scared and not confident. RN #2 tried the Heimlich maneuver and noticed some small pieces of food. Resident #1's color turned from gray to pink. Resident #1 was "gurgly with a little bit of airway." The DNS stated Resident #1 never put his hands to his throat during the incident. The DNS said RN #2 called the physician first rather than EMS as Resident #1 was alert, e.g., his eyes were open. The DNS stated LPN #2 completed another abdominal thrust, and "wrenched quite hard." The DNS stated RN #2 then directed 911 be called as Resident #1's condition was deteriorating. Resident #1 then coughed hard and passed out. The DNS said Resident #1 was lowered to the floor with RN #2 performing abdominal thrusts until she became winded. At that time, CNA #6 assumed the task.</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>The DNS said by that time Resident #1 had passed and CPR was not initiated. The DNS stated the staff removed Resident #1 from the dining room for his dignity.</p> <p>5. Emergency preparedness information included:</p> <p>On 12/16/16 at 1:45 pm, Unit Manager RN #1 was asked for the location of the Crash Carts used during emergencies. RN #1 walked to the dining room where the crash cart was positioned against the outside wall. RN #1 stated she had worked for the facility for 3 years and the crash cart had been in that spot "for as long as I have worked here." The crash cart was observed to have a suction machine set up with tubing attached to a suction catheter. An oxygen tank was on the side of the cart. The drawers were labeled to identify the equipment in each drawer which included an ambu-bag, mouth barrier, gloves, and other misc. items.</p> <p>On 12/16/16 at 1:45 pm, RN #1 stated the unit managers help out in the dining room when needed. RN #1 said medication nurses were assigned to the dining room during meals. RN #1 stated the facility did stage mock codes, and the last one was within the last 6 months.</p> <p>As noted in example 1 above, during the choking episode Resident #1 was removed from the dining room, which included a suction machine and crash cart, and taken to his room. The Heimlich maneuver was not initiated and rescue efforts were further delayed as staff retrieved a suction machine from another location in the facility.</p>	F 323			

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F 323	Continued From page 21 6. Training after the 12/2/16 incident included: An In-Service Sign - In Sheet, dated 12/12/16, documented titles of "Choking and how to respond," "Supervision in the dining room," and "Heimlich maneuver" as documented topics of staff training. Eleven signatures were on the sign-in sheet dated 12/12/16. Upon review of the In-Service Sign-In Sheet and the Staff Assignment Sheets, all staff members who worked since 12/2/16 were not educated on the above topics. On 12/16/16 at 2:50 pm, the DNS was asked why the staff education started 10 days after the event. The DNS stated "Because you [SA] called, I had to re-look." The facility did not ensure its policies and procedures were followed when Resident #1 experienced a choking episode. The Heimlich maneuver was not initiated timely, EMS was not notified promptly, CPR was not initiated, interventions attempted were not consistent with current standards of practice, and a policy and procedure was not current with standards of practice. Removal of Immediate Jeopardy: Facility Administration was informed of the Immediate Jeopardy and the need to develop and implement an acceptable plan to remove the Immediacy at 5:25 pm on 12/16/16. On 12/19/16 at 3:20 pm, the facility provided evidence that an acceptable plan to remove the	F 323			

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F 323	<p>Continued From page 22</p> <p>immediacy had been developed and implemented. The plan included:</p> <ul style="list-style-type: none"> * Prior to the their next scheduled shift, each nursing staff would be re-educated by a CPR Certified Instructor on Obstructed Airway Intervention Procedures and staff competency demonstrated through return demonstration. * The facility's daily staff assignment sheets were updated to ensure adequate CNA and licensed nursing personnel were supervising the dining room during meal times. * Licensed nurses were educated that they could not leave the dining room while residents were eating until relieved by another licensed nurse. In addition, the education was provided by the Executive Director. * Any nursing staff who was not present for the education and training would not work until they had completed the training. * The facility provided re-education to the nursing staff on rounding during meal times and observing residents for swallowing difficulties. The facility added education to its skills orientation, and a requirement for an annual verification of competency. <p>The facility documented the plan would be implemented and the Immediate Jeopardy removed effective 12/20/16.</p> <p>An on-site IJ follow up survey was completed on 12/21/16. Implementation and compliance with the above IJ removal plan was verified and the</p>	F 323			

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F 323	Continued From page 23 Administrator and DNS were informed the Immediate Jeopardy was removed effective 12/20/16.	F 323			
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a	F 353		1/11/17	

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F 353	<p>Continued From page 24</p> <p>licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and review of the facility's investigations and policy, it was determined the facility failed to ensure nursing staff were competent to perform lifesaving interventions for residents who were choking. This was true for 1 or 4 sampled residents (Resident #1). This deficient practice resulted in a lack of appropriate and timely responses to Resident #1 as he was choking, which culminated in his death. It also created the potential for all residents who consumed food orally, to receive delayed, or lack of, appropriate interventions for a choking episode, due staff incompetence. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 5/2/16, with diagnoses which included Parkinson's disease and dementia.</p> <p>Resident #1's Nutrition Care Plan, revised 12/8/16, documented interventions including:</p> <p>* Provide Resident #1's diet as ordered by the</p>	F 353	<p>Resident affected: Resident #1 discharged from Genesis Meridian Center on 12/02/2016.</p> <p>Other Residents with the potential to be affected: On December 19th, 20th, or before next scheduled shift the Nursing Staff were reeducated by a CPR certified instructor on the Obstructed Airway Intervention Procedure with correlating return demonstration to validate competency testing.</p> <p>Licensed Nurses and Certified Nursing Assistant staff were reeducated by a CPR certified instructor on recognition of airway emergencies.</p> <p>Staff daily assignments sheets were updated to include CNA, and licensed nursing dining room assignments to ensure adequate dining room supervision.</p>		

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F 353	<p>Continued From page 25</p> <p>physician, revised 12/8/16.</p> <p>* Honor Resident #1's food preferences within his meal plan, revised 12/8/16.</p> <p>* Staff to encourage Resident #1 to chew and swallow each bite, revised 12/8/16.</p> <p>Resident #1's December 2016 physicians' orders documented:</p> <p>* Resident #1 was to receive a regular/liberalized diet, initiated on 5/2/16.</p> <p>* Resident #1 had a DNR order, initiated on 5/2/16.</p> <p>* Speech Therapy was to evaluate and treat Resident #1 for increased swallowing difficulties, ordered on 11/29/16.</p> <p>On 12/9/16, the facility submitted a self-reported Summary of Investigation to the State Agency [SA] which documented Resident #1 choked during the evening meal on 12/2/16, and died of asphyxia. The investigation did not include a review of staff's compliance with facility policies and procedures or if staff's actions in response to the choking were consistent with current standards of practice. The SA contacted the facility on 12/12/16 and requested further information.</p> <p>On 12/14/16 the facility provided the following additional information to the SA:</p> <p>* An undated Investigation Report - The Report documented that on 12/2/16 at 5:20 pm, CNA #6 provided a dinner tray to Resident #1 which contained chicken, potatoes, squash, and a biscuit, and offered to cut up the chicken.</p>	F 353	<p>Licensed nurses were educated that they cannot leave the dining room while residents are eating until they are relieved by another licensed staff member to ensure licensed nurse supervision in the dining room during meal times by the Executive Director or designee.</p> <p>Any Nursing Staff that were not available for education and training on December 19th or 20th will not work until the above actions are completed (including education completed by a CPR certified instructor) and competency is demonstrated.</p> <p>Systemic Change: A review of the centers policy for managing an obstructed airway, and CPR were reviewed by the Center Nurse Executive on 12/17/2016. The Center policy for obstructed airway was updated by Sr. Director, Clinical Operations and Corporate Policies and Procedures Genesis HealthCare to reflect current standards of practice by the center IDT on 12/19/2016.</p> <p>On or before 12/20/2016 Licensed nurses and CNA's were re-educated by a CPR</p>		

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F 353	<p>Continued From page 26</p> <p>* An undated Incident Report Witness Statement from CNA #7 - CNA #7 documented Resident #1 received his dinner meal at approximately 5:15 pm. CNA #7 stated she heard someone coughing and turned and saw Resident #1 touching his throat and struggling to breathe. CNA #7 went to Resident #1's side and tapped him on the back to make sure he was sitting in an upright position. CNA #7 encouraged Resident #1 to cough and noticed Resident #1's face had turned red from trying to cough and expel the food. CNA #7 asked CNA #6 for assistance in locating a nurse. CNA #6 stated the RN had stepped out of the dining room. CNA #7 asked CNA #6 to take Resident #1 from the dining room to find an RN.</p> <p>* An undated Incident Report Witness Statement from CNA #6 - The statement documented CNA #6 "rushed" Resident #1 to LPN #2 who was in the hall. LPN #2 instructed CNA #6 to take Resident #1 to his room and LPN #2 would be there quickly with a suction machine. The statement documented LPN #2 tried using the suction machine and when it was not successful the nursing staff started the Heimlich maneuver. In addition, the statement documented the two CNAs stood Resident #1 up while LPN #2 performed the Heimlich maneuver. The statement documented Resident #1 had to be lowered to the floor and abdominal thrusts were attempted.</p> <p>* An undated Incident Report Witness Statement from CNA #8 - The statement documented CNA #8 went to assist CNA #6 when she heard her calling for help in the hallway. The statement documented Resident #1 was red in color and was coughing hard and CNA #8 encouraged</p>	F 353	<p>certified instructor on managing an obstructed airway intervention Procedure (policy updated 12/19/2016) and emergency recognition with correlating return demonstration to validate competency testing.</p> <p>A review of new orders including but not limited therapy evaluations will be reviewed during the morning clinical meetings with Director of Rehab or designee present to validate acknowledgement of orders and evaluations schedule.</p> <p>Obstructed Airway and emergency recognition training will be completed at time of new hire skilled training and annually thereafter.</p> <p>Audit Beginning 12/19/2016 weekly dining room assignment audits will be completed by Center Executive Director or designee to validate Licensed Nurse supervision in dining room schedule as assigned.</p> <p>Beginning the week of 12/19/2016, weekly audits of newly hired direct care staff will be completed Center Nurse Executive or Designee to validate that Obstructed Airway and Emergency Recognition was completed during skills portion of orientation.</p> <p>The results of these audits will be compiled by the Center Nurse Executive and reported to the QAPI committee for</p>		

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F 353	<p>Continued From page 27</p> <p>Resident #1 to continue coughing. CNA #8 continued to wheel Resident #1 down to towards the nurses' station where LPN #2 was located. CNA #8 documented Resident #1's face turned a dusky/gray color. LPN #2 instructed CNA #8 to take Resident #1 to his room while he grabbed the suction machine. While LPN #2 suctioned Resident #1's mouth, he was able to dislodge small pieces of chicken. CNA #8 documented Resident #1 was stood up and the Heimlich maneuver was performed. She described Resident #1 as taking raspy breaths. Staff sat Resident #1 in his wheelchair and the nursing staff attempted to suction him again. The nurses stood him up again and tried the Heimlich maneuver. CNA #8 documented Resident #1 was losing his color after another unsuccessful attempt with the Heimlich maneuver. After the failed attempt they laid him on the floor and initiated abdominal thrusts. She documented Resident #1 passed away.</p> <p>* An undated Incident Report Witness Statement from LPN #2 - The report documented that on 12/2/16 at 5:25 pm, LPN #2 stated he was heading to the dining room, when CNA #6 met him in the hall and told him Resident #1 was choking. LPN #2 instructed one of the CNAs to get the RN, and directed the other to take Resident #1 to his room. LPN #2 stated he got a suction machine and tried to suction and clear Resident #1's airway. After a bit, RN #2 entered the room and the nurses started to perform the Heimlich maneuver. LPN #2 was able to get some food particles out, however Resident #1 remained cyanotic and did not respond to verbal stimuli. The statement documented LPN #2 continued to perform the Heimlich maneuver and</p>	F 353	review monthly X3 months or until substantial compliance is sustained. The Center Nurse Executive is responsible for monitoring and follow-up.		

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F 353	<p>Continued From page 28</p> <p>RN #2 called Resident #1's physician. The physician instructed the staff to call 911. RN #2 took over performing the Heimlich maneuver while LPN #2 left the room and called 911. When LPN #2 returned to the room, Resident #1 was on the floor and non-responsive. The paramedics declared Resident #1 dead when they arrived.</p> <p>* Summary of an interview facility staff completed with LPN #2 - The summary documented LPN #2 as stating Resident #1's room was approximately 125 feet from the dining room and when he went to grab the suction machine he was "...only away [from Resident #1] maybe two minutes while I got the equipment."</p> <p>* Copy of RN #2's 12/2/16 Nurses' Note as an Incident Report Witness Statement from RN #2 - Resident #1's Nurses' Note, dated 12/2/16, documented RN #2 was notified at 5:30 pm, that Resident #1 was possibly choking on food. Another LN had taken Resident #1 to his room and begun an assessment. The note documented Resident #1's face was dusky and he presented with "taking gasping respirations with mucus heard in [his] airway." In addition, it documented Resident #1 did not respond to verbal stimuli. The note documented the Heimlich maneuver was performed by LPN #2 and several small food particles were expelled. RN #2 took over the thrusts and more food particles were expelled. Resident #1's facial color was turning pink and Resident #1 clamped his mouth shut when the nurses attempted to suction him again. Nursing staff stood Resident #1 up again and provided him additional abdominal thrusts. The note documented at 5:43 pm, Resident #1's physician was called and gave orders for the RN</p>	F 353			

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F 353	<p>Continued From page 29</p> <p>to call 911. The note documented Resident #1 coughed, lost consciousness, and was dusky. He was placed on the floor and abdominal thrusts were performed. In addition, the note documented, at 5:50 pm, Resident #1 had no heartbeat or respirations and when the emergency medical crew arrived, Resident #1 was declared dead.</p> <p>* An undated Summary of Investigation: Accidental Death Report - The report documented an initial coroner's report determined the cause of death for Resident #1 was mechanical asphyxia [airway obstruction or choking on a foreign object] from a food bolus in the trachea.</p> <p>An on-site visit was made to the facility on 12/16/16.</p> <p>During an interview on 12/16/16 at 11:45 am, LPN #2 stated he was assigned to start his shift in the dining room at 5:15 pm; however he was assisting another resident with his/her needs and was walking to the dining room at 5:20 pm. As he was walking to the dining room CNA #6 was pushing Resident #1 down the hall in his wheelchair towards him. LPN #2 stated Resident #1 was cyanotic and could not speak. However, Resident #1 could look at him and did respond to verbal commands to cough. LPN #2 stated he encouraged Resident #1 to cough, only Resident #1 was unable to cough with much force. LPN #2 stated when Resident #1 could not cough or clear his airway he instructed a CNA to take him to his room and another CNA to find the RN. LPN #2 stated he ran to get a suction machine from an O2 storage closet because it was close to his</p>	F 353			

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F 353	Continued From page 30 approximate location. He stated the crash cart was down in the dining room and the O2 storage closet was closer. LPN #2 met CNA #6 and Resident #1 in his room where he initiated suctioning of the food. LPN #2 stated the suction was able to get some small food particles out and LPN #2 instructed Resident #2 to try and cough between suctioning. LPN #2 stated RN #2 entered Resident #1's room, and when Resident #1 was unable to cough at all the nurses started to perform the Heimlich maneuver. CNA #6 and #8 picked Resident #1 up into a standing position and LPN #2 performed 6-8 thrusts. He stated some food particles did come out. RN #2 was standing in front of Resident #1 and assessing him. LPN #2 stated RN #2 said Resident #1's airway was not clear and she would do thrusts. RN #2 performed 6 thrusts on Resident #1. LPN #2 stated he attempted to suction Resident #1 again and he clamped his mouth shut. LPN #2 stated he asked RN #2 to call Resident #1's physician while he took over the abdominal thrusts. LPN #2 stated he performed 6-10 thrusts with more pressure and Resident #1 was able to expel more food particles. LPN #2 stated at the 10th thrust Resident #1's physician told RN #2 to call 911. LPN #2 stated RN #2 took over performing thrusts and instructed him to go call 911. He stated he left the room and made the phone call to 911. In addition, LPN #2 stated he initially chose to use the suction machine on Resident #1 because he had a history of coughing often with meals and when staff tapped him on the back, Resident #1 would get upset; swat at their hands; and tell staff to not hit him because it hurt. LPN #2 stated he chose the suction because it was "less invasive."	F 353			

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F 353	<p>Continued From page 31</p> <p>On 12/16/16 at 3:30 pm, CNA #6 stated she was called to assist another CNA in the dining room with a resident that appeared to be choking. CNA #6 stated Resident #1 was coughing when she approached him at approximately 5:25 pm [on 12/2/16]. CNA #6 stated Resident #6 did not say anything, when asked if he was choking Resident #1 nodded his head. CNA #6 assisted with transporting Resident #1 from the dining room. She stated he continued coughing until they reached the nursing station. She stated he made eye contact but did not follow simple directions. CNA #6 stated when they reached Resident #1's room he was blue.</p> <p>The website mayoclinic.org states, the universal sign for choking is hands clutched to the throat. If the person does not give the signal, to look for these indications:</p> <ul style="list-style-type: none"> * Inability to talk * Difficulty breathing or noisy breathing * Inability to cough forcefully * Skin, lips and nails turning blue or dusky * Loss of consciousness <p>The facility's 6/20/16 policy, Obstructed Airway Intervention, instructed staff that if a resident was choking and could not speak, cough, or breathe, emergency medical services [EMS] was to be activated and subdiaphragmatic thrusts began [Heimlich maneuver].</p> <p>The undated Investigation Report received in the SA on 12/14/16, included an approximate time line of events. Key points included:</p> <ul style="list-style-type: none"> * 5:25 pm - A CNA noticed Resident #1 coughing, 	F 353			

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F 353	Continued From page 32 stating with difficulty, "I can't breathe." One CNA instructed another CNA to take Resident #1 from the dining room and find an LN. * 5:26 pm - The CNA took Resident to LPN #2 who was in the hall walking toward the dining room. LPN #2 assessed Resident #1 and described his skin as dusky in color. LPN #2 directed the CNA to pushed Resident #1 to his room while he got a suction machine. * 5:28 pm - Resident #1 was in his room, appeared "gurgley, and gasping for breath." * 5:29 pm - Resident #1 appeared dusky, non-verbal, and his eyes were open and pupils dilated. Resident #1's mouth was checked and no food observed. An unsuccessful suction attempt was completed with a small amount of food expelled. * 5:30 pm - Resident #1's skin was dusky and he appeared to be gasping for air. The Heimlich maneuver was attempted and some food was dislodged. Resident #1's skin appeared pinker. Suction was again attempted, however, Resident #1 clenched his teeth shut and suctioning could not be performed. * 5:43 pm - The Heimlich maneuver was attempted again without success. Resident #1's physician was called and the physician directed staff to call 911. * 5:44 pm - 911 was called. * 5:45 pm - Resident #1 was coughing and lost consciousness. Abdominal thrusts were continued without response. * 5:50 pm - Resident #1 was without a pulse and respirations. * 5:50 pm - Paramedics arrived [within 6 minutes of 911 call] and did not attempt further interventions.	F 353			

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F 353	<p>Continued From page 33</p> <p>The first lifesaving intervention [suctioning] was initiated 4 minutes after Resident #1 began choking and stated he could not breathe. There was no further documentation of words spoken by Resident #1. The Heimlich maneuver was first attempted 5 minutes after the incident began. 911 was called 19 minutes after Resident #1 began choking and paramedics arrived 6 minutes later. The website BrainInjuryFoundation.org, states that without oxygen reaching the brain, irreversible brain damage starts to occur within 5 minutes. The facility failed to initiate appropriate, timely lifesaving measures necessary to sustain Resident #1's life.</p> <p>2. Professional standards of practice review and policy review included:</p> <p>a. The American Red Cross: Basic Life support for Healthcare Providers Handbook 2015, documented the practice to follow for individuals who are choking is:</p> <ul style="list-style-type: none"> * Ask the individual if s/he is choking and would the individual like assistance. * Notify the individual that you are trained to assist him/her. * If the individual cannot breathe or has a weak or ineffective cough, initiation of the Heimlich maneuver is required. * Emergency response [911/EMS] should be called if the individual was identified as requiring the Heimlich maneuver. * Deliver "abdominal thrusts until the object is forced out; the person can cough, speak or breathe; or the patient becomes unconscious." * If an individual has lost consciousness, immediately initiate CPR, starting with chest 	F 353			

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F 353	<p>Continued From page 34 compressions.</p> <p>In addition, the handbook documented a blind finger sweep [when an object is not observed in the mouth] was not to be performed and to continue CPR. The handbook documented further to "never try more than 2 ventilations during one cycle of CPR, even if the chest doesn't rise."</p> <p>b. The facility's Obstructed Airway Interventions Policy and Procedure, revised 6/20/16, documented if a resident was choking EMS was to be activated, and if the resident was conscious, the Heimlich maneuver initiated. If the resident became unconscious staff was to open the resident's mouth and look for the object. If they saw the object they were instructed to remove it with their finger. If objects were not visualized, staff was to open the resident's airway by tilting the head and attempting two rescue breaths. If the chest did not "clearly" rise, staff was instructed to re-tilt the head and perform another rescue breath. If the chest continued to not rise, staff was instructed to begin CPR.</p> <p>Facility staff failed to promptly initiate the Heimlich maneuver while Resident #1 was conscious, as instructed in the facility's policy. Additionally, the facility's Policy and Procedure for Obstructed Airway Interventions was inconsistent with the standards of practice described in the American Red Cross: Basic Life support for Healthcare Providers Handbook 2015. The facility's policy did not instruct staff to immediately initiate CPR if the choking resident became unconscious.</p>	F 353			

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F 353	<p>Continued From page 35</p> <p>c. The facility's Cardiac and/or Respiratory Arrest Policy and Procedure, revised 11/30/15, documented if a resident had a DNR order, CPR and ALS would not be initiated. However, under certain emergency circumstances, a resident who had a DNR order would be provided lifesaving treatment; for example if they were choking, staff would initiate obstructed airway interventions.</p> <p>On 12/16/16 at 2:50 pm, the DNS stated that the nursing staff watched videos for training on CPR and choking. He stated there was information in a book on the crash cart regarding how to manage choking. The DNS stated that in the case of Resident #1, the staff did not use the crash cart and probably did not look at the book. The DNS stated rescue breathing was not initiated by the staff, and they did not check the heart rate. The DNS stated the reason the rescue breaths and heart rates were not check was because Resident #1 was alert, his eyes were open, and he was coughing. They did not check for pulse. The DNS stated the RN checked Resident #1's airway but Resident #1 went quickly from staff completing abdominal thrusts to loss of consciousness. The DNS was asked if the staff recognized the signs of an occluded airway vs a restricted airway. The DNS stated Resident #1 was coughing and talking. He stated his staff would not initiate the Heimlich maneuver due to trauma, which may cause the foreign object to become lodged. The DNS stated Resident #1's cough was hard and forceful, and then became weak. The DNS was unable "to speculate why the resident's cough weakened." He stated the initiation of the Heimlich, when someone was choking, was when there was no airway; no</p>	F 353			

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F 353	<p>Continued From page 36 talking; and no coughing.</p> <p>On 12/16/16 at 3:00 pm, the Administrator and DNS stated the facility's corporate office required CNAs to be CPR certified. The DNS stated he initiated an "After-Action Assessment review," spoke with staff regarding the event. The DNS stated each licensed nurse should be familiar with how to respond in accordance with the facility's policy and procedure and CNAs need to be able to recognize and identify episodes of choking. CNAs were considered to be first responders. The DNS stated CNAs Scope of Practice "does not include assessment."</p> <p>The American Red Cross: Basic Life Support for Healthcare Providers Handbook, 2015, documented a definition for Scope of Practice as being: "The range of duties and skills you acquire in training that authorizes you to perform by your certification to practice."</p> <p>3. Interviews with staff on how they would respond to residents who were choking:</p> <p>* On 12/16/16 at 7:30 am, CNA #1 was in the dining room preparing to serve residents breakfast. She stated several residents had difficulty with swallowing and, "They sit in the back. More will be coming that [area] will be full." She stated she received her CPR certification a year and a half ago and commented, "I have been trained." She stated that if she encountered a resident choking she would take care of them the best she could. She said she would have someone run for help and check to see if the resident was breathing. She said nurse should come soon and by then she would put the</p>	F 353			

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F 353	<p>Continued From page 37</p> <p>resident on the floor and help the resident clear the food from the his/her airway. She further stated, "I might have to do the Heimlich, it is so hard, I have not had to do it. Both CNAs and nurses are usually always close. Have the resident take a drink if they are talking to me to try to clear it." Asked if she had read the facility's Policy and Procedure for obstructed airway, CNA #1 stated "I imagine so, I am not positive. I know they are always having us read."</p> <p>* On 12/16/16 at 7:48 am, LPN #2 stated he would recognize a choking victim when they used the "universal sign of choking," of placing hands to the throat; were unable to talk; had changes to their skin color; and had a panicked look on their faces. He stated he would initiate the Heimlich maneuver if he came across someone choking. LPN #2 stated his most recent CPR training had been before he started working at the facility and he had been there for 11 months. He stated the facility had provided an in-service on managing choking incidences earlier that week.</p> <p>* On 12/16/16 at 7:50 am, Unit Manager LPN #1 was assigned to the medication cart which was positioned just outside the dining room. She stated she was still in orientation and was currently reviewing the Policy and Procedures in the training. She stated she received her CPR certification in July 2015. She stated that if she encountered a resident choking, she would assess them and encourage them to cough for about a minute. LPN #1 further stated, "I would provide privacy; probably take them to their room." Unit Manager LPN #1 stated if a resident was unconscious she would start the Heimlich and if not breathing she would begin</p>	F 353			

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F 353	<p>Continued From page 38</p> <p>compressions and suction if indicated to dislodge the piece of food.</p> <p>* On 12/16/16 at 7:50 am, CNA #10 stated she would recognize choking if the resident started to cough. She stated if the resident was obviously not breathing, she would probably do the Heimlich. She would have to decide whether to do it in the dining room or not, depending on how the resident looked due to the potential for it being traumatic for other residents to see. CNA #10, employed in her position for the last 3-4 months, stated the decision would be made based on color. If the resident was blue she would initiate the Heimlich maneuver in the dining room; if not blue, take them out to do it. CNA #10 said she was trained on the Heimlich maneuver 1-2 months ago as part of CPR training. She stated she had no training on the Heimlich/choking response since that time.</p> <p>* On 12/16/16 at 8:00 am, CNA #9 stated she would recognize that a resident was choking by their facial expression and coughing. CNA #9 stated she would encourage the resident to cough and send another CNA to get a nurse. If the resident was not breathing, she would lift the resident's arms over his/her head. If the resident was still not breathing, she would do CPR but would first check the facial expression to see if the resident's color was purple or blue. When asked if she had been trained in the Heimlich maneuver, CNA #9 asked "What is the Heimlich maneuver? I don't know this, should I have been to a class?"</p> <p>* On 12/16/16 at 8:15 am, CNA #2 stated there were usually 3 CNAs present in the dining room</p>	F 353			

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F 353	<p>Continued From page 39</p> <p>for breakfast, 4 for lunch, and 3 for dinner. She stated there was usually a nurse there. CNA #2 stated she received CPR certification 11/2015. She stated if she encountered a resident choking, she would either encourage them to cough or start the Heimlich, mostly keep encouraging them to cough it up. She stated she would not pat them on the back. She stated she would start CPR (chest compressions and breathing). CNA #2 had been employed in her position for a year. She stated she had not seen mock codes for choking used for training.</p> <p>* On 12/16/16 at 8:31 am, CNA #4 stated she would recognize a choking victim when the resident used the "universal sign of choking," of placing hands to the throat; were unable to talk; and turned red. She stated she would ask the resident if s/he was ok, and pat the resident on the back. If the resident did not respond she would get an RN. CNA #4 stated she had CPR training recently and the facility had done an in-service earlier that week as a refresher. In addition, she stated someone had choked last week and had passed away.</p> <p>* On 12/16/16 at 8:40 am, CNA #3 stated assignments for the dining room were communicated on Hall assignments. She stated they rotate but are very clear. CNA #3 has been in her position for approximately 2 and ½ years with her current CPR certification valid until sometime in 2018. She stated she has not participated in mock codes as continued training during her employment. CNA #3 stated that if she encountered a resident choking, she would assess them, encourage them to breathe and cough. "If the airway was blocked, I would call for</p>	F 353			

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F 353	<p>Continued From page 40</p> <p>help and start the Heimlich maneuver. I would visually check the airway before performing the Heimlich, finger sweep if they could not open their mouth on their own. I would begin the process of CPR on the ground, chest compressions and rescue breathing." CNA #3 stated she would do this where the resident was because it was an emergency. CNA #3 stated she had read the policy and procedure on obstructed airway but could not remember the date.</p> <p>* On 12/16/16 at 8:42 am, CNA #5 stated she would recognize a choking victim if they were coughing and turned blue. She stated she would ask the resident if s/he were ok, have them try to cough harder, and see if the person could talk. If the resident did not respond she would get an RN. CNA #5 stated she would initiate the Heimlich maneuver when they stopped coughing. CNA #5 stated she had CPR training recently and the facility had done an in-service earlier that week, which she was unable to attend. She did not know when the next in-service was scheduled. In addition, she stated someone had choked last week and they had passed away.</p> <p>* On 12/16/16 at 8:50 am, LPN #3 stated she would recognize a choking victim when the person used the "universal sign of choking," of placing hands to the throat and were unable to speak. She stated she would initiate the Heimlich maneuver in the dining room, to try and clear the airway as fast as possible, if she came across someone choking. In addition, she stated she would perform finger sweeps to try and get the food out. She stated she was current on her CPR and the facility had done an in-service earlier that</p>	F 353			

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F 353	<p>Continued From page 41</p> <p>week because there was a resident who had died a couple weeks ago from choking.</p> <p>The facility failed to ensure all nursing staff were knowledgeable of, and had demonstrated competency, in the provision of life-saving measures to residents who experience choking episodes.</p> <p>4. Interview with the DNS:</p> <p>On 12/16/16 at 2:50 pm, the DNS stated staff interviews were completed following the event. He stated LPN #2 was a newer nurse, scared and not confident. RN #2 tried the Heimlich maneuver and noticed some small pieces of food. Resident #1's color turned from gray to pink. Resident #1 was "gurgly with a little bit of airway." The DNS stated Resident #1 never put his hands to his throat during the incident. The DNS said RN #2 called the physician first rather than EMS as Resident #1 was alert, e.g., his eyes were open. The DNS stated LPN #2 completed another abdominal thrust, and "wrenched quite hard." The DNS stated RN #2 then directed 911 be called as Resident #1's condition was deteriorating. Resident #1 then coughed hard and passed out. The DNS said Resident #1 was lowered to the floor with RN #2 performing abdominal thrusts until she became winded. At that time, CNA #6 assumed the task. The DNS said by that time Resident #1 had passed and CPR was not initiated. The DNS stated the staff removed Resident #1 from the dining room for his dignity.</p> <p>5. Emergency preparedness information included:</p>	F 353			

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(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	
F 353	<p>Continued From page 42</p> <p>On 12/16/16 at 1:45 pm, Unit Manager RN #1 was asked for the location of the Crash Carts used during emergencies. RN #1 walked to the dining room where the crash cart was positioned against the outside wall. RN #1 stated she had worked for the facility for 3 years and the crash cart had been in that spot "for as long as I have worked here." The crash cart was observed to have a suction machine set up with tubing attached to a suction catheter. An oxygen tank was on the side of the cart. The drawers were labeled to identify the equipment in each drawer which included an ambu-bag, mouth barrier, gloves, and other misc. items.</p> <p>On 12/16/16 at 1:45 pm, RN #1 stated the unit managers help out in the dining room when needed. RN #1 said medication nurses were assigned to the dining room during meals. RN #1 stated the facility did stage mock codes, and the last one was within the last 6 months.</p> <p>As documented in example 1 above, during the choking episode Resident #1 was removed from the dining room, which included a suction machine and crash cart, and taken to his room. The Heimlich maneuver was not initiated and rescue efforts were further delayed as staff retrieved a suction machine from another location in the facility.</p> <p>6. Training after the 12/2/16 incident included:</p> <p>An In-Service Sign - In Sheet, dated 12/12/16, documented titles of "Choking and how to respond," "Supervision in the dining room," and "Heimlich maneuver" as documented topics of</p>	F 353			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 353	<p>Continued From page 43</p> <p>staff training. Eleven signatures were on the sign-in sheet dated 12/12/16. Upon review of the In-Service Sign-In Sheet and the Staff Assignment Sheets, all staff members who worked since 12/2/16 were not educated on the above topics.</p> <p>On 12/16/16 at 2:50 pm, the DNS was asked why the staff education started 10 days after the event. The DNS stated "Because you [SA] called, I had to re-look."</p> <p>The facility's Orientation Agenda for nursing staff included the following</p> <ul style="list-style-type: none"> * For licensed personnel: Obstructed Airway for licensed Personnel. * For CNAs: Obstructed Airway tx for non-licensed competency. <p>On 12/16/16 at 2:50 pm, the DNS stated that the nursing staff watched videos for training on CPR and choking. When the DNS was asked if return demonstration was a requirement in the training he stated he was not sure and he would have to check with the Nurse Practice Educator regarding any return demonstration requirements. In addition, the DNS stated the Basic life-support CPR and abdominal thrusts, were an annual training requirement for nursing staff.</p> <p>The facility failed ensure nursing staff were competent to meet the needs of Resident #1 when he experienced a choking episode. The Heimlich maneuver was not initiated timely, EMS was not notified promptly, CPR was not initiated, and interventions attempted were not consistent with current standards of practice.</p>	F 353			

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