

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555736	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2014
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NAME OF PROVIDER OR SUPPLIER Avalon Care Center - Sonora	STREET ADDRESS, CITY, STATE, ZIP CODE 19929 Greenley Rd., Sonora, CA 95370-5996 TUOLUMNE COUNTY	<i>POC acceptable 4/27/16 P.S. Pinkham HFES</i>
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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 03-2003-0012183-F Complaint(s): CA00411801, CA00410834</p> <p>Representing the Department of Public Health: Surveyor ID # 22974, 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 483.25 Free of Accident Hazards/Supervision/Devices (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 following citation was written as a result of an unannounced visit to the facility on 9/2/2014 to investigate entity reported incident CA00410834 and complaint CA00411801. The Department determined the facility failed to ensure adequate supervision and direct assistance with a meal for one of three sampled residents (Resident 1) and failed to ensure his meal was provided in a texture Resident 1 could safely swallow. This failure resulted in an obstruction of Resident 1's airway and death due to choking.</p>		<p><i>To begin immediately and be corrected by 4/25/16.</i></p> <p><i>Appeal Rights Given on 4/21/16.</i></p>	

Event ID: IY5E11

4/18/2016

2:36:37PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Assistant Administrator* (X6) DATE *4/20/16*

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.

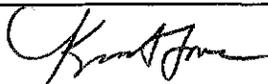
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	<p>Resident 1 was a 90 year old admitted to the facility on 12/26/13 with diagnoses which included food/vomit pneumonitis (lung inflammation due to inhaling food or vomit), encephalopathy (brain disease, damage or malfunction) and dementia.</p> <p>Review of the Minimum Data Set (MDS - an assessment tool), dated 6/26/14, indicated Resident 1 had long and short term memory problems and some difficulty in daily decision making in new situations. The MDS indicated Resident 1 needed extensive assistance with meal setup and one person physical assistance while eating. Resident 1 ate in the dining room.</p> <p>Review of the clinical record for Resident 1 identified a physician's order for a "Mechanical Soft with Ground Meat" diet dated, 12/26/13.</p> <p>Review of the facility Dietary Food Preferences, completed by the Dietary Manager (DM) and Resident 1's Responsible Party, indicated in the section for food dislikes, both wheat and white bread were circled.</p> <p>Review of the clinical record indicated a Dietary Memo/Diet Order form, dated 12/26/13, indicated as New Orders the following: mechanical soft and "ground meat" written on the form. A Dietary Memo/Diet Order form, dated 6/2/14, indicated handwritten notes, "extra sauce/gravy" and "ground meat" underlined.</p>		<p>This plan of correction constitutes the facility's allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or the conclusions set forth in the Statement of Deficiencies.</p> <p>F 323</p> <p>How Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>It is the Policy of Avalon Care Center Sonora that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Resident # 1 no longer resides at facility</p>		

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Assistant Administrator

4/25/14

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	<p>Review of the Diet Manual, dated May 2012, page 17, titled Mechanical Soft (Ground), indicated, "All meat (such as beef, fish, poultry and pork) should be ground or chopped. Gravy or sauces should be added to moisten dry ground and chopped meats ...for lubrication." Under definitions of terms, ground was described as "1/8" (inch) or less - consistency of ground meat." Another form titled, Mechanically Altered/Texture Modified Diets, declared the intended use was for "residents with chewing and/or swallowing problems." The form indicated the facility provided, "Two levels of mechanically altered diets on the Menu Spreadsheets ...Puree and Mechanical Soft Ground."</p> <p>Record review revealed Resident 1's "Dysphagia" (difficulty swallowing) care plan. There was no problem onset date. The plan indicated, "Resident is at risk for choking." Goals were "No choking episodes" and "Diet texture as ordered." The Approaches (what the facility would do to assist the resident to reach the goals) were listed as "ST [Speech therapy] screens as appropriate, Follow recommendations from therapy, To dining room for all meals," and "Assistance/supervision with all meals."</p> <p>Review of the "Dysphagia" care plan, dated 12/19/2013, for nutritional status, indicated as the Goal, "Resident food preferences will be honored through next review." The facility approaches were, "Encourage resident to</p>		<p>How the facility will identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken.</p> <p>All residents residing at the facility have the potential to be affected.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>All mechanical soft diets are served with ground meats unless otherwise specified, no other residents were found to be affected. Seating chart are placed in the dining room and updated weekly or as needed for any changes by the Unit Manager or designee. The resident is assigned by need; independent, assisted, dependent.</p> <p>Regional Nurse Consultant provided in-service on 12/3/14, 12/4/14, 12/5/14 regarding resident supervision and assistance while eating but not limited to symptoms of swallowing disorder.</p> <p>During new hire general orientation the staff is educated on swallowing disorder, but not limited to signs and symptoms of aspiration.</p>	

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	<p>consume 100% of breakfast, 75% of lunch, 50% of dinner and 100% of afternoon snack, Determine food preferences" and to "Give food that is easily swallowed."</p> <p>Review of the Speech Video Swallow Study done 1/16/14 indicated Resident 1's aspiration (breathing in food or fluid into lung) risk as moderate. The Speech Diet recommendations were for the National Dysphagia Diet (NDD) II-Ground, Liquids-Nectar thick. In the summary, a recommendation indicated NDD II (moist with extra gravy).</p> <p>Review of the Speech Language Pathologist (SLP - a specialist who evaluates and treats patients with speech, language, cognitive-communication and swallowing disorders in individuals of all ages) treatment note, dated 1/31/14, revealed the resident had a coughing/choking event: "Arranged for 1:1 [one to one] assistance w/ [with] meals." The SLP recommendations for Resident 1, dated 5/28/14, indicated, "In order to facilitate safety with oral intake, caregivers will assist patient in use of rate moderation [encourage resident to eat slower], bolus size modification [smaller bites], alternation of liquid/solids, second dry swallow [swallowing without food in mouth]...in order to decrease risk of choking and aspiration." Under, "Caregiver goals: Keep him from choking to death."</p> <p>Review of the SLP treatment note dated 6/2/14 revealed, "Pt seen @ [at] dining roomand</p>		<p>On 12/12/14, Licensed Nurses were in-serviced on choking hazards by the Unit Manager.</p> <p>On 12/15/15, licensed staff were in-serviced on speech therapy clinical brochure but not limited to oral discussion by the Director of Staff Development.</p> <p>As part of continuing education:</p> <p>On 3/11/15 CNA/RNA staff were in-serviced on by the Director of Staff Development on speech therapy included but not limited to oral discussion.</p> <p>On 3/12/15 CNA/RNA staff were in-serviced on choking prevention by the Director of Staff Development.</p> <p>On 3/15/16 and 3/17/16, CNA/RNA were in-serviced by Director of Staff Development on Dysphagia, but not limited to oral discussion.</p> <p>On 9/18/14, In-service was conducted on mechanical soft diet but not limited to altered texture diet. Mechanical soft are served with ground meats, unless otherwise specified.</p> <p>On 8/27/14, Dietary Manager provided in-service for dietary staff including but not limited to mechanical soft diet.</p>	

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	<p>dining room CNAs [Certified Nursing Assistants] present for training. Upon arrival, tray had dry chopped meat [with] no gravy and dry rice. Removed immediately and replaced [with] correct diet order." The SLP note for 6/6/14 indicated, "Pt needed consistent cues to take small/single sips and go at a slow rate." A treatment note, dated 6/10/14, confirmed "Instructed caregivers SSP</p> <p>[Swallow/Strategies/Positions: to facilitate safety and efficiency, it is recommended the patient to use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions]...to improve safety [with] oral intake, focused on the following-rate and bolus size modifications, alternation of consistencies, cough/re-swallow, single sips, double swallows and frequent breaks." Further review indicated that on 6/9/14, "Educated staff on SSP and supervision needed to prevent choking and decrease risk of aspiration w/ verbalized understanding demonstrated."</p> <p>A comprehensive review was done on the SLP notes and on 1/3/14, 1/10/14, and 2/6/14, the SLP noted either wrong food consistency or wrong liquid consistency on the resident's diet tray.</p> <p>Review of the facility incident reports indicated Resident 1 experienced choking events on food that was not indicated on a mechanical soft, ground meat diet or per the food preference form completed on admission by</p>		<p>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.</p> <p>12/2/14 to 1/31/15 Random meal checks were completed for all soft mechanical diet.</p> <p>On 12/2/14 to 1/30/15 Daily audits were completed to ensure that 2 nursing staff were available in west dining room for all meals.</p> <p>On 12/23/14 to 1/24/15 Daily audits were done to ensure that ADL assistance with eating were being provided by staff to the residents based on resident needs.</p> <p>On 1/21/15 Audits were brought to the monthly QAPI no finding identified</p> <p>On 2/18/15 Audits were brought to the monthly QAPI no finding identified</p> <p>On 3/18/15 it was recommended by the QAPI committee to discontinue the audits on mechanical soft diet due to no further concerns.</p>	

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	<p>the Dietary Manager. On 5/27/14, Resident 1 choked on cake which caused him to become "limp and cyanotic [skin turned blue from lack of oxygen]" and then on 6/21/14 Resident 1 choked on a dinner roll which caused him to become distressed and cyanotic."</p> <p>Review of the Facility Reported Event, dated 8/23/14, revealed that Resident 1 "...began choking at 12:15 PM," 911 was called and the Resident 1 was transported to the emergency department.</p> <p>Review of the Pre-hospital Care Report, dated 8/23/14, completed by the ambulance crew who responded to the 911 call, indicated the Field Clinical Impression as "Respiratory and cardiac arrest secondary to foreign body obstruction." The "Comments" section included, at 12:31, "Rice was suctioned form [sic] airway revealing a large foreign body obstructing [patient] airway." At 12:32, "A large piece of chicken approximately the sized [sic] of a fifty cent piece [30.6 millimeter or 1.2 inches] was removed form [sic] airway." The Call Summary indicated, "PT was found unresponsive, pulseless and apneic [not breathing] while lying on the floor...staff indicated that he started choking [sic] while eating lunch...Pt was found to have a large piece of chicken completely blocking his airway. After removal of foreign body and pt ventilated no improvement was noted and DNR [Do not resuscitate] was followed."</p>		Completion date for corrective action plan: December 12, 2014	

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Assistant Administrator

4/26/15

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	<p>Review of the emergency department reports, dated 8/23/14, in the History of Present Illness section, indicated "...They [EMT] were able to suction out the rice and remove the piece of chicken from his esophagus in the ambulance." Resident 1 was pronounced dead at the emergency department at 12:48 p.m.</p> <p>During an interview on 9/2/14 at 1 p.m., the SLP stated she had trained the family and the CNA's to encourage the resident to sit up when eating, slow down between bites, take smaller bites, and to swallow between bites.</p> <p>During an interview with Licensed Vocational Nurse 1 on 9/2/14 at 3:10 p.m., she stated she checked the lunch trays on 8/23/14. She stated she saw a "layered enchilada" cut in pieces on Resident 1's tray.</p> <p>An interview was conducted on 9/5/14 at 2 p.m. with the Dietary Manager (DM); she described how the chicken quesadilla was made. She said the frozen, precooked chicken pieces were thawed, heated and placed in food processor to be chopped "fine". The processed chicken was then placed in the oven until lunch. The cook placed a tortilla on a plate, put cheese and then the ground chicken on it, then folded the tortilla over the filling. Review of the lunch menu for 8/23/14 indicated Chicken Quesadilla, Spanish rice, and seasoned black beans.</p> <p>During an interview on 9/19/14 at 12:17 p.m.,</p>			

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	<p>Certified Nursing Assistant 1 (CNA 1) stated on 8/23/14 she was in the West dining room passing lunch trays alone. She stated that usually there were at least two CNA's in the dining room during meals but the other CNA was called out to care for a resident. CNA 1 said she served Resident 1 his meal, then went back to get the lunch tray for another resident at the same table. She heard a noise and looked at Resident 1, who looked "scared." She asked if he needed the choking maneuver and he nodded his head. She called for help and attempted to help the resident.</p> <p>During an interview with the Coroner on 9/19/14 at 9:15 a.m., he stated the ambulance crew removed a large piece of chicken from the patient's airway. He examined the piece of chicken, took pictures, and described it as a "single piece of chicken... not chopped... approximately the size of a quarter or 50 cent piece size." In his professional opinion Resident 1's death was consistent with choking due to a large piece of chicken in the airway.</p> <p>Review of the Certificate of Death, issued 9/19/2014, indicated the, "IMMEDIATE CAUSE" of death for Resident 1 as, "AIRWAY OBSTRUCTION" and "FOOD BOLUS." Under the description of how the injury occurred indicated, "CHOKED ON A PIECE OF FOOD."</p> <p>Therefore, the facility failed to ensure adequate supervision and direct assistance</p>			

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	with a meal for one of three sampled residents (Resident 1) and failed to ensure his meal was provided in a texture Resident 1 could safely swallow. This failure resulted in an obstruction of Resident 1's airway and death due to choking. These violations presented either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom and were a direct proximate cause of death of the patient or resident.			

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