

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>555318</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/13/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>VILLA RANCHO BERNARDO CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15720 Bernardo Center Dr, San Diego, CA 92127-5861, SAN DIEGO COUNTY</b>		
(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
	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p><b>CLASS AA CITATION -- DIETARY</b> 08-2445-0009783-S Complaint(s): CA00331193</p> <p>Representing the Department of Public Health: Surveyor ID # 29270, 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>F365 (CFR 383.35(d) Food prepared in a form designed to meet individual needs.</p> <p>The facility failed to follow the physician's orders for a chopped diet. The Cook, the Dietary Line Checker, the Licensed Nurse and the Certified Nursing Assistant did not verify that the prescribed diet, in the correct consistency, was checked prior to bringing the meal tray into Resident 1's room. Resident 1 was known to have behaviors, in which he immediately grabbed for food and stuffed the food into his mouth. As a result, Resident 1 grabbed 2 pancakes and 2 uncut whole sausage patties from his breakfast tray and put all 4 items into his mouth. The resident choked on the food and died.</p> <p>Resident 1, a 61 year old male resident, was admitted to the facility on 12 with a diagnosis</p>		<p>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 in the statement of deficiencies. This plan of correction is prepared and/or executed because it is required by the provisions of Health and Safety Code Section 1250 and 42 C.F.R. 405.1907.</p> <p>During the week following Patient A's choking incident all residents' diet orders were reviewed and revised, if necessary, by the Unit Managers to ensure the residents are receiving the correct consistency modified diets as ordered by the attending physician.</p> <p>A Licensed Nurse is assigned to the kitchen during meal tray assembly to ensure diet consistencies are accurate before the tray cart leaves the kitchen. This assignment has been implemented for each meal served since November 2012. Once the meal carts are delivered to the</p>	3/21/2013

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

TITLE

(X6) DATE

*[Signature]*

*ADMINISTRATOR*

*3-13-13*

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 7

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>of dementia (memory loss) per the Record of Admission. According to the Physician's Orders dated 12, Resident 1 had cognitive/behavior impairment (decreased mental status).</p> <p>Resident 1's clinical record was reviewed on 10/31/12. The resident was unable to make medical decisions for himself per the Advanced Healthcare Directive, signed and dated by the physician on 1/12. According to the Minimum Data Set (MDS) assessment, dated 10/3/12, the facility assessed Resident 1 with unclear speech, unable to understand others or be understood by staff, and unable to make daily decisions due to severe cognitive impairment. Per the same document, the facility assessed Resident 1 as requiring limited assistance with feeding himself and the assistance of one staff member for supervision. According to the Social Services assessment dated 9/26/12, Resident 1, "Speaks with few words: yes, no, eat, hungry...Can become aggressive especially when eating."</p> <p>Resident 1 was prescribed a mechanical soft, chopped diet, according to the Physician's Orders dated 1/12. The Physician's Orders were updated on 10/5/12 to include, "Feeding 1:1 (one staff to one resident) w/ (with) all meals re: at choking risk." An Interdisciplinary Team (IDT) review was completed on 10/5/12. According to the IDT notes, staff were instructed to watch the food trays and the food cart, as Resident 1 was, "Always looking for more food," and needed to be redirected frequently. The resident was placed on 1:1 (one staff member to one resident) during meals</p>		<p>dining areas the meal trays are again checked by the CNAs by review of the diet card and meal served. If discrepancies are observed, the tray is returned to the kitchen for correction. CNAs report discrepancies to the station's charge nurse. Charge Nurse will note discrepancies on the 24 hour report.</p> <p>Between meal snacks, late meals and substitutes will be also be checked by a licensed nurse before the food leaves the kitchen.</p> <p>The facility's Dietitian reeducated the Dietary staff on ensuring proper diet consistencies are served to the residents. The Dietary Staff will also be instructed by the dietitian not to deliver food to the stations without first being checked by a licensed nurse.</p> <p>The facility's Directors of Staff Development reeducated the direct care nursing staff on review of the diet card and meal served to ensuring the residents are served the</p>	

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	<p>due to his behaviors.</p> <p>On 10/30/12 at 1 P.M., the Cook was interviewed by phone. The Cook said he worked the breakfast meal on 10/28/12. He said it was his responsibility to match the food ticket (diet order) and plate the food on the kitchen line. The cook said he prepared a chopped diet of sausage and pancakes for Resident 1. He said he would usually cut the sausage patty into 9 pieces. The pancakes were not cut, as they were soft.</p> <p>The Food Line Checker, a second person that reviewed the diet for correctness, said on 10/30/12 at 1:15 P.M., she was quite busy on 10/28/12. She said since it was a Sunday, she was responsible for answering the phone and responding to requested food changes. She said she was also responsible for checking the trays before the trays were loaded onto the service cart and taken to the nursing station. The Food Checker said the phone rang frequently on 10/28/12. She was uncertain if she reviewed all of the trays on the line that morning.</p> <p>Licensed Nurse (LN) 1 said on 10/31/12 at 1:30 P.M., she was the Charge Nurse on the day shift on 10/28/12. She said she was aware that Resident 1 was a compulsive food seeker. She said Resident 1 grabbed and ate the applesauce when it was left unsupervised on the top of the medication cart. She said she was responsible for checking each tray on the cart before the Certified Nursing Assistants (CNAs) delivered the trays.</p>		<p>proper diet consistencies, procedures to follow if diets do not match physician orders and methods to document the diets were verified.</p> <p>Compliance will be monitored by the Director of Nursing or Assistant Director of Nursing during review of the 24 hour report at the facility's Department meeting. The results of the meal accuracy noted at the Department meeting will be reported monthly by the Director of Nursing to the facility's Continuous Quality Improvement meeting for the next 12 months, then quarterly thereafter.</p> <p>All corrective actions described above will be completed by 3/21/2013.</p>	

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	<p>LN 1 said at about 8 A.M. on 10/28/12, "I was in a hurry." Resident 1, "Stood in front of the food cart. I wanted to make sure he did not grab any other resident's food. I made a mistake. I was not careful to match the diet card with the food on the plate, when I checked the tray," for Resident 1. LN 1 said she handed Resident 1's tray to CNA 1 to move Resident 1 away from the other food trays.</p> <p>CNA 1 said on 10/31/12 at 12:30 P.M., she was assigned to care for Resident 1 on the day shift on 10/28/12. CNA 1 said she was aware Resident 1 wandered throughout the facility and grabbed food from others. She said she was aware Resident 1 was only to have chopped food. CNA said she knew Resident 1 was on 1:1 supervision for meals.</p> <p>CNA 1 said LN 1 handed her Resident 1's breakfast tray from the cart on 10/28/12 at about 8:05 A.M. She told Resident 1 she had his food and he immediately followed her to his room. CNA 1 said she usually checked the trays when she got into the rooms. She said as she lifted the plate cover, Resident 1 grabbed 2 pancakes and 2 uncut sausage patties and stuffed them into his mouth. CNA 1 said Resident 1 walked out of his room and into the hallway. CNA 1 followed behind him with some milk, intending to encourage Resident 1 to drink the milk. CNA 1 said she immediately told LN 1 that Resident 1 grabbed his food and put it into his mouth. Within a minute or two, Resident 1 collapsed on the floor in the hallway, in front of his room. CNA 1 said she called for help.</p> <p>LN 1 said on 10/31/12 at 1:35 P.M., she was in the</p>			

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	<p>hallway on 10/28/12 at about 8:10 A.M. and saw Resident 1 fall to the floor. She rushed to Resident 1. He was foaming at the mouth and he looked pale. LN 1 she said she put on gloves and swept the Residents mouth. Some food was removed. LN 1 said she tried to do the Heimlich maneuver (emergency technique to unblock the airway) on the floor, but it was not successful. Resident 1 was not breathing and his skin color was blue. LN 1 said she started CPR (cardiopulmonary resuscitation - mouth to mouth breathing and chest compressions). Another staff member called a "code blue" (resident not breathing and CPR initiated). Other staff members arrived and Resident 1 was carried from the hallway, outside of his room, to his bed. The physician was notified and 9-1-1- was called, while the CPR continued.</p> <p>According to the facility records, the Emergency Medical Technicians (EMTs) arrived at 8:20 A.M. and took over the care of Resident 1. The EMTs transported Resident 1 to the acute care hospital.</p> <p>According to the hospital records, the Emergency Room (ER) physician removed food from the throat of Resident 1, to establish an airway. Resident 1 was unable to be resuscitated and was pronounced dead, due to airway obstruction.</p> <p>On 10/31/12 at 12:30 P.M. the Registered Dietician and Food Services Manager cooked a sausage patty, the same sausage as prepared on 10/28/12 for Resident 1. The patty was circular and measured 3 inches by 3 inches.</p>			

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	<p>According to the facility undated policy titled, Choking Prevention, "Prior to serving the trays to the Residents have the license nurse assigned to the dining room to check that all the meal matches the diet slip...Certified Nursing Assistants (CNAs), are to double check meals after the nurse has checked the tray for any missed items or wrong diet in the tray that the nurse may have over looked."</p> <p>According to the facility diet manual, Healthcare services Group I, Diet Manual Third Edition 2011, a Mechanical Chopped Diet consists of: Meats chopped to the consistency of small dice (1/2 inch).</p> <p>According to the Medical Examiner's report dated 12/24/12, Resident 1 due to airway obstruction and aspiration (inhalation) of food.</p> <p>The facility failed to follow the physician's orders for a chopped diet. The Cook, the Dietary Line Checker, the Licensed Nurse and the Certified Nursing Assistant did not verify that the prescribed diet, in the correct consistency, was checked prior to bringing the meal tray into Resident 1's room. Resident 1 was known to have behaviors, in which he immediately grabbed for food and stuffed the food into his mouth. As a result, Resident 1 grabbed 2 pancakes and 2 uncut whole sausage patties from his breakfast tray and put all 4 items into his mouth. The resident choked on the food and died.</p> <p>This violation presented an imminent danger that</p>			
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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

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	death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or a substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom, and was a direct proximate cause of the death of the a patient.			

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