

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555768	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2011
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT YORBA LINDA	STREET ADDRESS, CITY, STATE, ZIP CODE 17803 IMPERIAL HWY, YORBA LINDA, CA 92886 ORANGE COUNTY
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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) COMPLETE DATE
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	<p>Continued From page 1</p> <p>shall have sufficient knowledge of food values to make appropriate substitutions when necessary.</p> <p>72519(a) The licensee shall maintain written transfer agreements with other nearby health facilities to make the services of those facilities accessible and to facilitate the transfer of patients. Complete and accurate patient information, in sufficient detail to provide for continuity of care shall be transferred with the patient at time of transfer.</p> <p>The facility failed to provide finely chopped meat for Patient A, as ordered by her physician.</p> <p>The facility failed to provide Patient A with her dentures when her lunch was served.</p> <p>The facility failed to implement their plan of care by not providing supervision when Patient A was eating lunch. Patient A was found unattended, unresponsive and cyanotic (blue color from lack of oxygen), with a partially eaten sandwich in front of her. The Heimlich maneuver (an emergency technique used to prevent suffocation when a person is choking) was performed and was unsuccessful. Patient A was transferred to the acute hospital, where a large piece of meat was removed from her airway. Patient A was admitted to the intensive care unit, where she remained unconscious and died six days later from cardiac and respiratory arrest due to foreign body aspiration (choking). Findings:</p> <p>Review of the facility's P&P (policy and procedure)</p>		<p>Members of the Interdisciplinary Team (IDT) have identified the residents requiring these plans of care. An audit is being conducted to verify that the Care Plans are appropriate, consistent with the needs identified in the patient assessments, and being implemented as written.</p> <p>3) Nursing Staff, Dietary Staff, and members of the IDT will be in-serviced on the policy and procedures of Patient Assessment. Care planning, and implementation of the plan of care.</p> <p>4) The Director of Nursing or Designee in conjunction with the Dietary Service Supervisor and other members of the IDT will conduct daily audits of the New Admission charts, change of conditions and any new Physician orders verifying that Plan of Care reflects the individual needs of the resident related to therapeutic diets and special</p>	
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Event ID: X6GB11

11/30/2011

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

TITLE

(X6) DATE

Quell-Filber

Executive Director

12/15/11

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	<p>Continued From page 3</p> <p>The Nurse's Notes dated 1240 hours, documented by RN (Registered Nurse) 1, showed CNA (Certified Nursing Assistant) 1 summoned LVN (Licensed Vocational Nurse) 1 because Patient A did not "look good" and was "turning blue or purple." LVN 1 noticed the patient's lunch tray on her bedside table and immediately checked the patient's airway but the patient's mouth was clenched shut. Patient A was "purple, cyanotic" and "nonresponsive" and oxygen was administered to the patient. The Heimlich maneuver was attempted by LVN 1 without success. LVN 1 then summoned RN 1.</p> <p>The Nurse's Notes showed at 1241 hours, Patient A's family member was notified by telephone and at 1242 hours, 911 was called. At 1247 hours, the emergency response team arrived. LVN 1 told them Patient A was turning purple and the patient's lunch tray was in front of her when she was found. The Heimlich maneuver was attempted. At 1300 hours, Patient A was transferred to the acute hospital.</p> <p>On 6/1/11 at 0745 hours, during an interview with LVN 1, the LVN stated CNA 1 called her for help and when she arrived to Patient A's room, the patient was in bed and looked blue. LVN 1 stated Patient A had eaten some of her sandwich and foam was coming out of the patient's mouth. LVN 1 stated the patient was unresponsive but had a pulse. LVN 1 stated CNA 1 told her the patient had been eating and maybe she was choking. The LVN stated the patient's jaw was clenched tightly and she could not perform a mouth check or sweep.</p>	72339	<p>1) All residents may be effected who require a Therapeutic Diet.</p> <p>Members of the Interdisciplinary Team (IDT) have identified the residents requiring therapeutic diets. An audit is being conducted to verify that the Diets being served are appropriate, consistent with the needs identified in the patient assessments, physician orders, and the care plans.</p> <p>2) Nursing Staff, Dietary Staff, and members of the IDT will be in-serviced on the policy and procedures covering therapeutic diets.</p> <p>3) Licensed Nurses will be assigned daily to confirm that the therapeutic diets served each meal are correct per physician orders.</p> <p>DNS or Designee will conduct bi-weekly visual inspections to verify compliance in</p>	
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(X6) DATE

[Signature] Executive Director

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	<p>Continued From page 4</p> <p>The LVN stated she attempted "back blows" and the patient was limp. The LVN stated RN 1 came to the room and she asked the RN to check the patient's code status and to call the patient's family member. The LVN stated Patient A had a seizure that morning and they kept her in bed for lunch that day because she was usually weak after a seizure. LVN 1 stated she documented the incident in an "initial report."</p> <p>On 6/1/11 at 0830 hours, during an interview with DSS (Dietary Services Supervisor) 1, the DSS stated the ham used in a sandwich for a mechanical soft finely chopped diet would be prepared by chopping up the meat.</p> <p>On 6/1/11 at 0915 hours, during an interview with CNA 1, the CNA stated she dropped off the lunch tray at Patient A's bedside and then left the room to pass out other patient's trays. CNA 1 stated when she returned to Patient A's room, she noticed the patient's color was grey and purple and she had foam coming out of her mouth. The CNA stated Patient A was sitting up in bed with her tray in front of her. She stated Patient A was served a ham sandwich and a bite had been taken out of the sandwich. The CNA stated the ham was in the form of a slice, not chopped. The CNA stated Patient A had some bottom teeth but no top teeth and she wore an upper denture. The CNA stated she "forgot" to place the upper denture in Patient A's mouth before the lunch meal was served that day. The CNA stated they all thought she was "choking" and the ham sandwich was an "issue."</p>	72519(a)	<p>providing accurate therapeutic diets.</p> <p>The results of all audits and inspections will be reviewed and monitored monthly in the Quality Assurance committee.</p> <p>1) All residents who may be transferred to another facility could be effected.</p> <p>2) A new transfer form has been implemented to provide accurate communication of the residents condition upon transfer. Nursing and Management staff have been in-serviced on the new form and on the policy/procedures and regulations regarding resident transfers including complete, accurate and detailed documentation to facilitate continuity of care.</p>	12/08/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

K. S. Miller

TITLE

Executive Director

(X6) DATE

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	<p>Continued From page 5</p> <p>On 6/1/11 at 1135 hours, during an interview with Patient A's family member, she stated on she received a telephone call from RN 1. The RN told her Patient A was turning blue and asked her permission to send the patient to the acute hospital and she agreed to the transfer. She stated she was not told Patient A was possibly choking. The family member stated she went to the acute hospital's emergency room and spoke with the emergency room physician. However, she stated the emergency room physician talked to her about intubating (a flexible tube placed into the trachea to open and maintain an airway) Patient A to provide ventilation and to try and find out why the patient was in respiratory distress. The family member stated when the emergency room physician was attempting to place the tube he pulled out a "wad of ham." She stated the emergency room physician told her it was a good decision to intubate because they now knew the cause of the respiratory distress. She stated Patient A was then admitted into the intensive care unit and never regained consciousness and died. The family member stated she had contacted the facility a day or two after the patient went to the hospital to express her concerns. The family member stated the DON (Director of Nursing) told her Patient A not having her dentures in at the time she ate lunch was a mishap.</p> <p>On 6/1/11 at 1545 hours, during an interview with Physician 1, the physician stated he received a phone call from the facility telling him Patient A was in respiratory distress. Physician 1 stated the patient was transferred to the acute hospital and he</p>		<p>3) Director of Nurses, or Designee will conduct an audit of each resident transfer during weekly facility stand-up meeting to verify that complete and accurate patient information was transferred with the patient at the time of transfer.</p> <p>Results of these audits will be reviewed and monitored monthly in the Quality Assurance Committee meeting.</p>	12/08/11

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	<p>Continued From page 6</p> <p>spoke with the emergency room physician. Physician 1 stated the emergency room physician told him slices of ham were removed from Patient A's airway. Physician 1 stated the patient was then transferred to the intensive care unit.</p> <p>On 6/22/11 at 1125 hours, during an interview with the DSS 2, the DSS stated the incident happened on the weekend and when she returned to work she heard Patient A had been sent to the hospital. The DSS stated she was unaware of the circumstances at the time but later found out Patient A had choked. The DSS stated the facility traced it back to a ham sandwich. The DSS stated they received a report from the acute hospital showing the patient had choked.</p> <p>On 6/22/11 at 1510 hours, during an interview with the ST (Speech Therapist), the ST stated if a patient was used to eating with dentures in, then she would expect the dentures to always be used when the patient was eating. The ST stated Patient A was encouraged to eat meals in the dining room because she would be sitting upright in a chair and staff would be supervising her.</p> <p>On 6/24/11 at 0945 hours, during an interview with RN 1, the RN stated she was called to help LVN 1 in Patient A's room. RN 1 stated she was asked to check Patient A's health record for her "code status" (a set of instructions outlining treatment to be given in the event of an emergency) and to call the patient's family member and 911. RN 1 stated the paramedics arrived and transferred the patient to the acute hospital. RN 1 stated she</p>			

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	<p>Continued From page 7</p> <p>documented the account of the incident, including the Heimlich maneuver, in Patient A's health record for LVN 1. The RN stated she was helping LVN 1 by documenting the note because LVN 1 was "uneasy" and "distraught" about what happened. When asked if she was part of any facility investigation, the RN stated yes, she provided a written account the following day. When the RN was asked if the facility made any conclusions as a result from their investigation, the RN stated shortly after the incident they received a report showing the patient had choked.</p> <p>Review of the ambulance service's Patient Care Report dated _____, showed an emergency call was received at 1242 hours. The chief complaint was "unresponsive" and Patient A was found in bed and unresponsive.</p> <p>On 7/25/11 at 1605 hours, during an interview with EMT (Emergency Medical Technician) 1, the EMT stated he responded to an emergency call made at the facility. The EMT stated the call came in indicating a patient was in respiratory distress and he arrived just before the fire department. EMT 1 stated if he had known the patient was a possible choking victim, he would have noted that on his report. The EMT stated he later found out Patient A had a large chunk of meat cleared from her throat at the hospital from hospital staff.</p> <p>On 8/4/11 at 1020 hours, during an interview with Physician 2, the physician stated Patient A was brought into the emergency department in "extreme" respiratory distress. Physician 2 stated</p>			

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Rudolf J. Jellen

Executive Director

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	<p>Continued From page 9</p> <p>Review of the Certificate of Death showed Patient A's cause of death was cardiopulmonary arrest due to respiratory failure due to foreign body aspiration.</p> <p>Review of the Coroner's report dated 2/9/11, showed Patient A's cause of death was cardiopulmonary and respiratory arrest due to foreign body aspiration. The manner of death was an accident.</p> <p>Review of the Orange County Sheriff Coroner's Case Notes report dated 4/26/11, showed Patient A's death was reported to them by the acute hospital. The report showed the patient's family member stated there were times when the patient's food was not cut up and she was found unsupervised while eating. The family member spoke with the emergency room physician and was told he pulled a nearly intact slice of ham from the patient's throat which was blocking her airway. The family member found out from the facility that Patient A was not feeling well that day and stayed in bed. A whole ham sandwich was served to the patient, she was unsupervised and she did not have her dentures in place. The report showed Physician 1 spoke to the emergency room physician and was told a chunk of sliced ham was removed from the patient's airway. The incident happened on _____ while the patient was unsupervised and "per the doctor, that food should have never been on that plate."</p> <p>The facility failed to provide Patient A with her dentures, supervision and finely chopped meat as ordered, causing Patient A to choke to death.</p>			
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