STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	92000289	A. BUILDING: _____ B. WING _____	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLMAR HEALTH AND REHABILITATION CENTER	12220 FOOTHILL BLVD SYLMAR, CA 91342

(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
C 000	Initial Comments	C 000		

The following reflects the findings of the California Department of Public Health during an investigation of one complaint and one Facility Reported Incident (FRI).

Facility-Reported Incident Number: CA00908829

Complaint Number: CA00908878

The inspection was limited to the specific complaint/ facility reported incident and does not represent the findings of a full inspection of the facility.

No deficiencies were issued for Complaint Number: CA00908878

A deficiency was written for FRI Number CA00908829 (please refer to T22-72523).

C4130	T22 DIV5 CH3 ART5-72523(a) Patient Care Policies and Procedures	C4130		

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

This Statute is not met as evidenced by:
Based on interview and record review, the facility failed to implement its Choking (occurs when a foreign object lodges in the throat, blocking the flow of air) Assessment policy and procedure for one of three sampled residents (Resident 1) when Registered Dietitian 2 (RD 2) did not perform two observation trials with the use the Meal Observation Trial form after Resident 1 had a choking incident on 1/3/2024.

DON

8/14/24

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C4130	Continued From page 1 This deficient practice resulted in Resident 1 not provided with an appropriate plan of treatment to prevent choking. Findings: During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 12/7/2023 with diagnoses that included unspecified (unconfirmed) schizoaffective disorder (a mental health problem where you experience psychosis [a collection of symptoms that affect the mind, where there has been some loss of contact with reality] as well as mood symptoms), personal history of other mental and behavioral disorder and unspecified chronic bronchitis (inflammation [swelling] and irritation of the bronchial tubes. These tubes are the airways that carry air to and from the air sacs in your lungs). During a review of Resident 1's History and Physical (H&P) dated 12/8/2023, the H&P indicated Resident 1 had fair decision-making capacity. During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 6/14/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 1's Progress Notes dated 1/3/2024 timed at 6:02 p.m., the Progress Notes indicated on 1/3/2024 at 5:30 p.m., Resident 1 had a choking episode during the evening meal. The Progress Notes indicated Heimlich maneuver (a first-aid method for	C4130		

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C4130	Continued From page 2	C4130		

choking, also known as abdominal thrusts, because the method involves thrusting into the abdominal area) was performed, the physician was notified, and a one to one sitter was assigned to monitor Resident 1 during mealtimes.

During a review of Resident 1's Progress Notes dated 7/8/2024 timed at 10:51 p.m., the Progress Notes indicated Resident 1 was eating pureed tuna at approximatley 5:50 p.m., when a Certified Nursing Assistant (CNA) called code blue (an emergency code that indicates a patient is experiencing a life-threatening medical emergency, usually cardia arrest or respiratory failure) after observing Resident 1 making "bizarre" hand gestures and the CNA performed Heimlich manuever (also known as the abdominal thrust, is an emergency first aid technique used to help someone who is choking) with food expelled and oxygen via mask was administered. The Progress Notes indicated the paramedic were called via 911 at 5:55 p.m. Resident 1 was sitting and was responsive and following staff instruction. The paramedics removed the oxygen mask and laid Resident 1 on his back, Resident 1 then became unresponsive and cardiopulmonary resuscitation (CPR-is an emergency lifesaving procedure performed when the heart stops beating). CPR was continues for thirty minutes and was pronounced as expired at 6:36 p.m.

During an interview on 7/10/2024 at 8:57 p.m., with the Director of Nursing (DON), the DON stated Resident 1 had an episode of choking prior to 7/8/2024.

During an interview on 7/11/2024 at 1:36 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had a one-to-one sitter

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C4130	Continued From page 3	C4130		

because Resident 1 gets excited to eat and does not know how to slow down.

During an interview on 7/11/2024 at 2:37 p.m., with Registered Nurse 1 (RN 1), RN 1 stated Resident 1 had a choking episode on 1/3/2024 and facility provided one to one sitter with meals to remind Resident 1 to eat slowly.

During an interview on 7/19/2024 at 10:26 a.m., with Registered Dietitian 2 (RD 2), RD 2 stated she (RD 2) does observe residents during meals. RD 2 stated she documents her meal observation if requested.

During an interview on 7/19/2024 at 11 a.m., with the Incident Report Coordinator (IRC), the IRC stated there was no Meal Observation Trial form documented for Resident 1.

During an interview on 7/19/2024 at 11:01 a.m., with the Case Manager (CM), the CM stated he (CM) has never seen the Meal Observation Trial form. The CM stated he (CM) was not aware of the policy and procedure for choking assessment.

During a concurrent interview and record review on 7/19/2024 at 11:10 a.m., with the DON, facility's policy and procedure titled, "Choking Assessment" dated 12/6/2021 was reviewed. The PnP indicated, "The following policy will address the procedures taken in identifying residents who are at risk for choking to ensure safely and to provide a suitable plan of treatment for each resident. Within seven days of admission or sooner, the dietitian will perform two observation trials during meals with the use of the Meal Observation Trial Form. The dietitian will assess for the following: cognitive or behavioral problems that interfere with safe eating (i.e. eating or

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C4130	Continued From page 4 drinking too fast. not chewing food well enough prior to swallowing. inattention to eating. excessive volume per bite. non-compliance with prescribed modified diet) shortness of breath. gagging. coughing. labored respiration (gurgling). and overall oral health (i.e. missing teeth. pain/difficulty chewing or swallowing. etc.). Upon the completion of these tasks. a recommendation will be provided and presented to the resident's Nurse Case Manager. The Nurse Case Manager will review all recommendations and will notify primary doctor to determine a suitable plan of treatment. Post incident of choking, 2 The Dietitian will be informed of the choking episode and will perform two observation trials with the use the Meal Observation Trial form. The Dietitian's findings and recommendations will be submitted to the patient's Nurse Case Manager. 3.The Nurse Case Manager will review the findings and recommendations and present findings to the doctor to determine a suitable plan of treatment." The DON stated meal observation were done for residents upon admission, but it was not documented. The DON stated it's something they have to correct. The DON stated staff were not aware of the Meal Observation Trial form.	C4130		

The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with State and Federal law. This plan of correction serves as our written credible allegation of compliance.

Facility-Reported Incident Number: CA00908829
Complaint Number: CA00908878

C4130

- **Corrective Action:**
  - No further direct corrective actions can be implemented for Resident 1.
  - From 7/9/2024 to 7/12/2024, the QA Nurse in-serviced the unit staff on identifying residents with chewing and/or swallowing difficulties for evaluation and treatment and referring identified residents to the Registered Dietician for initiating meal observation trials.

- **Identification of Other Residents and Corrective Actions Taken:**
  - On 7/8/24, Nurse Case Managers reviewed residents currently on pureed diets and those who had a history of choking episodes. From this review three residents were identified and the residents were seen and evaluated by a speech therapist on 7/11/2024.
  - On 8/7/2024, Nurse Case Managers reviewed all resident records documenting a choking episode within the past six months. The objective was to ensure that the Registered Dietitian conducted the required two observation trials using the Meal Observation Trial form. Three residents were identified as being affected by this oversight. The Registered Dietitian has been notified, and meal observations have been scheduled for 8/13/2024.

- **Measures to Prevent Recurrence:**
  - From 8/5/2024 to 8/8/2024, the QA Nurse conducted an in-service training for the nursing staff on the facility's policy and procedure titled "Choking Assessment," with a specific emphasis on the importance of timely notification of the Registered Dietician (RD) following a choking incident.
  - On 8/7/2024, the Assistant Director of Nursing (ADON) provided an in-service to the Registered Dietician on the policy and procedure titled "Choking Assessment," with a specific focus on the requirement to perform two observation trials post-choking episode and the proper use of the Meal Observation Trial form.
  - The Director of Staff Development (DSD) will continue to include comprehensive training on choking risk management and assessment during the orientation process for all new hires.
  - Annual competency evaluations will be conducted by the DSD to ensure all staff maintains proficiency in identifying and responding to choking incidents. This will include a skill check-off list focusing on practical applications and policy adherence.

- **Monitoring Performance and Integration into Quality Assurance and Performance Improvement Program:**
  - The Director of Nursing (DON) or a designee will monitor all choking incidents to ensure that the Registered Dietician is notified promptly and that two observation trials using the Meal Observation Trial forms are completed as required. Monthly audits will be conducted to track compliance, and any identified trends or areas of concern will be addressed promptly.

    Data collected from monthly audits will be compiled and presented to the Quality Assurance and Assessment Committee on a monthly basis for the next three months. This review will include analysis of compliance rates, identification of recurring issues, and recommendations for process improvements.

The findings and recommendations from the QAAC reviews will be integrated into the facility's QAPI program. This will ensure that corrective actions and improvements are continuously monitored and evaluated for effectiveness, contributing to overall quality enhancement.

- Starting 8/12/2024, the DSD will perform random checks on three floor staff twice a week over a three-week period to assess their understanding with post-choking incident procedures. Results will be documented and reviewed for continuous improvement. Findings from these random checks will be reported to the Quality Assurance and Assessment Committee (QAAC) for review and to inform further training or policy adjustments as necessary.

  Data collected from this audit will be compiled and presented to the Quality Assurance and Assessment Committee. This review will include analysis of compliance rates, identification of recurring issues, and recommendations for process improvements.

  The findings and recommendations from the QAAC reviews will be integrated into the facility's QAPI program. This will ensure that corrective actions and improvements are continuously monitored and evaluated for effectiveness, contributing to overall quality enhancement.

- **Date of Compliance: 8/23/2024**