

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2010
FORM APPROVED
OMB NO. 0938-0391

*Poz accepted
3/11/10 @ SPM*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055388	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/16/2009
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 75 N. 13TH STREET SAN JOSE, CA 95112
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during investigation of an entity reported incident and a complaint conducted on 8/31/09 and 11/16/09. For Entity Reported Incident CA00199676 regarding Quality of Care, and Complaint CA00200856 regarding a resident's death, a State Class "AA" citation and a Federal deficiency were issued (see Code of Federal Regulations, F224). Inspection was limited to the specific entity reported incident and complaint investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: [REDACTED], Health Facilities Evaluator Nurse and [REDACTED] Health Facilities Evaluator Supervisor.	F 000	This Plan of Correction is my credible allegation of compliance. F 224 483.13 (c) Mistreatment/Neglect/Misappropriation I. Corrective Action Resident 1 expired. 8/24/09 For failure to implement appropriate emergency procedures, RN B was terminated on 11/16/09. The Director of Nursing (DON) at the time of occurrence is relieved of the duties of the position.	8/24/09 11/16/09
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide the necessary services to prevent harm when staff failed to promptly respond to a life-threatening situation involving	F 224	The DON conducted an inservice to the Licensed Nurses that included: a. Requiring the Charge Nurse to be stay with the resident until paramedics arrived and assist the resident. b. The new policy to ensure that oxygen E-tanks are available for use in case of emergency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cestia Carson, Lvn administrator</i>	TITLE <i>3/11/10</i>	(X6) DATE
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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. (See instructions.) Except for nursing homes, the findings stated 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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F 224

Continued From page 1
one of three sampled residents (1).

The facility failed to perform an emergency procedure (Heimlich maneuver) to assist Resident 1 in clearing his obstructed airway on 8/24/09.

Resident 1 was assessed as a high risk for aspiration due to difficulty in swallowing. On 8/24/09 at 5:20 p.m., certified nurses assistant A (CNA A) was feeding the resident his dinner when suddenly Resident 1 started coughing. According to documentation gathered, Resident 1 was gasping for air and became distressed. Although staff suspected Resident 1 was choking on food, no immediate attempt was made to perform abdominal thrusts to clear the resident's obstructed airway.

The facility failed to promptly call 911 for emergency services. The facility staff stated they called 911 (paramedics) at 5:30 p.m. However, according to the emergency dispatch office, the facility called at 5:49 p.m., a delay of approximately 19 minutes. An investigative report from the police indicated the resident was already deceased when the paramedics arrived on the scene. Resident 1 was pronounced dead at 6:09 p.m. on 8/24/09. Findings:

Resident 1's medical record indicated that he was admitted to the facility with diagnoses including Alzheimer's disease and dysphagia (difficulty swallowing). The Minimum Data Set (MDS), an assessment tool, dated 7/28/09 indicated Resident 1 had short and long-term memory loss, was severely impaired, and was totally dependent on staff for eating. Resident 1 was on aspiration precaution (use of special

F 224

The Director of Staff Development (DSD) had conducted inservices to the nursing staff on the topics of:

- Obstructed Airway:
Conscious Adult - 6/25/09
- Cardiopulmonary Distress (including Activating 911)
7/24 & 27, 2009
- Feeding a Resident (including Heimlich Maneuver)- 11/18, 20, 2009 and 12/7/09

An Emergency Cart equipped with a suction machine and suction catheter, Oxygen (E-Tank) set up and ready to go, ambu-bag and other emergency equipment and supplies is available to the staff. It is located in the hallway by Station I.

The night shift to ensure that the Oxygen tank is not empty and that the suction machine is set-up checks the emergency cart. This is documented in the emergency cart log.

6/25/09

7/24 & 27/09

11/18 - 20/09

12/7/09

3/10/10

5/10/10

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feeding techniques to assist with swallowing) and had a physician's order dated 7/17/09 for a puree diet with honey thick liquids.

The Preferred Intensity Level of Treatment form dated 7/17/09 indicated when necessary the resident's preference was to be transferred to an acute care hospital. The form also indicated a "No CPR" (cardio-pulmonary resuscitation). The form specified "No CPR" meant no cardiac compression, defibrillation (stimulate heart electrically), intubation (insert tube into windpipe to provide oxygen), mechanical ventilation, ACLS (advanced cardiac life support) medications or vasopressors (medications to raise blood pressure) Nevertheless, the definition of "No CPR" did not preclude the performance of abdominal thrusts as done during a Heimlich maneuver.

During an interview on 11/16/09 at 4:02 p.m., CNA A stated around 5:20 p.m., she was feeding Resident 1 while he was in his bed and sitting with his head up about 50 degrees. After she fed the resident two spoonfuls of pureed food, Resident 1 started coughing. CNA A stated she immediately called for registered nurse B (RN B) to come to the resident's room. CNA A stated RN B came but then left the room. CNA A also stated she did not attempt to ask Resident 1 to spit up anything because when she opened the resident's mouth, she stated there was "no food" and so she did not "push on his stomach".

During an interview on 11/16/09 at 4:30 p.m., licensed nurse F (LN F) stated the resident was non-responsive when he entered the room. He was unable to state the exact time he entered the room but stated Resident 1 was having shallow

F 224

II. How To Identify Other Residents

There are currently 23 of residents on mechanically altered diets due to swallowing problems. There have been no incidents of choking recorded.

There were no other residents identified that required the performance of the Heimlich maneuver.

There were 10 of residents that required 911 services for change in condition for the period covering August 25, 2009- March 11, 2010. There were no reports of delays in notification of 911 services that resulted in negative outcomes to the residents sent out. *3/11/10*

III. Systemic Changes

To prevent a recurrence of the same situation the following is in place:

Effective 11/09/09 the following policies were implemented: *11/09/09*

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F 224 : Continued From page 3

and labored respirations. LN F stated the resident ' s oxygen saturation was only 54% (therapeutic range is 94% to 100%) so he grabbed an oxygen tank to administer oxygen.

During review on 11/16/09, the licensed nurse ' s progress note dated 8/24/09 at 5:35 p.m. indicated "resident was not looks good, assess resident right away, found resident in bed, face looks pale, no verbally responsive." It further indicated Resident 1 "can not open his eyes (resident usually can be verbally responsive)." The note indicated when touched, Resident 1 moved his face but his breathing was slow and shallow and when the resident ' s mouth was opened there was no food found. With no timeline documented, the note further indicated, " Inform to MD office & (and) try to call the son (name), but he did not answer telephone. So, left message, resident is no CPR but hospitalization @ (at) this time. "

The resident ' s vital signs (normal ranges accessed at <http://www.healthsystem.virginia.edu/uvahealth/adult_nontrauma/vital.cfm>) were recorded as follows: blood pressure of 60/40 (normal reading is in the range of 120/80), pulse 32 (normal range is 60 to 100 beats per minute), respirations 8 (normal range is 15 to 20 per minute) and the temperature was 96.4 degrees Fahrenheit (F) (normal is around 98.6 degrees F). The note had no time documented when the resident had, " O2 sat (oxygen saturation) 60% RA (room air). So, call 911, about 3-4 min (minutes), 911 team came..." The note indicated the licensed nurse called 911 only after she had made attempts to call the physician and the resident ' s son

F 224

1. Assistance with meals that include the dining room, residents confined in bed, and residents requiring full assistence. Emphasis given on the positioning of residents when served and fed in bed must be 90 degrees. The resident should remain in that position for at least 30 minutes.

2. Guidelines for Emergency Services that emphasizes the immediate attention of the nurse for instituting appropriate services. Accuracy of Documentation is key. The DON conducted inserviecs to the Licensed Staff on the following topics:

1. General Guidelines for Emergency Care- Key points:
 - a. Charge nurse must stay and attend to the resident needs immediately, at the same time call of assistance of other staff.

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During an interview with RN B on 11/16/09 at 3:30 p.m., she stated she was not sure of the exact time CNA A called her to go to Resident 1's room. When she arrived in the room, she stated the resident was lying in bed, with the head of his bed at a 50-degree angle. RN B stated Resident 1 was "pale, breathing really slow, moving his head and was not verbally responsive." She said she suspected Resident 1 choked on the food. She said she also could not remember what kind of pureed foods were served to the resident. RN B stated she left the room to call the paramedics.

During review on 11/16/09, there was no documented evidence in Resident 1's medical record that staff attempted to clear the resident's obstructed airway as done in a Heimlich maneuver.

During review on the same date of the skilled nursing facility's (SNF) records, it indicated a staff in-service about an "Obstructed Airway: Conscious Adult" was conducted on 6/29/09. The in-service included instructions for when a person is choking, to use abdominal thrust and repeat the thrust until the obstruction is cleared.

During review on 11/16/09, the police officer's (investigative) report dated 10/5/09 regarding the death of Resident 1 indicated the emergency fire personnel summoned the police to the facility on 8/24/09.

The police officer's report indicated the emergency dispatch office verified the facility called them at 5:49 p.m. The paramedics were dispatched immediately. When the paramedics arrived, the resident was already deceased and they pronounced him dead at 6:09 p.m.

F 224

b. If a resident is in respiratory distress, and the resident has just eaten, assess for choking.

c. Do the Heimlich maneuver

d. If Oxygen is needed, the charge nurse can ask the resident to get the tank, but administration is the licensed nurses' responsibility.

e. If a resident is choking, regardless of the code status, Heimlich should be performed.

f. If the vital signs are not normal, licensed nurse must assess the possible causes and proceed with emergency care.

g. You are in charge, the CNAs rely on your direction.

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F 224	Continued From page 5 The police officer ' s report indicated on 8/24/09 around 5:20 p.m., CNA A was feeding the resident puree diet with a spoon. CNA A stated the resident was not swallowing the pureed food and was only " moving his face " . Then Resident 1 started gasping for air and his eyes were moving in distress. CNA A ran and got RN B for help. The police officer wrote that CNA A stated she fed Resident 1 two spoonfuls of food starting at 5:20 p.m. When the resident started choking, RN B immediately responded and after they attempted resuscitation, called the emergency medical services (EMS-911) at 5:30 p.m. The same report indicated when the police officer asked staff how they intervened with the choking, they stated they "propped the resident up in bed and patted him on the back. " The police officer ' s report indicated at no time did any of the nurses describe doing a Heimlich maneuver (an emergency procedure using abdominal thrusts to clear the airway of a choking victim). A further review on the same date of the SNF ' s in-service teaching plan for "Obstructed Airway. Conscious Adult" conducted on 6/29/09 indicated if there is a suspicion the person is choking, " Do not pat the person who is choking on the back. When you do, you risk jarring the object and having it settle more firmly, completly (sic.) cutting off the airway. " The police officer ' s report reviewed on 11/16/09 also indicated the police officer noted a discrepancy when the emergency call from the facility came 20 minutes later than the staff	F 224	h. Assign other nurse to call 911, but must give a brief description of the problem to the nurse. i. If the situation requires, call 911 first before calling the attending MD. j. Notification of the responsible party can be done after the emergency needs have been attended to. k. Prevention of Choking and Heimlich maneuver Reviewed. l. In the event of Choking at meals, the tray is saved for inspection by the charge nurse. Done: 11/25/2009 2. Change in Condition	11/25/09

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F 224	<p>Continued From page 6</p> <p>claimed. Although the facility staff stated they called the emergency services at 5:30 p.m., the emergency dispatch office noted the call was received at 5:49 p.m.</p> <p>The police officer ' s report indicated Resident 1 was already deceased before the emergency services (paramedics) arrived in the facility. It documented Resident 1 was in " asystole, pulseless and apnetic {sic}." The police officer wrote the nurses claimed they called the paramedics immediately when the resident started choking. The same report indicated the facility ' s nurses maintained they had suctioned and given the resident oxygen. The report indicated the Fire personnel found the suction machine sitting on a nightstand, clean, with no tubes attached, and it was not plugged in. According to the same report, the oxygen was not running (not administered) at the time the paramedics arrived at the facility.</p> <p>The medical examiner investigator ' s report was reviewed on the same date and it indicated the nursing staff told the fire personnel " they used an oxygen machine " . However, the " (name) fire personnel found the machine in the hallway, still with a plastic cover on it " .</p> <p>During review on 11/16/09, the coroner's autopsy report for Resident 1 dated 10/27/09 documented "the cut surface of the larynx and adjacent trachea indicated a dark red mucosa approximately 30 ml of beige finely particular fluid." The coroner's report further indicated that multiple sections of the lungs showed the presence of food matter in the small airways. The pathological diagnosis included aspiration of food bolus, asphyxia (lack of oxygen), and abundant</p>	F 224	<p>Procedures Done/12/20/09</p> <p>3. Prevention of Resident Abuse with emphasis on Neglect (failure to provide goods and services). Done: 03/10/10</p> <p>4. The Dining Program was reviewed and residents with swallowing problems who are able to sit up on a wheelchair will be served meals in the dining room for lunch and dinner for closer supervision. The program is under revision due to changes in residents and will be implemented on 03/15/10</p> <p>A repeat inservice shall be conducted to Licensed Nurses and CNAs on the Prevention of</p>	<p>12/20/09</p> <p>3/10/10</p> <p>3/15/10</p>

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F 224 Continued From page 7
particular fluid present within the upper and lower airways. The coroner determined the resident's cause of death was asphyxia due to aspiration of food bolus.

F 224

Choking/Heimlich Maneuver by 3/17/10
03/19/2010/.

The DSD, DON/ Designee will conduct annual competency exams on performance of Heimlich maneuver.

The policy of requiring Licensed Nurses to be CPR certified and the Certified Nursing Assistants to possess at least a First Aid Certificate/CPR preferred will continue to be implemented.

IV. Monitoring

The DSD/ DON/ designee/Charge Nurses shall conduct daily rounds at different meals to ensure that correct feeding procedures are followed.

Supervision of residents who are mechanically altered diets (pureed, thick liquids) due to swallowing problems and are fed in rooms shall be included in the rounds. 3/11/10

Although Resident 1 had requested not to be resuscitated if his heart stopped, Resident 1's heart had not stopped when he coughed while being fed. According to the online article entitled "Part 4: Adult Basic Life Support" by American Heart Association and accessed at (<http://circ.ahajournals.org/cgi/reprint/112/24_suppl/IV-19>), regarding "Foreign-Body Airway Obstruction (Choking)", pages IV-28 and IV-29, staff must act quickly if the foreign body airway obstruction (FBAO) produces signs of severe airway obstruction. Severe airway obstruction can occur when the cough becomes silent and respiratory difficulty increases or the victim becomes unresponsive. The EMS system should be activated quickly if the resident is having difficulty breathing. Also, if more than one rescuer is present, one rescuer should attend to the choking victim while the other person telephones 911.

In case reports involving severe FBAO, the article states there is increased success when performing the combined techniques of back blows or "slaps", abdominal thrusts and chest thrusts. The article also indicates that in a series of choking episodes report, 50% of airway obstructions were not relieved by performing a single technique. Although the same article indicated "... chest thrusts, back slaps and abdominal thrusts are feasible and effective for relieving severe FBAO in conscious (responsive) adults..." in order to simplify training the recommendation is for "the abdominal thrust be

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F 224	Continued From page 8 applied in rapid sequence until the obstruction is relieved ". Given that abdominal thrust is an emergency technique performed to clear an obstructed airway prior to CPR, the same article states, " If the adult victim with FBAO becomes unresponsive, the rescuer should carefully support the patient to the ground, immediately activate EMS, and then begin CPR. "	F 224	<p>The Dining Room Committee (DON, DSD, RN MDS Coordinator, Dietary Services Supervisor, Activity Director) will review and evaluate those residents in the Dining Program to identify those residents that may need Speech Therapy Services. The DON/Designee is responsible for referring these residents to the attending physician.</p> <p>The Department Managers/Designee/ Charge Nurses will assist in making rounds at meal times to ensure the safety of the residents during feeding.</p> <p>The DON shall provide a quarterly report to the Quality Assurance Committee for review and or corrections.</p> <p>The Medical Records Director shall conduct audits of resident charts that 911 services calls, and emergency procedures rendered to the resident are documented accurately. A report shall be submitted to the Administrator of corrective action.</p>	