

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>CLASS AA CITATION -- PATIENT CARE 02-2352-0011617-F Complaint(s): CA00407437</p> <p>Representing the Department of Public Health: Surveyor ID # 28184, 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>F309 Title 42, Code of Federal Regulations, § 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>The facility violated the aforementioned regulation when it failed to follow their policy and procedure to provide a safe dining experience, and failed to implement their care plan to consistently assist and assure that safe eating occurred for Resident 1. Resident 1 complained of difficulty swallowing and was known to eat quickly and not chew adequately. Licensed staff wrote a care plan instructing staff to, "Assist and monitor during meals; alternate between bites of food and sips of fluids". As a result of these failures, Resident 1</p>		<p><b>This Plan of Correction constitutes our allegation of compliance. Submission of the Plan of Correction is not an admission of any fact or that any deficiency whatsoever exists or that any deficiency was cited correctly.</b></p> <p>The facility respectfully disagrees with findings under F309 and has submitted an Informal Dispute Resolution (IDR) requesting this finding be removed from the Statement of Deficiency</p> <p><b>F309 §483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b> SS=G</p> <p>(Revised on 10/23/14 at CDPH request)</p> <p><u>Correction for Residents Affected:</u> Resident 1 no longer resides at this facility.</p> <p><u>Identification of Residents with the Potential to be Affected:</u> Residents with the potential to be affected will be identified through their diagnosis of dysphagia, residents self-reported difficulty swallowing and through staff-reported observations of difficulty eating or swallowing during dining. The Registered Dietician (RD) will review all current diets to identify any diets with an altered texture of a single food item and notify the Director of Nurses (DON) for follow-up. Medical records will report to the DON any new diet orders with an altered texture of a single food item for follow-up.</p>	

Event ID: HLUU11 *Lee Ann Calnie* 7/13/2015 7:53:30AM *Administrator* 7/13/15  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lee Ann Calnie* TITLE *Administrator* (X6) DATE 7/13/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 10  
 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>choked on food and died.</p> <p>Review, on 9/10/14, of the facility's policy and procedure, titled, "Dysphagia and Swallowing Risks," no revision date, showed, "If a resident appears to be exhibiting signs of Dysphagia (difficulty with swallowing or moving food or liquid safely from the mouth to the stomach) or has a swallowing risk (physiological, neurological, structural, behavioral or other issues) which increase the likelihood of a hazardous event (i.e. aspiration, food goes down the wrong pipe), choking, reflux stomach acids go back up the esophagus), a referral to a Speech Pathologist should be initiated, physician/ physician's assistant and conservator should be notified."</p> <p>The policy and procedure, titled, "Group Dining," revised 5/7/14, reflected, "Residents who attend group meals or group snack times are provided a supportive and safe dining experience. Upon admission and with each comprehensive MDS (complete resident assessment), resident's dining skill level will be evaluated and care plans developed and updated to reflect current individual needs."</p> <p>According to the medical record, reviewed on 9/10/14, Resident 1 was admitted to the facility on 11/9/12. Her diagnostic list, dated 5/28/14, included head injury from a motor vehicle accident, and dysphagia (abnormal or difficulty with swallowing). Resident 1 was sent to the emergency room emergently after choking on</p>		<p><b>Steps Taken to Prevent Recurrence:</b> The primary physicians for those residents identified as having the potential to be affected will be notified for possible orders, including but not limited to: orders for swallowing evaluation; orders for alteration of food and/or fluid textures; orders for speech therapy. The physicians will also be notified of any resident's refusal to accept the orders or to participate in testing or therapy. Residents with a diagnosed swallowing disorder, or residents who exhibit or complain of swallowing problems and who refuse testing, therapy or interventions related to the prevention of a choking event, and residents who have a history of unsafe eating behaviors, such as eating too fast, stuffing large amounts of food in their mouth, pocketing food, as observed and reported by staff will be placed in the facility's new Orchid Dining Club, closely observed and assisted by nursing staff during each meal. Participants are served meals prior to other residents and have at least one nursing staff at each table to quickly intervene if a choking episode occurs. Meal tray cards will continue to include swallowing risks related to medical or behavioral causes. Residents with</p>	

Event ID:HLUU11

7/13/2015

7:53:30AM

*LeeAnn Calorie Administrator 7/13/15*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05A427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>Crestwood Manor - Fremont</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA 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>food and having a cardiac arrest, on 7/26/14, in the dining room.</p> <p>Review of nursing care plans, dated 10/23/13, showed:</p> <ol style="list-style-type: none"> <li>"Focus: Impaired cognitive function or impaired thought processes related to short term memory loss, impaired decision making.</li> <li>"Focus: Variable appetite/ weight variance" with the intervention, "Encourage resident's socialization and interaction with table mates during meals.</li> <li>"Focus; Resistive to care related to diagnosis..., history of head trauma, refusing recommended consultations/ appointments/ medical interventions...being resistive when staff attempts redirection or instruction..."</li> </ol> <p>A nurse's note, dated 1/15/14, showed, "During breakfast, resident was noted to be eating faster than usual. Kept putting food fast in her mouth. Staff intervened always whenever resident was eating fast. Resident had food in her mouth when she exited the dining room. Staff intervened and let her swallow first before leaving. No difficulty swallowing noted."</p> <p>A "Nursing to Therapy Referral," dated 1/15/14, showed, "Please route to speech therapy. Resident has shown recent changes in the following areas: Safety- coughing; choking. Complained of difficulty swallowing on</p>		<p>swallowing disorders or risks will continue to be included in the Dining Monitor Book used by nursing staff. There are currently 8 residents included in the Orchid Dining Club. If an at risk resident refuses to participate in the Orchid Dining area, nursing staff will be assigned to the at risk resident's table regardless of where the resident consumes their food.</p> <p>Licensed staff and interdisciplinary team members (IDT) will be in-serviced on care planning for swallowing risks, care plan review and care plan revisions, including target dates.</p> <p>Certified nursing assistants (CNA) and program staff will be in-serviced on the signs and symptoms of dysphagia or behavioral swallowing risks, to include basic techniques to improve swallowing safety and / or following individualized recommendations by the speech therapist (i.e. serving one food item at a time, encouraging to alternate bites of food with liquids, encouraging to sit up straight and eat smaller amounts of food at one time, etc.).</p>	

Event ID:HLUU11

7/13/2015

7:53:30AM

*LeeAnn Calucci Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>1/14/14."</p> <p>The physician's assistants notes, dated 1/15/14, showed, "Informed by nursing yesterday evening by phone that patient complained of difficulty swallowing a vegetable in the dining room. Did not have a choke, was able to cough."</p> <p>A physician's order, dated 1/15/14, showed, "Clinical swallowing evaluation for dysphagia; Change diet to no added salt with chopped vegetables."</p> <p>A physician's order, dated 1/19/14, showed, "Discontinue speech therapy evaluation order, evaluation only, as patient is performing at her highest level of functioning Rx (Prescription) - Continue her current regular diet with chopped vegetables with strict swallow precautions. Re-consult speech therapy if any signs or symptoms of aspiration/ penetration or change in swallow status occurs."</p> <p>Review of care plans, dated 1/19/14, showed, "Concern: Potential for aspiration due to poor dentition, edentulous (lack of teeth), history of poor eating habits; resident gobbles food quickly. Refused swallowing evaluation on 1/17/14 but observed by speech therapist on 1/19/14. Strict swallow precautions." The heading titled "Concern" showed, "Resident will have no choking/ aspiration episode to 3/19/14." The heading titled, "Approach" showed, "Monitor for signs and symptoms of</p>		<p><b>Monitoring and Responsibility:</b> The facilities Quality Assurance and Performance Improvement (QAPI) committee will review, no less than quarterly, the "Safe Group Meal and Group Snack" internal audit tool to ensure nursing staff are placed at each table of all residents who are at risk of choking, regardless of which dining area they choose to eat at. Recommendations for improvement will be made by the QAPI committee as needed. The Director of Nurses (DON) and Administrator are primarily responsible for safe eating and providing care and services to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>To be completed by October 10<sup>th</sup>, 2014</p>	

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cecilia Cabrera Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05A427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>Crestwood Manor - Fremont</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA 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>choking/ aspiration; Staff assistance and monitoring; Encourage to take small bites, eat slowly and not talk while food in mouth; Alternate between bites of food and sips of liquids; Speech/ swallowing evaluation as needed, ordered 1/15/14; Notify physician and conservator of any change as needed." There was no revision date.</p> <p>A care plan, dated 6/9/14, titled, "Potential for aspiration", showed the goal, "Resident will follow diet as ordered (regular, no added salt with chopped vegetables) x 90 days." The Interventions included, "Encourage to take small bites, eat slowly and not talk while food in mouth, alternate between bites of food and sips of liquids, staff assistance and monitoring."</p> <p>The MDS (minimum data set, a complete resident assessment), dated 6/19/14, reflected Resident 1 was independent in eating and only needed 'set-up.' Under the heading, "Swallowing/ Nutritional Status," showed "Loss of liquids/solids from mouth when eating or drinking." It reflected that Resident 1 was on a therapeutic diet, no added salt, and the space next to, "Mechanically altered- required change in texture of food or liquids," was blank.</p> <p>Review of the written report sent to the Department by the facility administrator (ADM) on 7/26/14, showed, "The following incident happened today at noon meal. RN 1 verified all the diets and CNA's passed the trays in the assisted dining area....LVN 1 heard, 'That</p>			

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cell Ann Calverie Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>resident needs help.' She was assisting another resident about ten feet away at another table. LVN 1 saw that Resident 1 was bluish, called for help, and began the Heimlich maneuver...LVN 1 swept a small piece of meat from her mouth... No pulse was detected so CPR was started until emergency responders arrived."</p> <p>During an interview on 9/10/14 at 11:30 a.m., the MDS coordinator was asked about the assistance Resident 1 required during meals. She stated, "We have CNAs (certified nursing assistants) going around looking at the residents. Resident 1 was independent in spite of having dysphagia. If a resident needed one to one assistant, it would be called 'supervision'. Resident 1's assessment showed zeros for 'self- performance,' meaning she needed no help. 'Set-up' is giving the tray, opening containers and cutting the meat if requested. I took this information from the CNA's ADL flow sheet."</p> <p>The activities of daily living (ADL) flow sheet, documented daily by the CNAs, reflected Resident 1 received 'set-up' and ate independently every day in 7/2014.</p> <p>During an interview on 9/10/14 at 12:30 p.m., the Director of Nurses (DON) stated, "Monitoring is when CNAs are going around in meal area and looking at residents while they eat. They will tell them to slow down, take small bites."</p>			

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cecilia Calvie Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05A427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>Crestwood Manor - Fremont</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA 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>During an interview on 9/10/14 at 12:35 p.m., the director of staff development (DSD) stated, "I saw staff stopping her (Resident 1) when she left the dining room with food still in her mouth. There were days when she wouldn't reality orient (having delusional thoughts)."</p> <p>During an interview on 9/10/14 at 12:50 p.m., registered nurse 1 (RN) stated, "I supervised the dining room on 7/26/14 when she (Resident 1) choked. I checked to be sure the diets were correct and delegated the CNAs to pass the trays. I walked around and observed and instructed to not talk while eating and chew properly, slowly and alternate with fluids. When Resident 1 choked, there was no coughing. LVN 1 heard someone say, 'This lady needs help.' We were in the community dining room. LVN 1 got to her first and called for help. Resident 1 was still sitting in the chair and her face was blue. LVN 1 gave her the Heimlich in the chair from behind and nothing came out. More staff came and we put her on the floor and tried thrusts. Her meat was not chopped." When asked how staff ensured alternating food and fluids, RN 1 stated, We reminded her. She was very independent and would reject our recommendations."</p> <p>During an interview on 9/10/14 at 1:30 p.m., the physician (MD 1) stated, "I feel they followed the speech therapist (ST) referral and I did, too. You should talk to the ST."</p>				

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cel Ann Calnie Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER  Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>During an interview on 9/10/14 at 1:45 p.m., licensed vocational nurse (LVN) 4 stated, "I was the one who called 911. She (Resident 1) was in the community center dining room which is for residents who need assistance like encouraging, cutting food if they want and feeding them if they are too delusional to focus."</p> <p>During a phone interview on 9/11/14 at 10:30 a.m., speech therapist (ST) stated, "I did observation on 1/19/14. She was uncooperative. I made a recommendation if they saw any problem with her forming a bolus (a pill shaped mass) to get a new ST referral to assess her swallow. I recommended chopped vegetables as the only change in texture because it was her preference. I saw her once, on 1/19/14, six months before the choking incident on 7/26/14."</p> <p>Review of the assessment by the emergency medical technicians who arrived on 7/26/14 showed, "Arrived at nursing home to find ...female patient lying on the dining room floor...There was report that this patient may have been choking when the (cardiac) arrest took place... When airway was assessed there was a lot of secretions with food content. Special instruments used to remove contents. While visualizing airway, a large piece of meat was removed from her airway."</p> <p>Review of the hospital emergency department records, dated 7/26/14, showed, "Chief</p>			

Event ID:HLUU11

7/13/2015

7:53:30AM

*Lecann Calnie Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  05A427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2014
NAME OF PROVIDER OR SUPPLIER Crestwood Manor - Fremont		STREET ADDRESS, CITY, STATE, ZIP CODE 4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA COUNTY		
(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>complaint: CPR (cardiopulmonary resuscitation). Patient coming from assisted living facility. Was eating, began to choke, CPR initiated. Down for 5 minutes prior to EMS arrival, on scene patient in asystole (no heartbeat)...Airway cleared of food...History: Patient choked on turkey...EMS pulled three chunks from mouth..."</p> <p>The hospital's discharge summary, dated 8/1/14, reflected, "...resident who was rushed to ER via emergency medical system (EMS) after she choked on a piece of chicken meat during lunch time. CPR was initiated in the facility. In ER she was intubated (a tube inserted into the trachea to maintain an open airway) and placed on a mechanical ventilator. She had a seizure in the ER...Bronchoscopy (examination of the deeper parts of the lungs with a scope) was done...removed a piece of chicken meat completely obstructing the left main stem bronchus....She was transferred to intensive care unit (ICU). Her mental status remained poor the next day, concerning her anoxic encephalopathy (lack of oxygen to the brain)...Comfort care initiated on 8/1/14. She expired at 3:30 p.m. Disposition: Deceased"</p> <p>During a phone interview on 9/11/14 at 2:15 p.m., the assistant director of nurses (ADON) stated, "Care plans are reviewed and revised every three months. There was no review of Resident 1's care plan to prevent aspiration between 1/19/14 and 6/9/14."</p>			

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cecilia Labrie Administrator 7/13/15*

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>05A427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/19/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>Crestwood Manor - Fremont</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4303 Stevenson Blvd, Fremont, CA 94538-2645 ALAMEDA 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>During a phone interview on 9/18/14 at 1:45 p.m., the dietary manager (DM) was asked about the change in vegetable texture (chopped) but not the texture of the meat. DM Stated, "She was on soft-cooked vegetables and chopped to be soft. If it wasn't soft, she wouldn't be able to tolerate it. I just follow the diet orders."</p> <p>During a phone interview on 9/19/14 at 2:15 p.m., the director of staff development (DSD) stated, "I haven't given an inservice on dysphagia; I just tie it into what to do after someone chokes."</p> <p>Review, on 10/17/14, of Resident 1's death certificate, dated 8/7/14, showed the immediate cause of death as, "Anoxic encephalopathy", and the underlying cause as, "Aspiration of food". There was a space for the coroner to fill in, "How injury occurred, (events which resulted in injury)". The deputy coroner documented, "Choked on food".</p>				

Event ID:HLUU11

7/13/2015

7:53:30AM

*Cell Ann Calnie Administrator 7/13/15*