STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365792	A. BUILDING _____ B. WING _____	05/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARIETTA CENTER	117 BARTLETT STREET MARIETTA, OH 45750

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents at risk for choking and aspiration pneumonia had a care plan that addressed safety interventions. This affected one (Resident #106) of six residents reviewed for dietary safety. The facility census was 105. Findings include: Review of Resident #106's medical record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the April 2014 physician's orders [REDACTED]. Further review revealed an order dated 04/19/14 to send a maroon spoon (a smaller spoon) with meals and the resident cannot eat meals alone. Review of the admission History and Physical dated 04/16/14 revealed the resident was admitted to the facility after having suspected aspiration and was treated for [REDACTED]. Review of the Dysphagia Evaluation dated 04/18/14 revealed the reason for the referral to speech therapy was the resident ate fast and choked and had a history of [REDACTED]. The signs and symptoms of oral dysphagia included the resident took large bites and the resident had some choking behavior with multiple large bites. The justification and medical necessity for skilled treatment was severe behavioral dysphagia with high risk for choking and aspiration risk. Further review of the medical record did not reveal a plan of care related to the resident's risk for aspiration or choking. On 04/29/14 at 3:59 P.M. interview with the Director of Nursing affirmed the resident did not have a plan of care related to her aspiration risk. This deficiency was an incidental finding identified during investigation of Complaint Number OH 453.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the emergency medical transportation report, review of the emergency room report, staff interview and medical director interview, the facility failed to supervise one resident to ensure swallowing safety in accordance with the physician's prescribed diet order. This resulted in Immediate Jeopardy for one (Resident #106) of six sampled residents of the 32 residents who resided on the Solana Unit (secured unit). Resident #106 choked while consuming peanut butter, required the Heimlich maneuver, cardiopulmonary resuscitation (CPR), and hospital transfer. The resident expired. The facility identified three residents on the Solana Unit received a pureed diet and/or thickened liquids (Residents #1, #2 and #3). Seven other residents resided in the facility and received a pureed diet and/or thickened liquids (Residents #33, #57, #65, #66, #73, #75 and #84). The census was 105. On [DATE] at 4:15 P.M., the Administrator and Director of Nursing (DON) were notified Immediate Jeopardy began on [DATE] at 12:00 P.M. when Resident #106 obtained a bowl of peanut butter from the Solana Unit kitchenette without staff knowledge. The resident ate the peanut butter, choked and required immediate staff intervention. The resident was transported to the hospital via emergency medical transport and expired at the hospital. The Immediate Jeopardy was removed on [DATE] at 7:00 P.M. when the facility implemented the following corrective actions: ? On [DATE] at 9:20 P.M., the facility had an emergency meeting that included the administrator, DON, medical director, admissions director, food service director, two unit managers and the nurse practice educator regarding the choking incident involving Resident #106. The meeting recapitulated what measures the facility immediately implemented and reviewed how many staff members had yet to be inserviced. ? On [DATE], the facility ensured all locks on the cupboards were functional on the secured Solana Unit. ? On [DATE], the facility searched all resident rooms for those residents residing on all units of the facility (Lafayette, Bennett, Putnam, Harmar and Solana Units) for food items and provided appropriate storage for each resident and removed inappropriate foods from resident rooms who were prescribed modified diets. ? On [DATE], the facility reviewed the care plans of all residents with mechanically altered diets for aspiration precautions and a list of residents with altered diets was provided to each of the five resident units for Residents #1, #2, #3, #33, #57, #65, #66, #73, #75 and #84. ? On [DATE], the facility ensured all foods were locked in a cabinet in the kitchenette of the Solana dining room that required use of a key to unlock. Staff were required to have a key for a lock to obtain food items. The key was kept on top of the refrigerator out of sight of the residents. ? On [DATE] and [DATE], the facility's DON provided staff inservices regarding abuse and neglect, altered diets, food storage and delivery and aspiration precautions to 42 State tested nurse aides (STNAs), 19 licensed practical nurses (LPNs), 11 registered nurses (RNs), one business office manager, two business office staff, 11 dietary staff, two social service staff , one medical receptionist, two maintenance staff, three activity staff, one administrator, nine housekeeping staff, three physical therapy assistants, two physical therapists, three occupational therapy aides, one occupational therapist and one speech therapist. Seven therapy staff members designated as ' as needed ' employees and two staff members on vacation would be educated prior to returning to work on the units. On [DATE] at 4:15 P.M., interview with the DON and the Administrator verified the seven therapy staff members and the two staff members on vacation would be in-serviced regarding the incident and new interventions implemented. ? On [DATE] a facility environmental safety audit was completed for all five resident units. Residents were assessed for the ability to unlock the kitchenette doors on the Solana Unit. Eight residents (Residents #4, #5, #8, #14, #15, #17, #25, and #27) were identified as being able to unlock the kitchenette. Solana Safety Audit Tool (addressed any safety issues/concerns noted during the unit assessment) will be completed by administrative staff every day for seven days including off hours beginning [DATE], then one time a week for four weeks then one time a month for three months and the results will be reviewed in the monthly quality assurance meeting. ? On [DATE], the facility sent letters to the families of residents who resided on the Solana Unit in regard to ensuring food items brought in would be safely secured. The families were advised and reminded that it's permissible to bring food for their loved one to the facility but let the nursing staff know what food item they brought in to the resident. ? On [DATE] and [DATE], interviews with one RN, three LPNs, three STNAs, and the administrator verified they had all been in-serviced regarding abuse and neglect, altered diets, food storage and delivery, and aspiration precautions. Although the Immediate Jeopardy was removed, the deficient practice continued at a level 2, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy as the facility has not yet inserviced all staff and have follow up on the newly implemented procedures and audits. Findings include: Review of Resident #106's medical record revealed a re-admission date of [DATE] with [DIAGNOSES REDACTED]. Resident #106 was placed on the secured Solana Unit. Review of the [DATE] physician's orders [REDACTED]. A new order dated [DATE] included a maroon spoon (a smaller spoon) to be provided with meals and the resident could not eat meals alone. Review of the facility's admission History and Physical dated [DATE] revealed the resident was initially admitted to the facility after having suspected aspiration and was treated for [REDACTED].M. a notation revealed the resident was receiving skilled services for respiratory status and therapies. Review

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) of the Nurses Admission assessment dated [DATE] at 11:30 A.M. revealed the resident had chewing and swallowing problems. Review of an undated MDS Kardex Report (Minimum Data Set quick guide information for the STNAs) revealed the resident required a small spoon with meals, could not eat alone, was to be monitored for aspiration precautions and was to receive a pureed diet with nectar thickened liquids. Review of the Dysphagia Evaluation dated [DATE] revealed the reason for the referral was the resident ate fast and choked, had a history of [REDACTED]. The signs and symptoms of oral dysphagia included the resident took large bites and the resident had some choking behavior with multiple large bites. The justification and medical necessity for skilled treatment was severe behavioral dysphagia with high risk for choking and aspiration risk. Review of the ST Progress Notes (PN) revealed on [DATE], the ST educated STNAs who were working that date (STNAs not identified) regarding using a small spoon and removing the bowl if necessary between bites. The PN dated [DATE] revealed the resident had a water pitcher. On [DATE], the resident had a water pitcher with thin liquids on her tray table in her room. The notes reflected the ST talked with nursing and it was determined the resident was taking water pitchers from other resident rooms. Nursing was aware and would monitor. Documentation revealed the STNAs were educated regarding resident supervision with intake and the use of verbal cues and tactile stimulation (touching arm) to cue the resident to increase safety with swallowing. No documentation was noted by ST that identified the requirement of a LPN or RN being present when Resident #106 ate. Review of the Change of Condition documentation dated [DATE] at 12:00 P.M. revealed the resident came out of the dining room and walked up the hallway. STNA #9 noticed the resident had peanut butter on her hands and in her mouth. The resident was assisted to the bathroom and the resident spit peanut butter out in the toilet and was swallowing hard. The Heimlich maneuver (emergency technique used for choking) was performed by LPN #10 and the resident spit out more peanut butter in the toilet. The resident walked away from LPN #10, LPN #12 and STNA #9 and sat on her bed. The resident was talking to staff and told STNA #9 her name. The resident then attempted to lie down and the staff assisted her back to a seated position to finish cleaning the peanut butter off of the resident's hands. The resident took a drink of nectar thickened liquid and a tan colored liquid came out of her nose and mouth and the resident then became unresponsive. LPN #10 then placed the resident on her side. STNA #9 got the suction machine and called a Code Blue. LPN #10 suctioned the resident for a moderate amount of tan liquid. Oxygen was applied and CPR was initiated. Emergency 911 was called by another unidentified nurse. Medical Director #1, who was the resident's physician, and Resident #106's Power of Attorney (POA) were notified at 12:10 P.M. Review of the Emergency Transport Report dated [DATE] revealed the service was notified of the need for transport at 12:05 P.M. and arrived at the scene at 12:07 P.M. The patient narrative revealed upon arrival to the unit, the nurses were doing CPR and using an Ambu (placed over mouth to provide ventilation) bag. The resident was eating peanut butter and apparently choked. The emergency transporters applied a cardiac monitor and the rhythm revealed asystole (no heartbeat) and CPR was continued. The resident had a massive amount of peanut butter in her mouth and airway and intubation could not be successful due to the blockage and suction was also ineffective. The emergency transporters were able to insert a nasal airway and provide air movement but there was no change in the cardiac rhythm. Review of the emergency room documentation dated [DATE], revealed the resident arrived in cardiac arrest after eating peanut butter and apparently choked. The documentation also revealed the emergency transporters were unable to place an airway due to peanut butter obscuring the visualization. Assessment of the mouth revealed peanut butter covering the resident ' s lips and most of the posterior pharynx (back of the throat). There was nothing further documented on the emergency room documentation. [DATE] at 8:38 A.M. interview with STNA #9 confirmed she worked on [DATE] and was on the unit during Resident #106's choking incident. STNA #9 stated she was walking down the hallway after checking on a resident and she noticed Resident #106 coming down the hallway with peanut butter on her hands and lips. The STNA asked the resident her name and the resident moved her lips but no words came out. STNA #9 notified LPN #10 and they walked Resident #106 back to her room. STNA #9 stood outside the bathroom while Resident #106 was in the bathroom with LPN #10. She stated the resident was spitting out peanut butter in the toilet. LPN #10 gave the resident nectar thickened water. STNA #9 and LPN #10 walked her back to her bed. She kept trying to lie down and LPN #10 told her she needed to sit up. LPN #10 and STNA #9 tried to clean the peanut butter off of her hands and mouth. STNA #9 asked the resident her name and she stated her name at that point. STNA #9 stated it was not clear but she could tell what she said and then Resident #106 became unresponsive. She stated LPN #10, LPN #12 and RN #14 suctioned for a while but the peanut butter was so thick. Nursing staff placed oxygen on the resident after they moved her to a flatter surface on the floor. An unidentified professional nursing staff called 911 and shortly after that the Emergency Medical Transport arrived. Further interview revealed peanut butter was normally sitting on the counter by the refrigerator in the Solana unit kitchenette. She also stated the kitchenette door was locked and she had never observed Resident #106 attempt to get into the kitchenette but she knew other residents could open the door. She stated six residents were in the dining room and there were residents that could open the kitchenette door in the dining room at that time. STNA #9 stated staff was to be in the dining room if the residents were served food, someone must be in the dining room. STNA #9 stated Resident #106 was on choking precautions which meant the resident was a higher risk for choking on foods and that was the reason she was on a pureed diet and thickened liquids. STNA #9 confirmed the MDS Kardex sheet informed the staff about the needs of the residents and the staff could also refer to the STNA flow records for additional information. She also stated Resident #106 required supervision with eating. She stated the staff had to be more observant of the residents on the unit and the staff on the unit received yearly behavioral and Alzheimer ' s training. She stated the ST would come into the unit dining room during meals and educate the staff. She stated ST #2 educated the staff about Resident #106's swallowing concerns and a small spoon. STNA #9 stated we were told we needed to remind the resident to stop and breathe to keep her from taking a huge spoonful as a bite. The ST department did tell us the resident was a choking risk . On [DATE] at 8:15 A.M., initial tour of the Solana Unit revealed several residents (unidentified) were seated in the dining room with staff supervision. Three residents were seated at the table in the kitchenette area. Locks were observed on the cabinets and refrigerator in the kitchenette area also located in the dining room. LPN #1, STNAs #2 and #3 were present in the dining room. No food items were observed on the countertops of the kitchenette area. The kitchenette was contained in an area secured with a wooden door-like gate with a locking door knob and a sliding lock located on the inside of the gate. The door knob required staff to turn the knob from the inside of the gate and the slide lock was located approximately half way down on the inside of the gate. On [DATE] at 8:18 A.M. interview with LPN #1 revealed snacks and other food items were to be secured in the locked cabinets in the kitchenette. On [DATE] at 8:21 A.M., interview with STNA #2 revealed the locked kitchenette cabinets contained chips, cookies, salt and pepper and other items for the residents. She also stated the gate to the kitchenette was double-locked. On [DATE] at 8:24 A.M., interview with STNA #3 revealed the residents can be seated in the kitchenette with staff outside the kitchenette area supervising them. The door to the kitchenette was always locked unless residents were in the kitchenette area. Further interview with the STNA revealed the key for the locked cabinets in the kitchenette was located on top of the cabinets. On [DATE] at 10:35 A.M. interview with DON revealed the facility was trying to maintain a homelike environment in the Solana Unit and some snacks were left out including peanut butter. The DON stated the peanut butter was stored on the counter next to the refrigerator beside the bread. Further interview with the DON revealed the facility had never observed Resident #106 attempt to get back in the kitchenette area. The DON stated the resident did not need supervision while she was in the dining room if meal preparation was not occurring. The DON stated at the time of the incident on [DATE], the nurse was sitting at the nurses ' station reviewing charts and STNA #11 had just gone to break. Further interview with the DON revealed the nurse's view of the kitchenette was partially obscured due to where the entrance of the dining room was in correlation with the nurse's station and the location of the kitchenette area. On [DATE] at 10:43 A.M., interview with Speech and Language Pathologist (SLP) #6 revealed Resident #106 was on swallowing precautions. SLP #6 stated peanut butter was not an appropriate food for an individual receiving a pureed diet and the pureed diet list did not indicate peanut butter was an acceptable food. SLP #6 stated it was not the bite size it was the rate in which she ate. SLP #6 stated the resident would perseverate (to repeat something insistently) on the movement to get food to her mouth. Further interview revealed eating was a compulsive motion for Resident #106 and the focus of treatment was to modify her eating strategies to make her swallow safe and to adjust her diet as needed. She stated the resident had a choking episode at the hospital prior to admission to the facility and was admitted to the facility with a pureed (smooth paste consistency) diet. SLP #6 stated she had hoped to get the resident on regular liquids at some point. On [DATE] at 11:15 A.M. interview with the Administrator revealed the peanut butter was kept in a bowl with a plastic lid next to the refrigerator in the kitchenette on the Solana Unit. On [DATE] at 11:30 A.M. interview with the DON revealed approximately one cup of peanut butter was kept on the countertop in a bowl with a plastic lid in the kitchenette on the Solana Unit. On [DATE] at 1:00 P.M., interview with SLP #6 revealed she has observed peanut butter on the secured unit. It was kept in a container with a lid on the

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) counter in the kitchenette. On [DATE] at 2:00 P.M. the kitchenette was observed. No food items were noted on the countertops in the kitchenette or on the dining room tables. On [DATE] at 2:08 P.M., interview with LPN #7 revealed the peanut butter did sit out on the counter in the kitchenette but she had never noticed Resident #106 attempting to get into the kitchenette. On [DATE] at 3:00 P.M. no food was noted out on the countertops of the kitchenette or on the dining room tables. On [DATE] at 4:28 P.M. interview with the DON revealed the facility did a re-enactment of the incident and began an action plan on [DATE]. The facility checked every pantry and completed audits of food storage. They implemented a protocol for snack delivery and foods from the dining room, where the trays were permitted to stay and the families were notified to let the staff know when they bring food in so the food could be secured. Further interview revealed all peanut butter was removed from the pantries and all Plans of Care were reviewed for residents receiving an altered diet. The facility also ensured the locks to the Solana Unit kitchenette unit were functional and the refrigerator had locks. On [DATE] at 8:15 A.M. observation of the Solana Unit dining room revealed residents were seated at the tables eating breakfast. STNA #501 and LPN #16 were present. No issues were observed with staff and resident interactions. On [DATE] at 9:51 A.M. interview with the Medical Director (MD) #1, who was Resident #106 ' s attending physician, revealed he felt she had a cardiac event at the time of the incident. MD #1 signed the death certificate and determined the cause of death to be cardiovascular arrest secondary to choking. He stated he was aware of the resident having behavioral dysphagia and a prior history of aspiration. He also verified he participated in the emergency administration meeting after the event on [DATE] and participated in the activation of interventions implemented to ensure resident safety. On [DATE] at 10:17 A.M., interview with LPN#10 confirmed she was seated at the nurses ' station signing papers and watching the residents through the window. LPN #10 stated she could see the kitchenette but she never noticed Resident#106 going into the enclosed area. The last time she observed Resident #106 was approximately 10:00 A.M. when she assisted the resident to the bathroom. LPN #10 stated there were other residents in the dining room but she was not sure how many were present. Once alerted by STNA #9, she immediately reacted and observed the resident spit peanut butter into the toilet. She was noted to be breathing a little hard. LPN #10 stated she administered the Heimlich maneuver and the resident seemed better. The resident then went to her bed and the nursing staff tried to clean the peanut butter off of the resident. LPN #10 stated the resident attempted to lie down but the staff encouraged her to sit on her bed. LPN #10 stated then she gave a sip of thickened water and then she became unresponsive. Attempts were made to suction the resident and CPR was started. On [DATE] at 10:30 A.M., interview with STNA #11 revealed he came in early for his scheduled shift on [DATE]. He stated he went into Resident #106 ' s room and she was not ready to get up for the day so he left the room to assist another resident with care. He stated he saw Resident #106 at 10:30 A.M. and she was requesting tomato soup. At approximately 11:00 A.M. to 11:15 A.M. he assisted Resident #2 from the kitchenette area. She was trying to get a drink of water from the faucet and she was to receive thickened liquids. STNA #11 stated he assisted Resident #2 from the kitchenette area and locked the door after he and Resident #2 exited. STNA #11 took a break at 11:40 A.M. and Resident #2 and Resident #27 were in the dining room. Resident #27 was able to unlock the gate to the kitchenette. Resident #106 was not in the dining room at that time. Review of the Dysphagia Protocol dated [DATE] revealed patients with swallowing difficulty/dysphagia will be referred to rehabilitation for evaluation and treatment interventions to promote adequate nutrition and hydration. Review of the Aspiration Precautions Policy dated [DATE] revealed residents identified being at risk for aspiration or those with a physician or mid- level provider ' s order for aspiration precautions will receive appropriate nursing interventions and be referred to dietary and/or rehab for evaluation. The policy also revealed to implement nursing interventions for Aspiration Precaution Interventions. There were no specific interventions identified per the policy. Review of Residents #1, #2, #33 and #65 medical records revealed all residents received pureed consistency diets. Residents #2 and #33 also received thickened liquids. No concerns were identified with the record reviews. On [DATE] at 11:30 A.M., Resident #33 was observed in the dining room with staff members present. The resident received the ordered diet consistency of pureed with nectar thickened liquids. On [DATE] at 12:45 P.M., observation of the dining room revealed Resident #1 and Resident #2 received the ordered diet consistency of pureed with regular liquids and pureed with nectar thick liquids, respectively. On [DATE] at 12:15 P.M., Resident #65 was noted in the dining room with ST #1 seated next to the resident. The resident was eating the prescribed pureed diet. This deficiency substantiated allegations contained in Complaint Number OH 453. This deficiency is also an example of continuted non-compliance from the annual survey completed [DATE].