

*Reviewed + accepted POC on 9/23/14. — M. Brault*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>WINDSOR GARDENS HEALTHCARE CENTER OF THE VALLEY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>13000 Victory Blvd, North Hollywood, CA 91606-2926 LOS ANGELES COUNTY</b>		
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:</p> <p>CLASS AA CITATION -- PATIENT CARE 92-2270-0010859-F Complaint(s): CA00370141, CA00362971</p> <p>Representing the Department of Public Health: Surveyor ID # 27787, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Code of Federal Regulations F323: Quality of Care - 483.25(h) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The facility's licensed nursing staff failed to ensure that Resident 1, who was assessed as having difficulties in swallowing, was not given oral medication mixed in applesauce. This violation resulted in the resident choking on the medications in applesauce, her oxygen levels decreased, the paramedics were called and upon arrival they had to intubate the resident (inserted a tube through the nose or mouth into the trachea to keep an open airway to deliver oxygen to the lungs). Resident 1 was transferred to the general acute care hospital (GACH) where she expired [redacted] days later as a</p>		<p><b><u>"Preparation and/or execution of this plan of correction, does not constitute admission or agreement by the provider, of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Health and Safety code section 1280 and 42CFR et seq".</u></b></p> <p><b><u>This Plan of Correction constitutes the facility's credible allegation of compliance.</u></b></p> <p><b><u>Windsor Gardens Healthcare Center of the Valley respectfully requests an IDR with regards to this citation.</u></b></p>	

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

*[Handwritten Signature]*

TITLE

*RN-Don*

(X8) DATE

*9/23/2014*

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s) 1 thru 9*

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. Except for nursing homes, the findings 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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	<p>result of aspiration pneumonia (infection of the lungs that develops due to the entrance of foreign materials, usually oral or stomach contents, into the lungs, often caused by an inability to swallow; the bacteria are different than those seen in more common types of pneumonia).</p> <p>On [REDACTED] 2013, and [REDACTED] 2013, the Department of Public Health received two complaints that alleged Resident 1 was given oral medication mixed in applesauce that resulted in choking and aspiration.</p> <p>According to the admission record, Resident 1 was admitted to the facility on [REDACTED], 2013, with diagnoses that included aftercare for healing traumatic fracture of the hip and chronic airway obstruction (long term lung disorder making breathing difficult).</p> <p>A review of the Progress Notes regarding the Admission Summary, dated [REDACTED] [REDACTED] 2013, indicated Resident 1 was awake, alert, verbally responsive, and oriented times one (level of alertness).</p> <p>A review of the facility's history and physical examination record dated [REDACTED] [REDACTED] 2013, indicated the resident had the capacity to understand and make decisions and had a fair rehabilitation potential.</p> <p>The Minimum Data Set (MDS), an assessment and screening tool, dated [REDACTED] 2013, which was</p>		<p><b><u>F-323</u></b></p> <p><b><u>How Corrective Action will be accomplished for residents affected:</u></b> Resident 1 was discharged on [REDACTED]/13.</p> <p>Speech Therapist 1 no longer works for contracted therapy company.</p> <p>An inservice was provided by the Director of Nurses to LVN1 and RN1 regarding assessment and charting guidelines of aspiration including nursing measures.</p> <p><b><u>Identification of Residents with the Potential to be Affected:</u></b> All residents have the potential to be affected. Safety rounds have been conducted by the DON, ADON or RN supervisor and found no other resident at risk.</p> <p><b><u>Measures to Prevent Recurrence:</u></b></p>	

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	<p>in progress and incomplete, indicated Resident 1 required extensive assistance with eating.</p> <p>According to the Progress Notes of [REDACTED] 2013, the entry written at [REDACTED], indicated a line of events that started at [REDACTED]. The notes indicated that at [REDACTED] Certified Nursing Assistant 1 (CNA 1), who was assigned to feed Resident 1, had reported to Registered Nurse 1 (RN 1) that the resident had difficulty swallowing when CNA 1 fed her breakfast. RN 1 went to the resident's room and assessed her, validating the resident had difficulty of swallowing. The documentation indicated there was no aspiration/congestion/coughing at the time of the assessment.</p> <p>The next event documented in the Progress Note indicated at [REDACTED] RN 1 informed the on-call physician about the resident's difficulty swallowing and obtained an order for a speech therapy evaluation and follow-up treatment, which was noted and carried out. RN 1 documented the speech therapist (ST) was in the building "and made aware," and Resident 1 was seen and evaluated by the ST.</p> <p>A review of the Speech Therapy Progress Note dated [REDACTED] 2013, obtained via fax that was stamped [REDACTED] 2013, at [REDACTED] indicated a ST screen was done because nursing reported that the resident was choking with the current regular and thin liquid diet. The resident was coughing with oatmeal after the CNA fed her one bite. The ST recommended discontinuing feeding</p>		<p>An inservice was given by the Director of Nurses to participants of three shifts of licensed nurses regarding assessment and charting guidelines of aspiration including nursing measures.</p> <p>An inservice was given by Administrator and/or Director of Rehabilitation to participants of the therapy team regarding screening and/or assessment and communication of findings. The therapy team will inform the charge nurse or RN supervisor verbally of any findings that require nursing intervention, as well as document their recommendations in the communication book and their own notes. A policy has been developed to reflect same.</p> <p>An inservice was given by the Speech Language Pathologist to participants of three shifts of Licensed Nurses and CNAs regarding swallowing precautions.</p>	

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	<p>the resident at breakfast due to coughing and demonstrating decreased arousal levels. The ST documented the CNA reported the resident demonstrated decreased alertness the day before, and recommended nursing to obtain ST evaluation orders.</p> <p>During a telephone interview with RN 1, on June 10, 2014, at 10:03 a.m., she stated on [REDACTED] 2013, CNA 1 informed her that Resident 1 was able to tolerate 10 percent of hot cereal, able to sip a little water, but had difficulty swallowing. RN 1 stated she went in the resident's room and assessed her to have a swallowing problem as indicated in her written Progress Note. RN 1 stated she called the physician and obtained an order for a ST evaluation, and she observed the ST in the resident's room, and that was the reason she documented "seen and evaluated by ST." When asked whether she received verbal or written communication from the ST, RN 1 stated she couldn't remember. When asked if she had communicated her assessment to the medication nurse, licensed vocational nurse 1 (LVN 1), she said he was aware.</p> <p>According to the physician's order and the medication administration record (MAR), the medications administered on [REDACTED] 2013, during the morning medication-pass were the following:</p> <ol style="list-style-type: none"> <li>1. Librium 25 milligrams (mg)</li> <li>2. Metamucil powder one teaspoon.</li> <li>3. Colace 200 mg.</li> </ol>		<p>An inservice was given by the Director of Staff Development to participants of three shifts of CNAs and Licensed Nurses regarding Aspiration Precautions.</p> <p>An inservice was given by the Director of Staff Development to participants of three shifts of CNAs and Licensed nurses regarding Choking Prevention.</p> <p><b><u>Monitoring Corrective Action and Responsibility:</u></b> Licensed nurses to monitor residents for swallowing problems through observation during daily medication pass.</p> <p>DON/designee to monitor residents for swallowing problems through observation during random daily rounds.</p> <p>DON/Designee to monitor through monthly random chart reviews.</p>	

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	<p>4. Folic acid one mg. 5. Lisinopril 10 mg 6. Thiamine 100 mg</p> <p>A review of the electronic Medication Administration Record (eMAR) dated [REDACTED], 2013, revealed documentation indicating the resident was unable to tolerate medications even with applesauce.</p> <p>On June 3, 2014, at 4 p.m. during an interview with LVN 1, he stated that at [REDACTED] on [REDACTED], 2013, he was with the RN 1, when she assessed Resident 1 with swallowing difficulties. LVN 1 also stated he was aware that the resident was having difficulty of swallowing that morning and was seen by the ST. However, he was not able to recall if the ST had informed him of her findings and recommendations.</p> <p>According to LVN 1, he documented in the MAR the resident was unable to tolerate the medications. When asked why he gave medications when the resident was having swallowing difficulties, he said he wasn't able to recall.</p> <p>On June 11, 2014, three attempts were made to contact the ST, however she was not available for interview. According to the director of rehabilitation, ST 1 was no longer employed by the facility.</p> <p>The Progress Note dated [REDACTED] 2013, entered at [REDACTED], indicated at [REDACTED] approximately five minutes after the oral medications were documented as administered, the</p>		<p>Interdisciplinary Team will submit Continuous Quality Improvement results to the QA quarterly for 6 months for review and action to ensure continued compliance.</p> <p><b>Date of compliance: 7/10/14</b></p>	

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	<p>resident had a change of condition manifested by labored breathing. The resident's vital signs were: blood pressure of 110/68, temperature 97 degrees Fahrenheit (reference range 97- 98.6), respiratory rate of 32 breaths per minute (reference range 12-20), heart rate 130 beats per minute (reference range 60-100), and oxygen saturation (amount of oxygen in the blood) was at 45 percent by room air. Oxygen was administered and was increased to 15 liters per minute by non-rebreather mask (device used to deliver oxygen in an emergency), and the head of the bed was elevated.</p> <p>Oxygen saturation in a range of 96% to 100% is generally considered normal. Anything below 90% could quickly lead to life-threatening complications. The margin between "healthy" saturation levels (95-98%) and respiratory failure (usually 85-90%) is narrow. American Journal of Nursing (AJN), May 2005 - Volume 105 - Issue 5 - Page 72).</p> <p>The Progress Note dated [REDACTED], 2013, entered at [REDACTED] indicated that at [REDACTED] the resident's oxygen saturation was 65 percent while receiving oxygen at 15 liters per minute by non-rebreather mask, the blood pressure was 112/65, and heart rate was 141 beats per minute. The note indicated 911 was called and to continue to monitor.</p> <p>The Progress Note then indicated that at [REDACTED] the resident's vital signs were: blood pressure 115/66, temperature of 97.4 Fahrenheit, respiratory rate of 35 breaths per minute, and heart rate of 145 beats per minute. The oxygen saturation fluctuated</p>			

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	<p>to 51 percent at while on oxygen at 15 liters per minute by non-rebreather mask. Documentation indicated Resident 1 was non-verbal and was responsive only to painful stimuli. At [REDACTED] the paramedics arrived at the facility and transferred the resident to the GACH.</p> <p>According to the Ambulance Services report dated [REDACTED] 2013, at [REDACTED], the resident was found in bed with a chief complaint of shortness of breath after eating breakfast. The resident was found with agonal respirations (abnormal pattern of breathing characterized by gasping, labored breathing), and airway obstruction. The resident was intubated (tube put into the airway for administration of oxygen) and oxygen saturation improved. The resident remained unresponsive during treatment and transport, according to the report.</p> <p>A review of the GACH Emergency Department Admission (ER) reports dated [REDACTED], 2013, indicated the resident had been intubated. The report indicated the paramedic informed the ER that when he was inserting the ET tube, there was a bolus (a rounded mass) of food stuck in the oropharynx (a section of the mouth and throat, located at the back of the mouth, when the mouth is opened wide), and trachea that looked like "applesauce" and the resident had a temperature of 101.2 Fahrenheit, pulse rate of 126 beats per minute, blood pressure of 122/56, respiratory rate of 48 breaths per minute, and oxygen saturation of 70 percent while she was being bagged by an ET tube.</p>			

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	<p>The resident was admitted to an intensive care unit (ICU) and had multiple physician consultations from [REDACTED] 2013 to [REDACTED], 2013. The GACH History and Physical Examination Record dated [REDACTED] 2013 indicated the resident had a fever, recent choking on food possibly leading to acute respiratory failure, possibly due to dysphagia (difficulty swallowing) and oral medication.</p> <p>The pulmonologist Consultation Record dated [REDACTED] [REDACTED] 2013, indicated the impression was acute hypoxemia (inadequate oxygenation of the blood) respiratory failure, likely due to aspiration (entry of food material into the lungs) with acute central airway obstruction resulting in hypoxemia, after intubation. Pulmonary embolus (blood clot in the lungs) was much less likely.</p> <p>A review of the GACH Death Summary dated [REDACTED] [REDACTED] 2013, indicated discharge diagnoses that included sudden death, acute respiratory failure, possible chronic obstructive pulmonary disease from previous smoking history, and possible aspiration leading to acute respiratory failure. The time of death noted on the summary was [REDACTED] 2013, at 12:52 a.m.</p> <p>A review of Resident 1's Death Certificate dated [REDACTED] 2013, indicated the resident's cause of death was cardio-respiratory arrest, aspiration pneumonia, and chronic obstructive pulmonary disease.</p> <p>Therefore, the facility's licensed nursing staff failed to ensure that Resident 1, who was assessed as</p>			

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	<p>having difficulties in swallowing, was not given oral medication mixed in applesauce. This violation resulted in the resident choking on the medications in applesauce, her oxygen levels decreased, the paramedics were called and upon arrival they had to intubate the resident. Resident 1 was transferred to the GACH where she expired two days later as a result of aspiration pneumonia.</p> <p>The above violation presented either imminent danger that death or serious harm would result, or a substantial probability that death or serious harm would result, and was a direct proximate cause of the death of Resident 1.</p>			

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