

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE HAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00144878.</p> <p>This visit resulted in a partially extended survey- 2 Immediate Jeopardy.</p> <p>Complaint IN00144878 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F323.</p> <p>Survey dates: March 5 ,6 and 7, 2014</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Surveyor: Tina Smith-Staats, RN, TC Karen Lewis, RN Toni Marley, BSW</p> <p>Census bed type: SNF/NF: 37 Total: 37</p> <p>Census payor type: Medicare: 0</p>	F000000	F0000This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal Regulations, and not because Brookside haven agrees with the allegations and citations listed on this statements of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegation of compliance. Brookside Haven respectfully request a return visit on the Plan of Correction.	

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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F000309 SS=J	<p>Medicaid: 36 Other: 1 Total: 37</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, 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> <p>Based on record review and interview, the facility failed to ensure the nursing staff followed a resident's advanced directives and to perform a full code on the resident. This failure resulted in death for 1 of 5 residents reviewed for following their advanced directives at the time of death in a sample of 7. (Resident #D)</p> <p>This deficient practice resulted in Immediate Jeopardy. This Immediate Jeopardy began on</p>	F000309	<p>F-309</p> <p>1.) Director of nursing immediately re-educated and in-serviced all nurses on following Advanced Directive Code Status, Policy, and Procedure of CPR, emergency medical technicians care/prompt calling of 911 & when to suction. (Exhibit A)</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) Director of nursing immediately re-educated and in-serviced all</p>	03/21/2014			

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	<p>1/7/14 when facility staff failed to identify a resident as being a "full code" at the time of his death and failed to initiate cardiopulmonary resuscitation. The Administrator and Director of Nursing were notified of the immediate jeopardy on 3/5/14. The Immediate Jeopardy was removed, but noncompliance remained at the no actual harm with potential for more than minimal harm that is not immediate jeopardy level, on 3/7/14, when the facility developed and had implemented a systemic plan of correction.</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 3/5/14 at 2:35 p.m. Diagnoses for the resident included, but were not limited to, schizophrenia, paranoia, osteoporosis, deafness, degenerative disc disease, constipation, depression, dementia, agitation, anemia, pain, and dysphagia.</p> <p>A recapitulation of physician's orders, signed 12/11/13, indicated Resident #D was a "full code". A "CARDIOPULMONARY RESUSCITATION STATUS FORM", dated 4/9/09, indicated</p>		<p>nursing staff on following resident Advanced Directive Code Status/CPR. A complete audit was initiated and completed of all face sheets, chart binder, faceplate, physician order, Care Plans & signed code status. We have color coded ("red for no code" and "green for full code") edge of all binders and face plates outside of each resident room. HFA, or Designee will monitor daily code status by checking edge of binder with faceplate on resident door for accuracy x 30 days, weekly x 2 months and monthly x 3 months. (Exhibit C) HFA will monitor along with professional nursing licenses monthly active CPR Certification, nurses will be notified by the HFA 30 days prior to their re-certification date. All new hires must have an active CPR Certification prior to employment. (See exhibit B) LPN# 4 was terminated February 19, 2014.</p> <p>4.)HFA or Designee will monitor code status for accuracy of each resident face plate and edge of binders daily with a current resident roster with current code status x 30 days, weekly x 2 months and monthly x 3 months to ensure all code status are in place and accurate with the color coding to ensure compliance. (See exhibit C) Nursing will check monthly, each face sheet, physician order, code status sheet, and edge of binder during each monthly re-write review to ensure accuracy. (See exhibit C) Social Service Consultant will review</p>				

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	<p>cardiopulmonary resuscitation (C.P.R.) would be initiated for the resident in the event of a cardiac arrest.</p> <p>A current health care plan problem/need, dated 5/20/13, indicated the resident requested to be a full code. Interventions for this request included, but were not limited to, in the event of cardiac arrest initiate C.P.R., call the paramedics, let the doctor and family know, and transport resident to nearest emergency room for treatment.</p> <p>A nursing note entry, completed by LPN #4, dated 1/7/14 at 7:10 p.m., indicated "Went to Res (resident) room to assess Res (resident) after Br. (breathing) tx (treatment). Res (resident) sitting up in w/c (wheelchair) RHC (respirations have ceased) no pulse no response no SaO2 (saturated oxygen) no B/P (blood pressure) no AHR (apical heart rate) per ausc (auscultation)".</p> <p>A nursing note entry, completed by LPN #4, dated 1/7/14 at 7:20 p.m., indicated "Admin (administrator) notified and will notify DON (Director of Nursing). Call placed to (emergency contact #1) left</p>		<p>code status monthly x 2 months, then every other month x 4 months and will make recommendations as deemed necessary x 6 months to ensure compliance. During MDS quarterly assessments or any significant change, all resident code status will be reviewed and updated as deemed necessary. The facility QA Committee will review resident code status monthly x 3 months then quarterly during regular scheduled QA meeting and will make recommendations and corrections as deemed necessary.</p> <p>5.) Date Completed 3/21/14</p>		

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	<p>message to call facility. (Emergency contact #2) called x 3 (3 times) busy signal".</p> <p>A nursing note entry, completed by LPN #4, dated 1/7/14 at 7:40 p.m., indicated "Call received from Admin (administrator)-to call (name of funeral home) for pick-up. MD (medical doctor) made aware".</p> <p>A nursing note entry, completed by LPN #4, dated 1/7/14 at 7:45 p.m., indicated "(Funeral home) notified and will come to transfer Res (resident)".</p> <p>A nursing note entry, unsigned, dated 1/7/14 at 9:55 p.m., indicated "Body released to (funeral home)".</p> <p>The Director of Nursing (DoN) was interviewed on 3/5/14 at 4:27 p.m. Additional information was requested related to the lack of performing CPR of Resident #D following his passing on 1/7/14. The DoN indicated LPN #4 called to notify her of Resident #D's death. LPN #4 indicated to the DoN that when she went to check on Resident #D after his breathing treatment he had "already passed". The DoN indicated if C.P.R. was initiated the emergency medical technicians</p>			

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	<p>were called. The DoN indicated the emergency medical technicians had not been called for Resident #D.</p> <p>The DoN indicated there was not a policy for when not to perform C.P.R. on a "full code" resident. The DoN indicated LPN #4 was no longer an employee at the facility.</p> <p>LPN #4 had been terminated by the facility and was not available for an interview.</p> <p>The DoN and the Administrator were interviewed on 3/6/14 at 9:17 a.m. They both indicated no facility investigation had been completed after the death of Resident #D.</p> <p>The DoN and Administrator were interviewed on 3/6/14 at 7:57 a.m. The DoN and Administrator indicated they had color coded the outside of each resident's chart and each resident's name plate on 3/5/14 to ensure each resident's code status information was readily available. This information would be monitored daily during rounds by the Administrator. An audit of all resident records was completed on 3/5/14 to ensure each record contained the correct code status. Code status in the resident's chart would be monitored monthly. In-services began 3/5/14 for all staff</p>			

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	<p>related to code status, CPR, and when to call emergency medical technicians</p> <p>The Administrator was interviewed on 3/7/14 at 7:37 a.m. She indicated in-services for all staff had been completed on 3/6/14. The facility completed CPR validations with the nurses. This information was provided for review.</p> <p>Two LPNs, two QMA/CNAs, and four CNAs over various shifts were interviewed during the survey. All knew where to find a resident's code status information and when to initiate CPR or notify nurse immediately, and call emergency medical technicians.</p> <p>Review of the current facility policy for "CARDIO-PULONARY RESUSCITATION (CPR)", provided by the Director of Nursing on 3/6/14 at 1:47 p.m., included, but was not limited to, the following:</p> <p>"POLICY: To assist the facility in ensuring that all residents suffering a cardiac or respiratory arrest will receive the treatment of CPR unless the resident has a Do Not Resuscitate Order....</p>						

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	<p>...2. All licensed nurses certified in CPR will know which residents requested Full Code status, and therefore must receive CPR if they arrest...."</p> <p>Review of the current facility policy for "ADVANCED DIRECTIVES RESIDENTS RIGHT TO REFUSE MEDICAL TREATMENT", updated 5/2013, provided by Social Services Director on 3/6/14 at 3:45 p.m., included, but was not limited to, the following:</p> <p>"...DEFINITIONS (FOR PURPOSES OF THIS POLICY ONLY) Advanced Directive: A written and signed document which is consistent with applicable law, voluntarily executed by a competent adult to specify his/her wished concerning the withholding or withdrawal of life-sustaining procedures and/or to name a surrogate decision-maker.... ...Do Not Resuscitate (DNR) Order: A written physician's order supported by appropriate consent and medical documentation, to suspend the otherwise automatic initiation of cardiopulmonary resuscitation in the event of cardiac arrest...."</p> <p>Review of the current facility policy,</p>				

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	<p>provided by the Dietary Manager on 3/7/14 at 9:02 a.m., titled "Resident Rights", included, but was not limited to the following:</p> <p>"...Quality of Life</p> <p>...(b) Self-determination and participation</p> <p>The resident has the right to--</p> <p>...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>The immediate jeopardy began on 1/7/14. The immediate jeopardy was removed but noncompliance remained at the no actual harm with potential for more than minimal harm that is not immediate jeopardy level, on 3/7/14 after the facility implemented a systemic plan that included the following actions:</p> <p>1.) LPN #4 was terminated by the facility.</p> <p>2.) A house audit of all resident records was completed on 3/5/14 related to each resident's code status information being readily available.</p>						

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F000323 SS=J	<p>3.) CPR verification of all nurses was checked and in-services related to code status, cardiopulmonary resuscitation and notifying emergency medical technicians were completed from 3/5/14 through 3/6/14.</p> <p>This federal tag relates to Complaint IN00144878.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on interview and record review, the facility failed to supervise an orientee staff person to ensure that she followed physician order for a pureed diet for Resident # A. The facility failed to supervise Resident #A while during food consumption. This failure resulted in the resident receiving solid food which resulted in him choking. The responding nurse was unable to use suction</p>	F000323	<p>F-323</p> <p>1.)Resident's air passage was opened by EMT and resident was transported to hospital where he later RHC'd, due to cardiac arrest and choking. Registered Dietitian immediately reviewed all Therapeutic Diet Orders and Care Plans for accuracy. Director of Nursing re-educated and in-serviced all nursing staff (Licensed Nurses, QMA, CNA)on Pureed Diets, difficulty swallowing, aspiration, code status, choking,</p>	03/21/2014

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	<p>equipment to prevent the resident choking to death for 1 of 3 residents in a sample of 7. (Resident #A).</p> <p>The Immediate Jeopardy began 2/21/2014 when staff failed to follow physician order for pureed diet resulting in the the death of Resident #A. The Administrator and the Director of Nursing were notified of the immediate jeopardy at 5:15 p.m., on 3/5/2014. The immediate jeopardy was removed, but noncompliance remained at the no actual harm with potential for more than minimal harm that is not immediate jeopardy level, on 3/7/14</p> <p>Findings include:</p> <p>The clinical record for Resident #A was reviewed on 3/5/2014 at 9:30 a.m. The clinical record indicated the resident's diagnoses included but were not limited to, peripheral vascular disease, seizure disorder, moderate cardiomegaly, dysphagia, history of hypoxia and depression.</p> <p>The nursing note, dated 2/21/14 at 4:10 a.m., indicated on 2/21/14 Nurse #1 was passing medications to the resident's roommate. Resident #A was transferred to his wheelchair and stated he was</p>		<p>when to suction, location of suction machines, Heimlich Maneuver, prompt calling of 911, emergency care, following diet orders and plan of care, a safety risk for patients with Developmental Disabilities. Also Licensed Nurses, QMA, CNA have been in-serviced and re-educated on orientee, they are not to perform any procedures or patient care unsupervised by their preceptor until their orientation papers have been completed and signed by the orientee, preceptor, DON and HFA to ensure compliance. On-going training by Dietitian or Dietary Supervisor on therapeutic diets will be done, Bi-Monthly and will monitor x 6 months.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3. All new orders or changes will be reviewed and updated daily during morning meeting to ensure follow through for accuracy. (See exhibit A) Director of Nursing will update CNA assignment sheets daily; will review with charge nurse and CNA on that assignment and both charge nurse and CNA will initial new order to acknowledge diet change. A copy given to the dietary supervisor; dietary supervisor will place an updated copy in the kitchen, in pantry, update tray card and update dietary card index to ensure compliance. Suction Machines, (one in DR and one in oxygen room) will</p>		

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	<p>hungry. Nurse #1 indicated she and precepting Certified Nursing Aide (CNA) #2 told orientating CNA #3 to take Resident #A to the dining room and get him some jello from the pantry. Nurse #1 walked up to the front and observed Resident #A sitting at a dining room table with an empty cup of pudding and a empty plastic wrapper. Resident #A's head was tilted back and he was blue in the face. Nurse #1 indicated she called for help from CNA#2 and CNA#3. She then indicated she looked in his mouth and noticed there was something lodged in his throat but she was unable to remove it with a mouth sweep. She indicated she then performed the Heimlich maneuver for approximately 2 minutes but was unable to "get the food out". Resident #A at this time had no pulse or respirations. Resident #A was lowered to the floor and Nurse #1 started CPR. The note further indicated 911 was called but did not indicate the time of the call. The EMT's arrived at 4:20 a.m. and continued CPR. The resident had a weak pulse and was taken to the hospital.</p> <p>The Internal Investigation 5 day follow up, dated 2/26/2014, indicated</p>		<p>be checked daily to ensure readiness of equipment for suctioning. Nurses will sign signature sheet daily; acknowledging equipment readiness of both suction machines, signature sheet will be placed in 24-hour report book. DON or Designee will check both suction machines and nurses signature sheet to ensure nurses are checking for equipment readiness. (See exhibit A-1) Employee hiring packet for all nurses will include facility policy on CPR, choking/when to suction, difficulty swallowing, and aspiration. (See exhibit C) Employee hiring packets for Licensed Nurse, QMA, CNA must sign exhibit D-1/Charge Nurse or exhibit D-2/CNA acknowledging that they understand as an orientee they are not to perform any procedures or patient care unsupervised by their preceptor until their orientation papers have been completed and signed by the orientee, preceptor, DON and HFA to ensure compliance. Nurse #1 has been disciplined, in-serviced and re-educated one on one; on when to suction, location of suction machine, which upon her hire, her orientation sheet had been signed off acknowledging location and supplies for suction machine.</p> <p>4.) Director of Nursing will update CNA Assignment sheets/Resident Room Roster daily with any diet changes and CNA's will monitor meals daily by initialing a current</p>	

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	<p>in "The Complete Over All Review" section: "Nurse #1, CNA #2, CNA #5 and CNA #3, a new orientee, were on the 10:00P-6:00A shift. Nurse #1 was in room #18 while the CNAs were doing bed checks and changing Resident #A. Resident #A complained of being hungry and requested to get up. The Nurse told the new staff CNA, CNA #3 to take him down to the dining room and give home some Jell-o out of the pantry and get another resident a peanut butter sandwich. The CNA inadvertently gave the peanut butter sandwich to the wrong resident. Staff saw that Resident #A was blue and his head was tilted back and he was not breathing. Nurse #1 immediately called out for help. Nurse #1 opened his mouth and could see something was obstructing his airway. She was unable to do a finger sweep due to the obstruction was too far down the throat. She attempted unsuccessfully several times to do the Heimlich on him and he then became unconscious. She lowered him to the floor and told the CNA (CNA#5) to call 911. Nurse #1 continued to perform CPR until EMS arrived and they took over CPR and transported resident to [name of an</p>		<p>Resident Room Roster with current diets of each resident prior to serving at each meal service daily x 4 weeks, weekly x 2 months, and monthly x 3 months to ensure compliance. A CNA, at random will be monitored daily by HFA, DON Charge Nurse, or Designee to ensure that CNA is monitoring for accuracy x 4 weeks, weekly x 2 months and monthly x 3 months to ensure that all residents receive the accurate diet per physician order. (See Exhibit B) The QA Committee will review monthly x 3 months and then quarterly thereafter in the regular quarterly QA Meeting and will make recommendations and corrections as deemed necessary.</p> <p>5.) Date Completed: 3/21/14</p>		

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	<p>area hospital] were he later passed from cardiac arrest."</p> <p>The written statement from CNA #2, dated 2/21/14, indicated: "She went into Resident #A's room with CNA #3, who was an orientee, to give AM care and to get him up. CNA#3 was asked to take Resident #A to the dining room and CNA#2 asked her to get another resident some jello while she was in the dining room. CNA #2 stayed and made the resident's bed and the nurse was giving his roommate medication. CNA #2 proceeded to another resident's room when she was called to by the nurse, from the hall, asking CNA #2 to go to the dining room with her. She started working on Resident #A gave him the Heimlich and we took him to the floor and she started CPR till EMT's the ambulance people got here to work on him too."</p> <p>The written statement from CNA #5, dated 2/21/14, stated "I was on East hall in room 18 when I heard the nurse and aide panicking. I ran out the room and saw that Resident #A was choking the nurse then took him out of the chair layed him on the floor and started CPR I then called 911 and the nurse gave me the keys</p>			

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	<p>to get supplies and I got paper work ready and waited for ambulance and they took over."</p> <p>The written statement from CNA #3, dated 2/21/14, stated "Me and another CNA got Resident #A up. He was laughing and saying he was hungry for vittles and coffee. The nurse was in room with other resident giving meds. Some how peanut butter and jelly sandwiches came up. I assumed they were talking about giving resident some. I gave him a peanut butter jelly sandwich and bowl of jello to eat. Twenty minutes later we found him unresponsive. We rushed him to his room and got him on floor while nurse performed CNA (sic). The other hall CNA called 911. I must have misunderstood."</p> <p>During an interview with the Administrator and the Director of Nursing on 3/5/14 at 2:17 p.m., The Administrator indicated all staff were educated on the Heimlich Maneuver by the Director of Nursing and the Corp Nurse Consultant but no documentation was presented. She also indicated that prior to the incident staff were made aware of resident dietary restrictions by information in the CNA assignment</p>						

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	<p>sheets and the tray cards. Since the incident, the facility has implemented a double checking system for tray distribution at meal times.</p> <p>The Director of Nursing indicated there were two suction machines in the facility at the time of the incident and staff present during the incident knew how to use the equipment. She further indicated orientee CNA's should not perform any task they have not been signed off on by their preceptor. She acknowledged CNA #3 had not worked during a time where she could participate and be checked off on meal distribution. She also indicated CNA #3 should not have been left unsupervised by her preceptor. "Orientation needs to be looked at and I am".</p> <p>During a tour and interview with the Director of Nursing on 2/6/14 at 9:00 a.m., the crash cart, consisting of a suction machine and supplies, was observed in the oxygen room. The machine was wrapped in a clear plastic bag with a tag indicating the last time the cart was checked. The tag was dated 3/5/14. The Director of Nursing indicated prior to the incident the cart was to be checked by the night nurse but there was no documentation or monitoring of this</p>						

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	<p>duty. The second suction machine, with supplies, was located in the dining room, wrapped in a clear plastic bag and tagged as having been checked 3/5/14. The Director of Nursing indicated the suction machine had always been in the dining room, even prior to the incident.</p> <p>During a telephone interview, on 3/6/14 at 8:36 a.m., with Nurse #1, she indicated she told CNA #1 and CNA3# to get Resident #A jello. She stated there was another resident present and she instructed them to provide that resident with a snack as well. She denied any mention of a peanut butter sandwich. Nurse #1 stated that when she saw the resident in the dining room he was blue and she could see he had something in his mouth but she "couldn't get it out." She then indicated she did the Heimlich Maneuver. She indicated she did this for approximately one minute, then checked for a pulse. The resident had no pulse or respirations at this time and she indicated she began performing CPR and told the CNA to call 911. She indicated suction equipment was in the oxygen room and she had sent the CNA to get the crash</p>						

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	<p>cart. She indicated when the crash cart arrived she could not find the needed equipment to suction the resident. She also indicated "it took her (CNA) awhile for her to even bring be the crash cart" She was not aware of the suction machine located in the dining room. When asked if a CNA on orientation could be asked to perform a skill she/he had not been checked off on alone or with out supervision she stated, "yes".</p> <p>During a telephone interview on 3/6/14 at 8:50 a.m., with CNA #1, she indicated the following: "I had an person I was training. At about 3:45 a.m. I went into Resident #A's room. He wanted up- his back was hurting. I told him I would be back about 4:00 a.m. (15 minutes) to get him up." CNA #1 and CNA #3 (trainee) both came back to Resident #A's room. They got him cleaned up, dressed, and put on his ted hose. CNA #1 and CNA #3 were both in Resident #A's room. While they were in Resident #A's room, another resident was yelling for CNA #1, telling her she wanted a snack. When CNA #1 and CNA #3 finished getting Resident #A ready, CNA #1 looked at CNA #3 and said 'roll him to the dining room.' She then asked</p>			

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	<p>CNA#3 'do you know the other resident (the one that was yelling) stating she wanted a snack?'. When CNA #1 asked, CNA #3 indicated at that time she did know the other resident. CNA #1 asked CNA #3 to get the other resident '2 jellos from the fridge'. The nurse was in the room providing care for Resident #A roommate. CNA #1 finished making Resident #A's bed then went down the hall- away from the dining room. CNA #3 had not returned."</p> <p>CNA # 1 indicated the nurse left the room also. CNA #1 then heard the nurse yell for CNA #1 to come on to the dining room. CNA #1 indicated the nurse did the Heimlich on the resident and lowered him to the floor. CPR was started and 911 called. The ambulance arrived and they took over the CPR. CNA #1 indicated she asked CNA #3 to roll the resident to the dining room, not to give him anything. She indicated she had asked CNA #3 to give the other resident 2 jellos. She also indicated did not hear the nurse say anything to the trainee. She indicted the trainee was suppose to come right back to be with her. CNA #1 indicated she learned residents during training by staying with the person training her and learned what</p>			
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	<p>the residents looked like and their names. She indicated she always ask about diets before giving a resident liquids or food because this could change. She indicated the nursing staff was very good about communicating changes in diets to the CNAs. She indicated they also have sheets with all resident information provided. CNA#1 could not remember if CNA #3 was in the dining room during CPR.</p> <p>During an interview with the Administrator on 3/6/14 at 8:31 a.m., the Administrator indicated they did not have a policy for calling 911, code status or CPR. She also indicated there was no documented staff education for CPR, code status or suctioning prior to the incident dated 2/21/14. She indicated suctioning and suction equipment was part of the orientation for nurses and part of the nursing orientation check off list. A copy of the Nursing Orientation Check Off List was provided.</p> <p>CNA #3 voluntarily terminated employment immediately after the incident and was not available for interview.</p> <p>Review of the inservice information,</p>			

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	<p>dated 2/21/14, provided by the Administrator on 3/5/14 at 1:00 p.m., included, but was not limited to, the following:</p> <p>The inservices included information related the differences between mechanical soft and pureed diets, how to prepare pureed foods and dietary compliance. 28 nursing staff members attended the inservice Nurse #1's signature was on the attendance sheet.</p> <p>The inservices included information related to meal service. 38 nursing staff members attended the inservice Nurse #1 and CNA #1's signatures were listed on the attendance sheet.</p> <p>The inservices included information related to code status, when to suction and prompt calling of 911. 26 nursing staff members attended the inservice Nurse #1, CNA #1;and CNA #2's signatures were listed on the attendance sheet.</p> <p>The inservices included information related to choking, Heimlich Maneuver and following dietary orders/plan of care.</p>			

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	<p>48 staff members attended the inservice Nurse #1, and CNA #1's signatures were listed on the attendance sheet.</p> <p>The inservices included information related to CNA orientation. 24 staff members attended the inservice Nurse #1, CNA #1;and CNA #2's signatures were listed on the attendance sheet.</p> <p>The inservices included information related to difficulty swallowing, aspiration choking. 34 staff members attended the inservice Nurse #1, and CNA #1's signatures were listed on the attendance sheet.</p> <p>The inservices included information related to how to use the suction machine and where suction equipments is located. 11 nursing staff members attended the inservice Nurse #1 signatures was listed on the attendance sheet.</p> <p>Review of the current facility policy, provided by the Administrator on 3/7/14 at 8:52 a.m., titled "Resident Rights", included, but was not limited to the following:</p>			

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	<p>"...Quality of Life</p> <p>...(e) Accommodation of needs</p> <p>A resident has the right to...</p> <p>(1) Reside and receive services in the facility with reasonable accommodations of the individual's needs and preferences, except when the health or safety of the individual or other residents would be endangered..."</p> <p>The immediate jeopardy began on 2/21/14. The immediate jeopardy was removed but noncompliance remained at the no actual harm with potential for more than minimal harm that is not immediate jeopardy level, on 3/7/14 after the facility implemented a systemic plan that included the following actions:</p> <p>1.) CPR validation of all nurses was checked on 3/7/14.</p> <p>2.) The facility "crash cart" was audited on 3/6/14 for the availability of all supplies needed.</p> <p>3.) Dietary manager or designee to monitor diet sheet in pantry and kitchen daily, started 2/24/14.</p>						

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	<p>4.) Charge nurse will monitor the daily CNA assignment sheets, started 2/24/14.</p> <p>5.) DoN, Administrator or designee will monitor any new diets or dietary changes and update CNA assignment sheets, started 2/24/14.</p> <p>6.) DoN or designee will check suction machine in dining room and oxygen room to ensure readiness of equipment for emergency use, started 3/6/14.</p> <p>This federal tag relates to Complaint IN00144878.</p> <p>3.1 - 45(a)(2)</p>				