Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#5286	**Fine in the amount of $500 was reduced by 35% to $325 on December 12, 2013, pursuant to Iowa Code Section 135C.43A (2013).**	**Date: November 18, 2013**
Granger Nursing & Rehabilitation Center		**Survey date: October 1-2,9,22-24,2013**
2001 Kennedy Street	**Surveyors: Becky Kraft RN, Lisa McNelly RN**	
Granger, Iowa 50109	**Ds/ss/ks**	

		Class	Fine Amount	Correction Date
56.6(1) **+**	**481-56.6 (135C) Treble and double fines.** **56.6(1) Treble fines for repeated violations. The director of the department of inspections and appeals shall treble the penalties specified in rule 481-56.3(135C) for any second or subsequent class I or class II violation occurring within any 12-month period, if a citation was issued for the same class I or class II violation occurring within that period and a penalty was assessed therefor.**	**I**	**$30,000 HELD IN SUSPENSION**	**Upon Receipt**
56.12 **+**	**481—56.12 (135C) Class I violation as a result of multiple lesser violations.** The director of the department of inspections and appeals may issue a citation for a class I violation when a physical condition or one or more practices exist in a facility which are a result of multiple lesser violations of the statutes or rules, but which taken as a whole constitute an imminent danger or a substantial probability of resultant death or physical harm to the residents of the facility.			
58.28(3)e **+**	**481—58.28 (135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (II, III)			
58.19(1)n(1)	**481-58.19(135C) Required nursing services for residents**. The program plan for nursing facilities shall have the following required nursing services under the 24 hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(1)** *Activities of daily living.* *n.* Nutrition and meal service. (1) Regular, therapeutic, modified diets and snacks; (I, II, III).			

Facility Administrator Date

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	Based on record review, observation and staff interviews, the facility failed to provide adequate supervision to ensure against hazards to self and failed to serve an appropriate diet to meet the needs of the resident (Resident #5) and failed to keep the medication cart locked when unattended. The sample consisted of 5 residents and the facility reported a census of 50 residents. Findings include: 1. Resident #5 had an MDS (Minimum Data Set) assessment with a reference date of 7/5/13 which identified diagnoses that included diabetes mellitus, cerebrovascular accident and hemiplegia. The MDS identified the resident required extensive assistance with eating. According to the MDS the resident required a mechanically altered diet. Review of the Speech Therapy Progress Note dated 6/6/13 through 6/12/13 revealed bread taken off the resident's diet as the resident did not tolerate this during meals and showing signs/symptoms of aspiration. Review of the Change of Diet document dated 6/5/13 revealed the resident should have a mechanical diet, thin liquids, fruits cut into bite sized pieces and no noodles. On 6/11/13 the Change of Diet document revealed the resident should not have bread. Review of the Speech Therapy Discharge Summary revealed the resident required cuing for safe intake and sat at an assisted feeding table. The Nutritional Progress Notes dated 6/13/13 reflected the speech therapy evaluation recommended no bread. The Nutritional Assessment			

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	dated 6/13/13 reflected the resident with decrease in chewing and swallowing and had a mechanical soft diet with no bread. The Care Plan dated 6/18/13 identified the resident had a history of dysphagia from an old cerebrovascular accident. The care plan directed staff to provide a mechanical soft diet with no bread. Review of the Departmental Notes dated 9/25/13 at 8:32 PM documented the following: At 7:20 PM the resident redirected from the outer dining room where/he/she wheeling [moving in chair] from table to table grabbing food off of the tables. The resident was directed towards his/her room. At 7:25 PM kitchen staff came out of the Bistro (dining room) yelling "he/she's choking, he/she's choking". Three nurses (licensed practical nurses) and RN (registered nurse) responded instantly. The resident in obvious respiratory distress noted by poor color, weak, wrenching like chest movements, unconscious and peaches and thick white substance falling out of the resident's mouth. Resident quickly moved to the floor and the Heimlich Maneuver process for an unconscious individual started. Peaches and white substance removed from the mouth by finger sweep method. At 7:26 PM staff called 911. At 7:28 PM resident reassessed as unconscious, without respirations and without pulse. Chest percussions started at 7:30 PM, ambu bag (administered oxygen) per face mask. Air went into lung freely with proper positioning of the neck and head and suing the jaw thrust maneuver. Color did not improve. 7:33 PM resident reassessed to be without pulse or respiration and color very dark. Staff changed positions and CPR resumed. At 7:33 PM EMS personnel arrived and took over CPR. 7:47 PM Paramedic unit arrived.			

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	Paramedic reviewed resident's diagnoses list and current condition by nursing staff. Paramedics called on call Physician. At 7:53 the on call Physician called the code [to stop] and pronounced the resident deceased. CPR stopped. The ambulance report identified the resident was pronounced dead at 7:53 p.m. On 10/2/13 at 5:20 PM, Staff C (licensed practical nurse) was interviewed and stated the resident had been trying to grab food in the dining room and she personally took him out of the dining room and to his/her room. The resident did not have food in his/her mouth. She brought the resident into the dining room and gave him/her a sandwich and drinks. Staff C stated she was called for help and Staff N was in with the resident. Staff N had already removed food from the resident's mouth. The resident started grinding his/her teeth and clenched. The resident went unresponsive and staff lowered him/her to the floor. Staff performed more thrusts and removed peaches. Staff continued CPR (cardiopulmonary resuscitation) and the ambulance [crew] came and took over. On 10/3/13 at 8:20 AM, Staff N, (licensed practical nurse) was interviewed and stated she went into the dining room to check the resident's vital signs for during medication pass [administration of medications]. Resident #5 did not look quite right with poor color, sweating and panic in his/her eyes. Staff N stated she looked for food in the resident's mouth. She called for Staff C to assist. Staff could not get anything out of the resident's mouth. The resident became unresponsive and staff then removed bread. They put the resident on the floor and started CPR after removing peaches, continued CPR and bagged			

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	[used ambu bag] the resident and the airway cleared. On 10/3/13 at 11:15 AM Staff O (licensed practical nurse) was interviewed and stated staff called for assistance with the resident in the dining room. The resident leaned forward in the wheelchair with clenched teach. Staff put finger in mouth and pulled out sandwich with bread and peaches after the resident went unresponsive. Staff O stated we could not see any more food in the mouth. Staff put the resident on the floor, did the Heimlich Maneuver, removed peaches and then continued CPR. 2. Observation on 10/2/13 at 7:50 AM revealed the medication cart in hall 1 unattended and unlocked. The cart consisted of 4 drawers containing resident medication in bubble packs and stock medication bottles. Observation revealed the narcotics drawer locked. Per the facility resident list, 17 residents reside in Hall 1. On 10/2/13 at 7:52 AM, Staff C was interviewed and stated she had the medication cart locked and had opened it to put insulin away but then didn't lock it. She further stated she always keeps the medication cart locked. Review of the Policy and Procedure titled Storage of Medications revised April 2007 revealed the following: a. Compartments containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. The facility identified 3 residents with wandering behaviors.			

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	FACILITY RESPONSE:			

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50.7(1)	**481-50.7 (10A, 135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1)** Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death **DESCRIPTION:** Based on record review, observation and staff interview the facility failed to notify the department following choking and death for 1 of 5 residents reviewed (Resident #5). The facility identified a census of 50 current residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment with a reference date of 7/5/13, Resident #5 had diagnoses that included diabetes mellitus, cerebrovascular accident and hemiplegia. The MDS identified the resident required extensive assistance with eating. According to the MDS the resident required a mechanically altered diet. Review of the Speech Therapy Progress Note dated 6/6/13 through 6/12/13 revealed bread taken off the resident's diet as s/he did not tolerate this during meals and showed signs/symptoms of aspiration. Review of the document titled Change of Diet dated 6/5/13 revealed Resident #5 should receive a mechanical diet, thin liquids, fruits cut into bite sized pieces and no noodles. On 6/11/13 the Change of Diet document revealed the resident to have no bread.	**II**	**$500**	**Upon Receipt**

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	Review of the Speech Therapy Discharge Summary revealed the resident required cuing for safe intake and sat at an assisted feeding table. Review of the Nutritional Progress Notes dated 6/13/13 revealed speech therapy evaluation and recommended no bread. The Nutritional Assessment dated 6/13/13 revealed the resident with decrease in chewing and swallowing and had a mechanical soft diet with no bread. The care plan dated 6/18/13 revealed the resident with a history of dysphagia from an old cerebrovascular accident. The care plan directed staff to provide a mechanical soft diet with no bread. Review of the Departmental Notes dated 9/25/13 at 8:32 PM documented the following: At 7:20 PM the resident redirected from the outer dining room where/he/she wheeling from table to table grabbing food off the table. The resident directed towards his/her room. At 7:25 PM Kitchen staff came out of the Bistro (dining room) yelling "he/she's choking, he/she's choking". Three nurses (LPNs (Licensed Practical Nurse) and RN (Registered Nurse) responded instantly. The resident in obvious respiratory distress noted by poor color, weak wrenching like chest movements, unconsciousness and peaches and thick white substance falling out of the residents mouth. Resident quickly moved to the floor and the Heimlich process for an unconscious individual started. Peaches and white substance removed from mouth by finger sweep method. At 7:26 PM staff called 911. At 7:28 PM resident reassessed as unconscious, without respirations and without pulse. Chest percussions started at 7:30 PM, ambu bag per face mask used to provide respirations. Air went into lung freely with proper positioning of the			

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	neck and head and using the jaw thrust maneuver. Color did not improve. 7:33 PM resident reassessed to be without pulse or respiration and color very dark. Staff changed positions and CPR (cardiopulmonary resuscitation) resumed. At 7:33 PM EMS personnel arrived and took over CPR. 7:47 PM Paramedic unit arrived. Paramedic reviewed resident's diagnoses list and current condition by nursing staff. Paramedics called on call Physician. At 7:53 on call Physician called the code and pronounced the resident deceased. CPR stopped. During an interview with Staff C, LPN on 10/2/13 at 5:20 PM she stated that the resident had been trying to grab food in the dining room and she personally took him out and he did not have food in his/her mouth. She brought the resident into the dining room and reed him/her a sandwich and gave the resident drinks. The resident did not have food in his/her mouth and she stated she took the resident to his/her room. The next thing she knew was she was called for help and Staff N in with the resident. Staff N had already removed food from the resident's mouth. The resident started grinding his/her teeth and clenched. The resident went unresponsive and staff lowered him/her to the floor. We did more thrust and removed peaches. We continued CPR (cardiopulmonary resuscitation) and the ambulance came and took over. During an interview with Staff N, LPN on 10/3/13 at 8:20 AM she stated that she went into the dining room to check the resident's vital signs for medication pass. The resident did not look quite right with poor color, sweating and panic in his/her eyes. She stated she looked for food in the resident's mouth. She called for staff C, LPN to assists. Staff unable to get anything out of the resident's mouth. The resident became			

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	unresponsive and got out bread. Put the resident on the floor and started CPR when peaches removed. We continued CPR and bagged the resident and the airway was clear. During an interview with Staff O, LPN on 10/3/13 at 11:15 AM she stated that staff called for assistance with the resident in the dining room. The resident leaned forward in the wheelchair with clenched teach. Staff put finger in mouth and pulled out sandwich with bread and peaches after the resident went unresponsive. We Could not see any more food on the mouth. We put the resident on the floor did the Heimlich and removed peaches. We continued CPR. During an interview with Staff A, RN on 10/2/13 at 4:25 PM she stated that she the resident did not choke because he/she had an open airway. She stated that she was the one who said he didn't choke because his/her airway was open. The resident had a chicken salad sandwich in mouth and peaches. The food removed with a finger sweep. She felt is looked like regurgitation. During an interview on 10/3/13 at 8:00 AM she stated that when she had entered the dining room the resident already on the floor and Staff O, performing abdominal thrusts. During an interview with the Administrator on 10/2/13 at 5:10 PM he stated that the facility did not notify the Department of the resident's death because he had talked with the RN on duty and she said the airway was open so it was not choking. The Corporate Nurse and Director of Nursing agreed. He further stated he did not talk to the other nurses because the RN was there and told him that the airway was open. **FACILITY RESPONSE:**			

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