

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F 000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00160464 and IN00161191 completed on 12/18/14.</p> <p>This visit was done in conjunction with the PSR to the Recertification and State Licensure Survey completed on 12/5/14.</p> <p>This visit was done in conjunction with the PSR to the Investigation of Complaint IN00162446 completed on 1/13/15.</p> <p>This visit was done in conjunction with the Investigation of Complaints IN00163785, IN00164923, and IN00164979.</p> <p>Complaint IN00160464-Not Corrected.</p> <p>Complaint IN00161191-Corrected.</p> <p>Survey Dates: February 23, 24, 25, and 26, 2015</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey Team:</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 309 SS=E Bldg. 00	<p>Heather Tuttle, RN-TC Lara Richards, RN</p> <p>Census bed type: SNF: 31 SNF/NF: 105 Total: 136</p> <p>Census payor type: Medicare: 31 Medicaid: 89 Other: 16 Total: 136</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 3, 2015, by Janelyn Kulik, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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>			
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	<p>Based on record review and interview, the facility failed to ensure the necessary care and services were provided related to following the facility's bowel protocol for residents experiencing signs and symptoms of constipation for 2 of 7 residents reviewed for constipation. The facility also failed to ensure staff were prepared for an emergency situation related to monitoring for signs and symptoms of choking and providing Cardiopulmonary Resuscitation (CPR) for 2 of 2 residents reviewed for choking. The facility also failed to ensure lung sounds were assessed for 1 of 3 residents who were exhibiting signs and symptoms of an upper respiratory infection. (Residents #B, #C, #F, #G, and #H)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 2/24/15 at 10:01 a.m. The resident's diagnoses included, but were not limited to, pneumonia and chronic airway obstruction.</p> <p>An entry in the 72 hour follow up change in condition dated 1/22/15 at 1:51 p.m., indicated "was reported that resident's daughter wanted an x-ray because of audible congestion, however, no congestion noted, no respiratory distress. Vital signs are within normal limits,</p>	F 309	<p>F309</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #F has completed her Antibiotic therapy for her UTI, pneumonia and Sepsis.</p> <p>Residents #G and #H have had bowel movements.</p>	03/04/2015

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	<p>resident makes needs known, Nurse Practitioner in facility today, will continue to assess and observe. Lung sounds clear, no cough or congestion noted, no change in appetite. 6:00 p.m., CXR (chest x-ray completed and MD aware of new orders. As resident is afebrile, no SOB (shortness of breath), lungs clear. No new orders at this time. Monitor for cough."</p> <p>Documentation on the 72 hour follow up report dated 1/23/15 at 11:52 a.m., indicated occasional barky cough noted this morning. Lung sounds are diminished and clear.</p> <p>An entry in the 72 hour follow up report dated 1/24/15 at 10:21 a.m., indicated occasional non productive cough noted this morning, will continue to observe. There was no assessment of the resident's lung sounds at this time.</p> <p>An entry in the Nursing progress notes dated 1/25 at 9:39 a.m. and on 1/26/15 at 1:00 p.m., indicated an occasional non-productive cough was noted.</p> <p>Documentation in the Nursing progress notes on 1/26/15 at 9:31 p.m., indicated the resident's lung fields were diminished.</p>		<p>Residents #B and #C are no long in the facility.</p> <p>2) How the facility identified other residents:</p> <p>Review done to determine if any other residents were exhibiting signs and symptoms of upper respiratory infection. Staff was educated on respiratory assessments (see attached).</p> <p>Reviewed bowel alerts and BM documentation to identify any residents who had not had BM in 48 hours. Bowel protocol initiated as needed.</p> <p>Any resident has the potential to choke. Reeducated staff on how and when to do the Heimlich (see attached).</p> <p>3) Measures put into place/ System changes:</p>	

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	<p>The next documented entry on 1/28/15 at 6:25 p.m., indicated the resident's daughter was in and fed the resident supper. Daughter was concerned that her mother was coughing and tired. Daughter requested that her mother go to ER (emergency room). Concerned about her cough. Some congestion to left lung fields noted. MD (Medical doctor) paged and called unit. Orders received to send to ER.</p> <p>An entry in the Nursing progress notes dated 1/29/15 at 2:19 a.m., indicated the resident was admitted to the hospital with the diagnoses of urinary tract infection, pneumonia, and sepsis. The resident returned to the facility on 2/2/15.</p> <p>Interview with the DON on 2/26/15 at 1:50 p.m., indicated a thorough assessment of the resident's lung sounds was not completed after coughing was noted.</p> <p>2. The record for Resident #G was reviewed on 2/25/15 at 12:46 p.m. The resident's diagnoses included but were not limited to Alzheimer disease, rheumatoid arthritis, and closed fracture of rib.</p> <p>The bowel movement elimination form was reviewed. The resident did not have</p>		<p>Respiratory Audit will be completed with oversight by DON or designee 5 times per week (see attached).</p> <p>Point Click Care was notified of system not properly issuing bowel alerts and system was corrected. Audits initiated to compare BM documentation to Alerts to monitor correction will be completed with oversight by DON or designee 5 times per week. A tracking tool to be overseen by DON or designee was added to the 24 hour report book to assist nurses with knowing which stage of the bowel protocol a resident is on (see attached).</p> <p>Meals will not be served without a Heimlich trained employee present. Supervision audit will be completed at least 5 meals per week by designated meal manager with oversight by Executive Director or designee (see attached).</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p>	

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	<p>a bowel movement on the following days: 2/5, 2/6, 2/7, and 2/8/15 2/10, 2/11, 2/12, and 2/13/15</p> <p>Physician Orders on the current 2/2015 recap indicated Hydrocodone (a controlled pain medication) 5-325 milligrams (mg) 1 every 8 hours as needed (prn) pain. Another Physician Order on the 2/2015 recap indicated "May follow facility 3 day bowel program, if no bm (bowel movement) times 48 hours give 30 cubic centimeters (cc) of natural laxative twice a day (bid), if no results after 24 hours give 30 milliliters (ml) of Milk of Magnesia (MOM) (a liquid laxative used for constipation) and continue natural laxative. If no results after 12 hours of MOM give suppository.</p> <p>Review of the 2/2015 Medication Administration Record (MAR) indicated the Natural laxative, the MOM or the suppository was not signed out as being administered for signs and symptoms of constipation.</p> <p>Continued review of the 2/2015 MAR indicated the Hydrocodone was signed out as being administered on 2/1, 2/3, 2/14, 2/20, and 2/25/15</p>		<p>months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: March 4, 2015</p>	

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	<p>Interview with the 400 Unit Manager on 2/25/15 at 8:45 a.m., indicated she was having the Nurse Consultant look into the matter.</p> <p>Interview with the Nurse Consultant on 2/25/15 at 11:00 a.m., indicated she had sent a note to the computer management company. She indicated there was a glitch in the system due to the bowel movements were not triggering after 48 hours. Continued interview with the Nurse Consultant indicated the computer management company instructed the facility on how to fix the problem.</p> <p>3. The record for Resident #H was reviewed on 2/25/15 at 11:00 a.m. The resident was admitted to the facility on 1/22/15. The resident's diagnoses included, but were not limited to, chronic airway obstruction, acute bronchitis, muscle weakness, chronic kidney disease, high blood pressure, diabetes, dialysis, and anxiety.</p> <p>The bowel elimination form was reviewed. The resident did not have a bowel movement on 1/23 and 1/24/15. The first documented bowel movement was documented on 1/25/15 at 3:47 p.m.</p> <p>Physician Orders on the 2/2015 recap indicated "May follow facility 3 day</p>						

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	<p>bowel program, if no bm (bowel movement) times 48 hours give 30 cubic centimeters (cc) of natural laxative twice a day (bid), if no results after 24 hours give 30 milliliters (ml) of Milk of Magnesia (MOM) (a liquid laxative used for constipation) and continue natural laxative. If no results after 12 hours of MOM give suppository.</p> <p>The Medication Administration Record (MAR) for 1/23 and 1/24 and 1/25/15 indicated the Natural Laxative had not been given to the resident after 48 hours of no bowel movement.</p> <p>Interview with the Nurse Consultant on 2/26/15 at 11:56 a.m., indicated there was a problem with the computer program and that was why the lack of bowel movements were not showing up on there reports after 48 hours.</p> <p>4. The record for Resident #B was reviewed on 2/24/15 at 1:45 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder, dementia, chronic airway obstruction, antisocial personality disorder, anemia, Alzheimer disease, muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 10/6/14 indicated the resident was rarely/never understood and</p>			

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	<p>was severely impaired for daily decision making. The resident required extensive assist with two person physical assist with eating.</p> <p>Physician Orders on the 11/2014 recap indicated the resident required CPR (cardiopulmonary resuscitation) with an original date of 6/5/14. The resident also was to receive a mechanical soft diet with nectar thick liquids.</p> <p>The current 9/24/14 care plan indicated the resident was at risk for aspiration related to dysphagia. The Nursing approaches were to monitor signs and symptoms of aspiration (coughing, wheezing, etc). Notify Physician if symptoms of aspiration were present. Consult speech therapy as indicated. Utilize individualized interventions as outlined by speech therapy (chin tucks, no straws, small bites/sips, ensure food was swallowed before giving another bite, liquid between bites). Provide plenty of time for food and liquid consumption. Provide assistance with food/liquid consumption as needed. Provide diet as ordered and thickened liquids as ordered. Requires cueing both physical and verbal during meals.</p> <p>Another plan of care dated 9/24/14 indicated Activities of Daily Living</p>			

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	<p>(ADL) self care deficit or potential for related to eating. The Nursing approaches were to escort to and from dining room before and after meals to sit back in chair and chair to be against table for meals. Special utensils for meals and serve food in bowls as needed.</p> <p>The last documented Dietary Progress note by the Registered Dietitian was dated 10/7/14 which indicated the resident eats 76-100% of meals on mechanical soft diet with nectar thick liquids. He needs assist with most meals. Food to be served in bowls to aid in self feeding.</p> <p>The incident report follow up form dated 12/3/14 was reviewed. The report indicated "Resident #B was in dining room being assisted by staff to eat. CNA #5 who was assisting him, called to nurse who was near by. Nurse noted that resident appeared to be spitting food out. Nurse thought resident may vomit and so removed him from dining room. Nurse states no change in skin color noted until resident went limp and became unresponsive. Resident was placed on floor to initiate CPR. 911 was called, resident treated until EMTs (Emergency Medical Transportation) arrived and took over. Resident transferred to nearest hospital. Family and Physician notified."</p>			

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	<p>The findings of the investigation were as follows: "On 11/27/14 at 1 p.m., this resident (Resident #B) was observed with productive cough with no shortness of breath. Physician made aware orders received for breathing treatment. Oxygen saturations remains between 92-95% on room air. No distress noted. Was sitting near nurses station without discomfort. Vital signs remain stable. Resident assisted to dining room just before 6 p.m. with staff member as per care plan to prevent resident grabbing at objects near him. He was placed at table but meal not within reach. CNA confirmed correct diet of mechanical soft was provided to resident. At 6:15 p.m. CNA #5 called to nurse to check on (Resident name) since he was observed having difficulty swallowing his food. The nurse assessed the resident and instructed him to spit food out. Resident removed from dining room and placed by nurses station where nurse assessed and remained with resident. Resident was noted to have color change and breathing difficulties. Staff proceeded to do Heimlich maneuver, but resident eventually became unresponsive, resident placed on floor and CPR initiated, as food in mouth visualized staff did mouth sweep to remove visible food. 911 called. All</p>			

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	<p>staff that was interviewed confirmed that (Resident name) was not observed reaching or grabbing anything while in the dining room. Review of medical records from the Emergency Room showed that it was not certain if resident choked on food. Stroke could be a factor. Conclusion: chest X-ray did not show any airway obstructions and neither any resistance nor obstructions when e-tube (endotracheal tube) was inserted."</p> <p>The investigation with staff interviews were reviewed. RN #1 indicated the following: the resident was sitting between two tables. There was one nurse and one CNA in the dining room. CNA #4 called the nurse over to check Resident #B out. The resident was spitting food out of his mouth, his color was fine. The nurse removed food from his mouth which was a piece of bread/bun. RN #1 took the resident out of the dining room and to his room, the resident was gagging. RN #1 went to get a suction machine. The RN placed the resident at the nurse's station and his color was turning. CNA #6 went to see if the resident was a code. CNA #6 indicated he was CPR. CNA #7 performed the Heimlich maneuver on the resident. RN #1 and CNA #7 laid the resident on the floor. RN #1 could not get the ambu bag to work from the crash</p>			

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	<p>cart and unable to hook up the oxygen from the tank on the crash cart. CNA #6 started manual breathing. RN #1 and LPN #3 neither nurse knew how to call the Code Blue over head. CNA #6 and CNA#7 continued CPR and 911 was called at 6:19 p.m.</p> <p>CNA #6's interview indicated she had seen Resident #B at the nurses's station. CNA #7 and LPN #3 performed the Heimlich on the resident. The resident started to turn blue. The resident was placed on the floor in the hallway and her and CNA #7 began CPR. A finger sweep was performed and a packet of butter was removed from his mouth. CNA #6 indicated no Code Blue was called over head. Both CNAs performed CPR for the resident.</p> <p>CNA #5's interview indicated the resident took two bites of his food and gagged. He was in the dining room. No condiments were on the table when he was at dinner. His tray was out of reach when served.</p> <p>LPN #3's interview indicated the resident was removed by RN #1 from dining room. Noted he had difficulty breathing. The Heimlich maneuver was done by CNA #7. LPN #3 got the crash cart. RN #1 was looking for the ambu bag and</p>			

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	<p>could not find masks. CNA #6 called 911. CNA #6 did a finger sweep and removed a packet of butter. CNA #6 and CNA #7 performed CPR.</p> <p>Interview with the Director of Nursing on 2/24/15 at 1:58 p.m., indicated she was not on duty at the time of the incident. She indicated the Assistant Director of Nursing took the staff statements. She further indicated CNA #6 did check the resident's code status before calling 911. The DoN indicated the Code Blue was not called overhead by the staff involved. She indicated she could not confirm the statement related to the ambu bag, whether it didn't work or RN #1 didn't know how to use the bag. She indicated she had not investigated that. The DoN indicated there were problems with the crash cart. She indicated the oxygen tank was empty and not sure if there was an ambu bag or not on the cart. The DoN indicated the CNAs performed the CPR as RN #1 was overseeing them. She indicated after the incident, she had implemented a policy for the crash carts to be checked every night on the midnight shift and then weekly by the Medical Record staff to ensure they were supplied and the oxygen tanks were filled. She indicated she did not do any additional inservicing on policies to staff in regards to responding to an emergency</p>			

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	<p>situation such as choking and when to perform the Heimlich maneuver on residents.</p> <p>5. The record for Resident #C was reviewed on 2/24/15 at 10:33 a.m. The resident's diagnoses included, but were not limited to, cerebral artery occlusion, chronic airway obstruction, muscle weakness, dysphagia due to cerebrovascular disease, dementia, congestive heart failure, difficulty in walking, heart block, anxiety disorder, depressive disorder, malignant neoplasm, hyperlipidemia, high blood pressure, and anemia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 2/2/15 indicated resident had a Brief Interview for Mental Status (BIMS) score of 9 indicating she was alert and oriented. The resident was an extensive assistance with a two person physical assist (means resident involved in activity, staff provide weight bearing support) with eating. The resident had no oral problems and was on a therapeutic diet.</p> <p>Physician Orders on the 2/2015 recap indicated a no added salt regular diet and regular consistency.</p> <p>A nutritional assessment dated 1/30/15</p>			

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	<p>indicated the resident received a regular diet no added salt. Her eating patterns indicated she needed assistance. The comments indicated she usually feeds self, received some assistance as needed in restorative dining program. She received her own snacks and eats well.</p> <p>The Occurrence report dated 2/3/15 at 7 p.m. indicated "choking in dining room, eating supper, pupils non reactive, not equal grasp, resident chair bound, first aid immediately applied. Staff witnessed, Physician notified at 6:50 p.m., called sister at 7 p.m., intervention: resident deceased. B/p: N/A, pulse N/A, respiratory rate N/A."</p> <p>The Nursing Progress Note by LPN #3 on 2/3/15 at 7 p.m., indicated "Called to dining room per CNA. Resident noted unresponsive and taken to room via wheelchair. Laid resident on side and nurse able to swipe piece of food from resident mouth. Resident became alert to person and place stating nurses (sic) name and (facility name) when asked. Oxygen applied to resident. Resident then stated "I'm so tired" and repeated times 3. Resident then became unresponsive again. Then suctioned only secretions noted. Resident noted at this time with no respirations, no pulse, and no blood pressure. (Physician name)</p>			

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	<p>called and notified. New order received and noted."</p> <p>The incident report form provided by the Director of Nursing was reviewed. The incident date was 2/3/15 at 6:00 p.m., with a follow up investigation dated 2/11/15. "Resident #C was in the dining room and was noted with her hand waving. The staff immediately responded to the resident and initiated the Heimlich maneuver. RN was present in the dining room and assessed. Resident was noted to have respiration, breathing through her nose with nasal secretions noted. Resident was also noted to have jaw and mouth clinched at this time. RN directed care and resident was transported to her room for further care. Resident was placed on her side. Resident's mouth was unclenched at this time and the nurse was able to visualize food substance near front of mouth. The nurse performed a finger sweep and retrieved the particle of food. Resident was responsive and able to answer questions, such as the nurse's name and her place of residence correctly. Resident was suctioned and retrieved a lot of secretions from oral cavity no other food particles obtained. Resident was conversing with staff without any distress noted at this time. Resident then repeated that she was tired three times and then started shaking, the</p>			

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	<p>jaw tightened and the eyes were focused per staff exhibiting the same signs and symptoms as previously in the dining room. Approximately 1 minute later the resident was noted unresponsive but breathing. Pulse was faint and oxygen saturation declined and tachycardia noted with oximeter. The nurse stated shortly thereafter there was no movement from the resident, secretions coming from nasal cavity and color was cyanotic. 911 arrived on the scene and was unable to detect a pulse. EMT called report into hospital dispatcher."</p> <p>The immediate action taken: "Heimlich was immediately initiated, assessed by a RN who directed care and the resident was taken to her room for further care, Oxygen initiated, finger sweep performed and oral cavity suctioned once jaw line relaxed. 911 initiated. Physician made aware and family member made aware. Resident diet reviewed and accurate. Correct diet served."</p> <p>The staff interviews from the investigation were reviewed. CNA #2's interview was reviewed. She indicated on 2/3/15 at 6:00 p.m., she noticed Resident #C was choking. She immediately called for help. Her and CNA #1 began the Heimlich maneuver. She indicated the Director of Nursing</p>			

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	<p>(DoN) came over to the table and told them both to stop the Heimlich and the resident needed to cough up whatever was in her throat. She and CNA #1 told the DoN she could not cough and was having trouble breathing. The resident then became unresponsive. They took the resident to her room and laid her on the floor. LPN #1 started to suction the resident and did a finger sweep and removed a piece of sausage out of her mouth. The resident became responsive and oxygen was placed on the resident. The resident indicated she was tired. LPN #1 continued to suction the resident and then she started having a convulsion and went unresponsive. 911 was called. The resident had a faint pulse and then was noted not to be breathing.</p> <p>CNA #1's interview indicated at 6:00 p.m. on 2/3/15 she was in the dining room when CNA #2 indicated Resident #C was choking. She told the DoN, Resident #C was choking. She indicated she performed the Heimlich maneuver on the resident. The DoN told her to stop because the resident was breathing and she just needed to cough. She indicated the resident was grasping for air and still choking. The resident became unresponsive and her lips were turning blue. She called for LPN #1 and they took her out of the dining room and down</p>			
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	<p>to her room. They laid the resident on the floor and on her side. LPN #1 performed a finger sweep and a piece of sausage was removed. She indicated LPN #1 indicated for someone to call 911. The resident became responsive and was able to tell us where she was and indicated she was tired. Shortly after that she had a convulsion and her vital signs were zero. She indicated the DoN began asking questions of what nurse was assigned to the dining room and why was she on a regular diet.</p> <p>LPN #1's interview indicated on 2/3/15 she was on the phone with the pharmacy when she heard CNA #2 call her name from the dining room. She then saw Resident #C in the wheelchair looking grayish in the face. They took her to her room and she told the CNAs to lay her on the floor. She turned her on her side and was informed she was choking in the dining room. She told the other nurse to get the crash cart. She opened her mouth and performed a finger sweep and removed a piece of polish sausage. The resident became responsive after the meat was removed. She was able to tell her where she was and what her name was. The resident had pulse and her oxygen saturation was 88-90%. The resident had a lot of clear secretions noted and she was suctioned. The resident indicated</p>			
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	<p>she was tired three times and then begun to have a convulsion. She yelled to the nurse to call 911. The nurse and the DoN indicated the resident was a DNR. She indicated to them she was still breathing and had a faint radial pulse. Her oxygen saturation was 87% on room air. Oxygen was applied per mask. The oxygen was titrated up when the oxygen saturation went below 90%. The resident's pulse was 183 beats. There was a lot of secretions coming out of the resident's nose and her color was dusky. 911 arrived and there were no vital signs noted at that time.</p> <p>The DoN's interview indicated she was in the 200 dining room at 6:15 p.m. on 2/3/15. She indicated she was walking into the dining room to get a carton of milk for another resident on the unit when she heard CNA #1 yell she was choking (Resident #C). CNA #1 was performing the Heimlich maneuver on the resident and nothing happened. She asked the CNAs to sit her in the wheelchair so she could be assessed. The resident was breathing through her nose with audible secretions to nostrils. The resident's mouth was shut tight as though she was having a seizure. For approximately 1 minute staff were asking the resident to cough. After that the resident started to slump over in the chair</p>			

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	<p>and another nurse came into the dining room. The CNAs took the resident to her room. The DoN went to get the crash cart. The resident was placed on the floor in her room. LPN #1 attempted to suction the resident but was unable to as her mouth was closed tight. Her oxygen saturation was 70%. She left the room to get the oxygen concentrator and oxygen was applied per nasal cannula. 911 was called. Approximately 5 minutes later the resident relaxed and opened her mouth and piece of sausage came out of her mouth. The resident was responsive and was able to state the nurse's name and indicate where she was. The resident indicated she was tired three times and then went unresponsive. A non re-breather mask was applied this continued until 911 arrived. The resident had no pulse or respirations.</p> <p>The LaPorte County Dispatcher was interviewed on 2/24/15 at 1:15 p.m. The dispatcher indicated the Nursing Home called 911 at 6:28 p.m. on 2/3/15 for Resident #C.</p> <p>Interview with the DoN on 2/24/15 at 12:32 p.m., indicated she was not assigned to the dining room and was just walking in there to get a carton of milk when the CNA called her name. The DoN indicated when she approached the</p>			

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	<p>resident she was breathing and it appeared the resident was having a seizure that was why she instructed the CNAs to stop the Heimlich. She indicated they do not immediately call 911 if the resident can cough up or bring up the food if they appear to be choking.</p> <p>Interview with CNA #3 on 2/23/15 at 12:25 p.m., indicated if some resident was choking she would start the Heimlich until the food was removed from the resident. She said there was always a CNA and Nurse in the dining room, and then the Nurse would take over if need be.</p> <p>Interview with CNA #8 on 2/23/15 at 6:21 p.m. indicated if he was to see someone choking he would start the Heimlich and get the Nurse.</p> <p>Further interview with the DoN on 2/24/15 at 1:00 p.m., indicated no additional training on emergency situations or when to perform the Heimlich maneuver was completed after the incidents with Resident #B or Resident #C. She further indicated there was no facility choking policy and procedue. The facility used the American Heart Association Standards but had notning in writing.</p>						

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F 363 SS=D Bldg. 00	<p>This deficiency was cited on 12/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a)(1)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview, the facility failed to ensure menus were followed related to the pureed bread and cornbread for the residents during the lunch meal service in 1 of 3 Dining rooms observed for meal service, (The Main Dining Room)</p> <p>Finding Includes:</p> <p>On 2/23/15 at 12:15 p.m., during the lunch meal in the Main Dining Room, Dietary Cook #1 was observed preparing and serving the residents their meals. At that time, she was observed using a #8 scoop to serve the pureed bread for the</p>	F 363	<p>F363</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute</i></p>	03/04/2015	

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	<p>residents. She placed 1/4 of #8 scoop of bread onto their plates. The #8 scoop was not completely full of the pureed bread. The cook continued to serve 7 residents their pureed bread as above.</p> <p>Interview with the Dietary Food Manager at the time 2/23/15 at 12:25 p.m., indicated the cook was supposed to be using a #8 scoop for the pureed bread because she was the person who put the scoops into each container prior to the meal service. The Dietary Food Manager further indicated the pureed diets received regular bread due to not having enough cornbread for everyone. She indicated the cook should have filled the #8 scoop completely full and served the whole serving to the residents.</p> <p>Review of the Daily Spreadsheet Week 2 Monday menu indicated the pureed diets should have received pureed cornbread #24 scoop.</p> <p>This deficiency was cited on 12/18/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-20(i)(4)</p>		<p><i>admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Dietary staff was reeducated on using proper scoop size and following menu as specified on the menu spreadsheet (see attached.)</p> <p>2) How the facility identified other residents:</p> <p>Residents receiving pureed diet have the potential to be affected.</p> <p>3) Measures put into place/ System changes:</p> <p>5 meals a week will be audited for</p>		

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			<p>proper scoop size (see attached) and for Pureed diet receiving items per menu with oversight by Dietary Manager (see attached).</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance:</p> <p>03/04/15</p>	