

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

POC REVIEWED
ACCEPTED 6/22/15
27785

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 066079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER GLENDORA GRAND, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 805 W Arrow Hwy, Glendora, CA 91740-5413 LOS ANGELES COUNTY
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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 95-2268-0011518-S Complaint(s): CA00399766</p> <p>Representing the Department of Public Health: Surveyor ID # 27785, 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>F323-Accidents The facility must ensure that the resident environment remains as free from accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>On 5/28/14 at 2:15 PM, an unannounced visit was made to the facility to investigate a self-reported incident regarding Resident 1, who was found unresponsive on the floor, in her room.</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent accidents by failing to:</p> <p>1. Ensure Resident 1, who had difficulty in swallowing and a history of choking, received adequate supervision during meals as indicated in the plan of care to prevent a repeat occurrence of choking. Consequently Resident 1 choked on some food particles and subsequently expired.</p>		<p>F 000 – Please accept this Plan of Correction as our Credible Allegation Package. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence no later than 04/17/2015. 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 conclusions set forth on the Statement of Deficiencies. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>F 323 – 483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES – It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents.</p>	
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Event ID:KWS411

6/19/2015

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

TITLE

(X6) DATE

Casencio Nacayanman NHA#6462

Administrator

6/19/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 6

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>During a review of the clinical record for Resident 1, the admission record (face sheet) indicated the resident was originally admitted to the facility on 5/11/12, and readmitted to the facility, on 9/13/13, with diagnoses that included dementia, bipolar disorder, and schizophrenia.</p> <p>The most recent comprehensive Minimum Data Set (MDS), a standardized assessment and care planning tool, dated 5/12/14, indicated Resident 1 had the ability to make herself understood and to understand others. According to the MDS, Resident 1 required supervision from staff for most of her activities of daily living, including eating. The MDS indicated she was receiving a mechanically altered diet.</p> <p>A review of Resident 1's medical record, with RN 1, indicated Resident 1 has had a history of choking on food materials. An entry in the Nurse's Notes, dated 5/13/12, at 2:20 PM, indicated at approximately 1:20 PM, Resident 1 was found lying in bed, with her mouth full of food, and with harsh breath sounds. Resident 1 was also noted to have cyanotic lips and fingertips. The nurse's notes further indicated the Heimlich maneuver was initiated, and suctioning was done, which improved the resident's condition. Resident 1 was then transferred to an acute hospital for further evaluation and was returned to the facility on 5/14/12.</p> <p>A review of an entry in the "Dysphagia (difficulty in swallowing) documentation report," with RN 1, indicated that on 5/18/12, Resident 1 had a</p>		<p>On 5/25/14, Resident 1 was given Heimlich maneuver immediately upon finding resident to remove lodged food. Resident 1 was given CPR until the arrival of paramedics whom then continued CPR and every effort to revive her.</p> <p>Because all residents are potentially affected by the cited deficiency, Director of Nursing reviewed all residents requiring a special diet or any special needs to ensure they are being supervised properly during meals. On 5/27/14 and 10/24/14, Director of Nursing and Staff Developer provided in-service to staff re: serving in-room meals to residents and Heimlich maneuver. Emphasis was placed on the responsibility of staff to check the tray before serving it to the resident to be sure that it is the correct diet ordered & that the food consistency is appropriate to the resident's ability to chew & swallow; as well as the supervision of the resident.</p> <p>To ensure that the deficient practice does not occur, the nursing department will conduct rounds during meals of residents</p>		

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	<p>speech/swallow evaluation by a therapist, who recommended that Resident 1 undergo swallow/diet management and safety training. The evaluation report indicated Resident 1 appeared to be tolerating a mechanically soft (MS) diet, with poor safety and risk for choking.</p> <p>A review of an entry in the "dysphagia documentation report" with RN 1, dated 5/21/12, indicated Resident 1 was on maximum assist (staff assistance in cutting, meal set-up, feeding) with meals for safety, due to being easily distracted, and with a risk for choking.</p> <p>Another entry in the "dysphagia documentation report" dated 5/29/12, indicated the resident had poor safety awareness, required maximum cues to slow down and take small bites, and cues to increase chewing. The report further indicated to continue 1:1 monitoring for cues and supervision.</p> <p>A review of an entry in the "dysphagia documentation report," with RN 1, dated 5/31/12, indicated Resident 1 was discharged from speech/swallow rehabilitation therapy but would still be on maximum assistance for safety compliance because of poor safety awareness and an increased risk for choking.</p> <p>A review of an entry in the Nurses Notes, with RN 1, dated 3/20/13, at 1:30 PM, indicated Resident 1 had another episode of choking. The entry indicated at approximately 1 PM, on 3/20/13, Resident 1 was noted by staff standing in front of her closet door and then she fell down on her back.</p>		<p>being served in-room to ensure proper supervision is given. The Director of Nursing and registered nurses will continue to monitor as well to ensure proper supervision is given. Any deficiency will be corrected immediately.</p> <p>A continuous quality improvement program was implemented, under the supervision of the Director of Nursing and Director of Staff Development, to ensure that residents receiving in-room meals are supervised properly. The Nursing department will perform the following systemic changes: document/record any special needs of the resident for meals, ensure staff is aware of any special needs of residents during meals, conduct rounds during meals of residents being served in-room to ensure proper supervision is given. Any deficiencies will be corrected immediately, and the findings will be documented and submitted at the quarterly continuous quality improvement committee meeting for further review or corrective action.</p> <p>Corrective action will be completed no later than April 17, 2015.</p>	4/17/15	

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	<p>Resident 1 appeared to be cyanotic and was unable to respond to tactile (touch) or verbal stimuli. The Heimlich maneuver was performed immediately and some liquid and soft food came out from the resident's mouth. After a few minutes Resident 1 responded well and was refusing care.</p> <p>A care plan developed in April 2014, and re-evaluated in May 2014, indicated Resident 1 was at risk for further choking and/or aspiration secondary to actual episodes of choking, history of choking, taking large bites of food, refusing staff to assist with feeding, taking food from other residents who were on different therapeutic diets, and taking and grabbing food from the food trays and carts. The care plan approaches included to monitor Resident 1 during meals, to observe for any difficulty in swallowing, supervise food trays and carts during meals, and to monitor for access to solid foods.</p> <p>The physician's orders dated 2/5/14, indicated that Resident 1 was on a fortified puree diet with non-fat milk and may deviate from this diet on special occasions and/or when the resident so desired.</p> <p>A review of an entry in the nurse's notes by Licensed Vocational Nurse 1 (LVN 1), dated 5/25/14, at 3 PM, indicated at approximately 12:22 PM, on 5/25/14, Resident 1 was found by her Certified Nurse Assistant 1 (CNA 1) in her room, on the floor, and gasping for air. Knowing that Resident 1 had a high risk for choking, CNA 1 yelled for help and initiated the Heimlich maneuver. LVN 1 immediately arrived and continued the Heimlich</p>				

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	<p>maneuver. Resident 1 was noted regurgitating puree food during the Heimlich maneuver. Emergency 911 was called and after two minutes of the Heimlich maneuver, resident was still unresponsive. Cardiopulmonary resuscitation (CPR) was initiated and continued until emergency personnel arrived. Fire department arrived and Resident 1 was attended to by three Emergency medical technicians, (EMT) for another 10 ten minutes. Resident 1 was unresponsive to CPR. At around 12:56 PM, Resident 1 was still without a pulse, and was pronounced dead by the EMT.</p> <p>During an interview with Registered Nurse 1 (RN 1), on 5/28/14, at 2 PM, she stated on 5/25/14, during lunch time, Resident 1 choked on a hot dog she took from her roommate's tray. She said Resident 1 was found in her room, on the floor, unresponsive, by CNA 1, who had been assigned to her. RN 1 said they tried the Heimlich maneuver on the resident, while waiting for the paramedics, but were unsuccessful. She further stated Resident 1 and her roommate usually ate in their room and Resident 1 required supervision during meals because she had difficulty in swallowing and a history of choking. RN 1 stated she did not know why Resident 1 was not supervised at that time.</p> <p>During an interview with CNA 1, on 5/28/14, at 2:45 PM, he stated after he delivered the food tray for Resident 1 and her roommate, he opened a carton of milk for her and left the room to deliver a food tray for a resident in another room. CNA 1 stated that he left Resident 1's room only for a short time but was not sure specifically how long he was out</p>				

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	<p>of the room. CNA 1 stated that when he came back to Resident 1's room she was already on the floor and unresponsive. He stated that he knew Resident 1 needed supervision while eating because she had a risk for choking. He further stated Resident 1's food tray should have been delivered last so Resident 1 could be supervised while eating.</p> <p>The coroner autopsy report, dated 6/3/14, indicated Resident 1's cause of death was choking due to an obstructive food bolus.</p> <p>The facility's failure to provide adequate supervision to Resident 1, during meals as indicated in the plan of care to prevent a reoccurrence of choking resulted in Resident 1 choking on some food particles and subsequently expired.</p> <p>This violation presented an imminent danger of death or serious harm to the patient and was a direct cause of death of the patient.</p>				

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