STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075234	A. BUILDING _____ B. WING _____	02/10/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE GREEN OF WALLINGFORD REHAB & HEALTH CENTER	55 KONDRACKI LANE WALLINGFORD, CT 06492

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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 a review of clinical records, facility documentation, interviews and policies, the facility failed to provide the physicians ordered therapeutic diet for one of four (Resident #1) residents, who were reviewed for receiving a therapeutic diet. This resulted in actual harm for R #1 who choked and subsequently expired. During the onsite visit, it was determined that the facility implemented immediate corrective measures resulting in immediate jeopardy that was corrected. The finding includes the following: Resident #1 was readmitted to the facility on [DATE] at 2:15 PM after hospitalization from an upper GI bleed. The clinical record identified that the resident had resided in this facility since [DATE] and had [DIAGNOSES REDACTED]. Review of a previous care plan dated [DATE] indicated that the resident had an episode of coughing severely when eating too fast with interventions that included to serve the resident meals in the dining room, provide one food item at a time, and monitor the resident throughout all meal and food intake. Review of the Discharge Report to the Facility (W-10) dated [DATE] indicated that the resident required a dysphasia level 1 (puree) diet. The admission nursing assessment dated [DATE] at 3:45 PM identified that the resident was disoriented, was edentulous (no dentures and/or own teeth), had chewing and swallowing problems, and required a mechanically altered diet. Nurse's notes dated [DATE] at 3:45 PM and 4:31 PM identified that the resident returned to the facility at 2:15 PM, was alert and verbally responsive, and the APRN was made aware of the resident's return to the facility. Review of the CNA care card (plan of care that the resident requires) identified that the resident was an aspiration risk, required set-up and supervision for all oral intake and was prescribed a puree, extra moisture diet. A dysphagia pureed diet was described as foods that are thick and smooth and have a moist pudding-like consistency without pulp or small food particles according to the facility approved diet list. Record review and interview with LPN #1 on [DATE] at 11:14 AM stated that CNA #1 reported that Resident #1 and Resident #2 did not have dinner trays delivered to the unit on [DATE]. LPN #1 identified that she ordered dinner trays for the two residents', delivered the meal tray to Resident #2 and upon entering Resident #1's room, observed the resident to be unresponsive with a meal tray in front of him/her. LPN #1 stated R #1 had received R #2's tray that consisted of a dysphagia advanced diet (chopped). LPN #1 stated she called for help and resuscitation was initiated at 6:21 PM, inclusive of CPR and suctioning. LPN #1 further stated that R #1 required supervision while in the dining room only as s/he had a history of [REDACTED]. Interview with LPN #3 on [DATE] at 12:20 PM stated she responded to R #1's room for a code and observed and suctioned carrots including a baby carrot from the resident's oral cavity prior to attempting rescue breathing (ambu bag). LPN #3 stated at that point LPN #2 attempted to aerate the patient, was unable and suctioned the patient again for more carrots. At that time EMS arrived and attempted the insertion of an endotracheal tube but was not successful. LPN #3 stated that the EMT utilized forceps to remove a carrot and a blob of food. Interview with LPN # 2 on [DATE] at 2:40 PM stated that upon entering the room he proceeded to the head of the bed to assist LPN #3 who was suctioning the resident. LPN #2 attempted to place an oral airway but met resistance, suctioned the resident for carrots and then placed the airway and attempted to aerate the resident. The resident was transferred to the hospital and subsequently expired. Interview with CNA #1 on [DATE] at 10:24 AM stated she informed LPN #1 that R #1 did not have a dinner tray then proceeded to assist other resident's with their meals. NA #1 denied giving R #1 a dinner tray on [DATE]. NA #1 further identified that she was never provided orientation to the facility and/or policies and would often float to different units. Interview with the Administrator on [DATE] at 9:30 AM indicated that based on the facility investigation, NA #1 provided Resident #1 with another resident's meal tray on [DATE] that was not pureed. The Administrator was unable to provide evidence that NA #1 was oriented to the facility. Review of the facility's action plan identified that staff were immediately educated ([DATE], ,[DATE] PM shift) to ensure the correct consistency for food/liquid be provided to the right resident. Audits (direct observation) of appropriate meal delivery, resident identification bands, physician diet orders, and CNA care card were completed and are ongoing. During the onsite visit on [DATE], the action plan was observed to be implemented. Review of the policy Assisting the Impaired Resident with In-Room Meals, revised [DATE], directed to check the tray before serving to the resident to be sure it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow.
F 0498 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documentation, and interviews, the facility failed to ensure that an agency CNA received orientation to the facility. The finding includes the following: Review of facility documentation dated [DATE] identified that Resident #1 resided in this facility since [DATE] and had [DIAGNOSES REDACTED]. The resident had a physician's orders [REDACTED]. On [DATE] at approximately 6:20 PM, the resident was found by the nurse to be unresponsive, a code was called, CPR was initiated and EMS transported the resident to the hospital where s/he had expired. Interview with the Administrator on [DATE] at 9:30 AM stated that based on the facility investigation, CNA #1 (agency staff) provided Resident #1 with another resident's meal tray on [DATE] that was not pureed and the CNA was removed from the resident care area. Review of the CNA care card indicated that the resident was on a puree diet. Interview with CNA #1 on [DATE] at 10:20 AM stated she did not provide R #1 with a dinner tray on [DATE] and had informed LPN #1 that s/he needed one. CNA #1 further stated she was never oriented to the facility and that on [DATE] she was provided with a list of rooms/residents she was assigned to with no further information provided including nursing report. Review of the Agency orientation packet in place at the time of the incident did not review diets, resident identification, the care card system and/or meal delivery. Interview with the Administrator on [DATE] at 11:05 AM indicated that she was unable to locate NA #1's orientation packet to the facility. At 1:30 PM the Administrator stated when agency staff are new to the facility, the orientation packet is reviewed, however, the expectation is that hands on orientation will be conducted on the unit by the CNA. The Administrator and Corporate RN stated there is no orientation policy. Interview with RN #2 on [DATE] at 3:00 PM stated although the breakdown sheets now have an asterisk placed beside the name of an agency aide or nurse, the agency staff were unfamiliar with the units and poorly orientated.

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.