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	165312	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FONDA SPECIALTY CARE	607 QUEEN STREET FONDA, IA 50540

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F 000	INITIAL COMMENTS Correction date: 03/21/2023 ✓ JFS The following deficiency resulted from investigation of complaints #108529-C, #108838-C, #108860-C, #109201-C, #109263-C, #110210-C, #110798-C, #111030-C, #111171-C, #111173-C, and facility reported incidents #108935-I and #111450-I conducted February 23, 2023 to March 8, 2023. Complaint #111171-C was substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Fonda Specialty Care does not admit that the deficiencies listed on this form exist, nor does the facility admit to any statements, findings, facts or conclusions that for the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice. The facility failed to give the required suctioning for 1 resident that required suctioning by patting/pointing and mouthing indicating that it was difficult to breathe, (Resident #2). The facility census was 43 residents.	F 695	Fonda Specialty Care will continue to provide care and services for respiratory care and tracheostomy care and suctioning. Resident #2 no longer resides in the facility. There are no like residents at Fonda Specialty Care. No current trachs. Current licensed staff have been educated to include trach care and suctioning of a trach. Upon any new admission with a trach, staff validation will occur prior to the admission to the building for current staff and any agency staff or new hires will be trained appropriately during orientation. Agency orientation checklist updated to include the trach training needed and competencies. Staff competencies and agency orientation checklist will be audited weekly for four weeks and monthly for two months to assure compliance for trainings and checklists for trach care are completed.	03/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Blair — TITLE: Administrator — (X6) DATE: 03/22/23

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 695	Continued From page 1 Findings include The 5-day Minimum Data Set (MDS) assessment dated 1/27/23, documented Resident #2 with diagnoses which included cancer, heart failure, pneumonia, Alzheimer's Disease, malnutrition, and respiratory failure. The MDS identified the resident as no speech, or absence of spoken words, with the ability to usually be understood (difficulty communication some words or finishing thoughts but is able if prompted or given time) and Brief Interview for Mental Status (BIMS) score of 5, for which indicated severe decision making abilities. The resident required extensive assistance of two for personal hygiene, bed mobility, dressing and one assist for eating. The resident received oxygen therapy, suctioning and tracheostomy cares. The Plan of Care with an initiated date of 10/19/22, had a focus area of "I am unable to care for my tracheostomy". Interventions include: *Perform my tracheostomy care every shift. *Suction as necessary. The Physicians Orders dated 9/29/22, instructed staff to: Irrigation/suctioning with 1 cc sterile saline every 8 hours as needed for phlegm. The Progress Notes dated and documented: *2/19/2023 at 3:41 a.m., documented: At 2:00 a.m. called to residents room resident is changing color to blue and yellowish, moist-diaphoretic. Difficult to get vitals Blood pressure 102/64, heart rate 78 and irregular, respirations 20 and unable to get a pulse oxygen reading. Orders checked, no order for nitro. Call to hospital talked with emergency	F 695		

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F 695	Continued From page 2 room nurse and order to transport for evaluation. Call placed and ambulance in route. Return call back from emergency room to send resident to local hospital. Residents condition continues to decline oxygen remains on, no responding from resident. Multiple calls have been placed to family members without answer and messages to call back as soon as they got the call. At 2:28 a.m., called back to room as getting paper work ready. Resident without respirations, no heart rate or blood pressure and color is ash yellow. At 2:40 a.m., ambulance arrives and check resident and run strip which is flat line. Continue with calls to family members no answer. *2/19/2023 at 4:08 a.m., Text: Return call from emergency room and order from doctor received to release remains. Return call from son, and will come to facility to see his father. Confirmed funeral home choice. Did let him know his father went fast and that we respected the DNR request we had on file. *2/19/2023 at 5:58 a.m., Family has been here with resident since prior 5:00 a.m., funeral home was notified to come and are here now. Spoke briefly with family. Family has left and funeral home staff is taking remains at this time. *2/19/2023 at 6:22 a.m., Discharge Summary Note Text: funeral home has picked up body. Family did not take belongings at this time. Pharmacy updated per fax medications to be destroyed and or gotten ready to go back to pharmacy. The Emergency Medical System dated 2/19/2023, documented, crew dispatched 911	F 695		

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F 695	Continued From page 3	F 695		

priority to nursing home for a 87 yr old male, unresponsive and unable to obtain an oxygen saturation reading. Crew responded emergent lights and no sirens as no traffic was encountered at the early time of day. Crew arrived to be greeted at the door by two employees who stated "You know he's dead right? Just come in and talk with the charge nurse, don't bring in any equipment" Crew entered the facility to find the charge nurse on the phone attempting to call the family. Charge Nurse, stated called time of death at 2:25 a.m., would you please confirm death?' I retrieved the cardiac monitor from the ambulance. We entered the patients room and observed an 87 yr old male sitting upright in his recliner, no pulse, not breathing; pale mottled skin cool to the touch, with lividly beginning to appear in his feet. Obtained the 12 lead while I spoke with the nurse and obtained a copy of the patients DNR order. Nurse stated he was very sweaty when she came in to check on him, patient had dented chest pain, and went unresponsive. Patient has a tracheostomy and was prescribed oxygen which the patient removed often. She tried to get an oxygen saturation reading and called for an ambulance. Patient expired prior to our arrival. 12 lead EKG shows asystole in all 12 leads. No resuscitation efforts were made due to the valid DNR order. No other EMS services were requested. Charge nurse thanked us and we returned to base, no patient transport, All times based on call summery report.

In an interview on 2/27/23 at 11:00 a.m., Staff A, LPN (licensed practical nurse), confirmed and verified that Resident #2 was able to communicate to staff that they needed to be suctioned by pointing/patting the stoma. Resident #2 would consistently have thick phlegm which

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F 695	Continued From page 4 would cause a difficult time with breathing and was a sign that the resident needed to be suctioned. Staff A confirmed and verified that there was a suction machine in the residents room and that a procedure for suctioning was at the nurses station. It was a common occurrence that he needed to be suctioned. In an interview on 2/27/23 at 12:26 p.m., Staff B, CMA/CNA (certified medication aide/certified nursing assistant) confirmed and verified that Resident #2 would need suctioning as soon as possible if resident was coughing/pointing/patting the stoma. Resident #2 would have thick phlegm which caused coughing and would scare the resident due to not being able to cough up the phlegm. Staff B stated that when Resident #2 would make sign gestures to be suctioned, you needed to get the nurse right away. The suction machine was available right there on the bedside dresser. In an interview on 2/27/23 at 1:00 p.m., Staff C, RN (registered nurse) confirmed and verified that Resident #2 would point/pat at the stoma when needed to be suctioned and would cough to try and bring up the thick phlegm. Staff C, stated that the resident would panic when the stoma needed to be suctioned. Staff C also confirmed and verified that the suction machine was available in the residents room and the procedure for the suctioning was at the nurses station. Resident was very good about making gestures to make his needs known especially since he was not able to talk. In an interview on 2/27/23 at 1:26 p.m., Staff D, CNA, confirmed and verified that Resident #2	F 695		

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F 695	Continued From page 5 was doing well and would let her know multiple times that he needed suctioning by patting or pointing to his stoma. About 2:00 a.m., went in to check and change the resident, he was sitting in his recliner, we stood him up and changed him, sat him back down, Staff D was cleaning up his room when Staff F, CNA, said that the resident is in trouble and we need to get the nurse right away, the resident was patting at the stoma and mouthing that he could not breathe and grasping for air. Staff D left the room to get the nurse, when Staff D came back a couple of minutes later, the resident was pale, turning purple and then blue. The nurse came in and took vitals. Staff D attempted to get O2 and it would not read, Staff D told the nurse that there was no reading. The nurse explained that it was normal since he was having a heart attack, Staff D told the nurse that he was pointing to the stoma and mouthing that it was difficult to breathe. The nurse said just a minute and left the room. Staff D explained that the resident was very good about letting the staff know when needed to be suctioned, by pointing/patting or mouthing the words that he needed to be suctioned. The suction machine was available right on the bedside dresser. In an interview on 2/27/23 at 2:50 p.m., Staff E, CNA, confirmed and verified that Resident #2 was very good about letting staff know when he needed to be suctioned due to a lot of phlegm, by pointing or patting on the stoma. The suction machine was readily available on the resident bedside dresser. In an interview on 2/27/23 at 4:10 p.m., Staff F, CNA, confirmed about 1:45 a.m., Staff F and Staff D went into Resident #2 room to do rounds, the resident was visibly soiled, Staff D and Staff	F 695		

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F 695	Continued From page 6 F, stood the resident up for which he had soiled himself with urine and bowel. Staff F and Staff D proceeded to sit the resident down in a recliner, the resident started to point to at the stoma and pat at it, indicting that the stoma needed to be suctioned. Staff D went out to get the nurse that the resident needed to be suctioned. Resident#2 started to get really pale, and started to gasp for air. Staff F went out to the nurse and said would you please suction him, he needs to be suctioned. The nurse came into the residents room, explained that she needed to do an assessment, and left the room. The nurse came back in with some supplies, took his blood pressure/pulse and attempted to take his 02 sats, the resident started to turn pale, purple and then blue. Resident #2 was very compliant with pointing or patting at his stoma to have the nurse suction him, there was a suction machine right in the room readily accessible. In an interview on 2/27/23 at 4:30 p.m., Staff G, LPN, stated that Staff D and Staff F came out of Resident #2 room, about 1:45 a.m., and told Staff G that the resident was having explosive diarrhea. Staff G went into help, he was standing with no problems, no problems with breathing but did appear to be exhausted from standing. Staff G then left the room. Around 2:00 a.m., Staff D came out of the room and said that the resident was looking pale and turning purple, Staff G went back into the room and the resident was sitting in the recliner, he looked dusty and purple, staff wanted me to suction him, I told the staff "no I was told that I would not have to do anything with the tracheostomy." I told the 2 staff that I needed to go get my supplies to check his blood pressure, pulse and 02 sats, I left the room and went to the nurses station to retrieve my	F 695		

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F 695	Continued From page 7	F 695		

equipment, I went back to the residents room and by then he was clammy, low blood pressure, and irregular pulse, I told the staff that I needed to go back to the nurses station and find out if the residents was a full code or DNR. Staff F then came out and said that I was needed right away in the residents room, I went back into his room and he had no blood pressure, no pulse, and no respirations, I pronounced him deceased, by this time the ambulance got to the facility and I showed them to the residents room and they pronounced him deceased also. I don't recall seeing any phlegm in his stoma, Staff D and Staff F did tell me that he needed to be suctioned due to pointing/patting at his stoma and mouthing that he was having a difficult time breathing. I again was told that I didn't have to do anything with his trach. Staff G, admitted that they did not attempt to suction. Staff G explained that her mind set went to the resident having a full blown heart attack and not needed to be suctioned. Staff G, stated that it did not occur to her to suction.

In an interview on 2/27/23 at 5:15 p.m., Staff H, CMA/CNA, confirmed and verified that Resident #2 was very good about letting staff know when he needed to be suctioned, he would attempt to cough and bring up his own, but if he could not bring up the phlegm then he would point/pat at the stoma indicating that he needed to be suctioned.

In an interview on 2/28/23 at 10:30 a.m., Staff I, ADON (assistant director of nursing), confirmed and verified that it is the expectation of the nurses to suction Resident #2 when he would point/pat at the stoma indicating that he needed to be suctioned or was having a difficult time with coughing up the thick phlegm. Staff I stated that

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F 695	Continued From page 8 the suction machine was readily available for the nurses to utilize. In an interview on 2/28/23 at 10:50 a.m., Staff J, RN, confirmed and verified that Resident #2 would point/pat at the stoma indicating that it needed to be suctioned. Staff J stated that the resident would have thick phlegm which he would attempt to try and cough up but if not able to would need to be suctioned and that the suction machine was readily available for the nurses to use and if staff stated that the resident needed to be suctioned, it was important to suction quickly. In an interview on 2/28/23 at 3:40 p.m., with the Primary Care Provider, confirmed and verified that if the resident expressed respiratory distress to the staff of pointing/patting his stoma then it would be a simple procedure to suction him. If the resident went into a hypoxia state, yes that would cause the heart to go into failure and cause a heart failure/attack. Just because Resident #2 didn't like the trach tube in does not mean that the staff should not have attempted to suction the resident. Resident #2 was very well aware of the need to be suctioned. If staff told the nurse that he needed to be suctioned due to respiratory distress, then the nurse should have at least attempted suctioning and then call 911 and send to the ER. Suctioning is a simple procedure that nurses should be able to do. If he did have a mucus plug that got lodged and he was not able to cough it up, yes, with out 02 to his heart, it could cause heart attack/failure and put the resident into cardiac arrest. However, even being a DNR does not mean that we don't treat the symptoms and send to the ER. Any resident with this type of condition, we need to educate the nurse to do suctioning and take care of the	F 695		

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F 695	Continued From page 9 secretions. The Lary Tube Care Procedure Guide from the University of Arkansas for medical sciences with no date documented the following: (Laryngectomy Tube) *Suctioning Your Trachea: For a while. you will probably need a suction machine to help clear the sputum from your airway. Before suctioning. check your Lary tube to be sure it isn't blocked with mucus. If it is blocked follow the steps above for cleaning the tube. If you still have trouble coughing up your mucus, you will need to suction. It is best to remove the Lary tube if' there are secretions/mucus. You may suction your trachea without the Lary tube in place. Steps included: 2. Wash your hands well and fill the bowl with water and set it aside, turn on the suction machine and adjust the regulator dial to the right selling. 4. Remove the suction catheter from its wrapper or airtight container. Attach the suction catheter to the control valve on the suction tubing. 5. Dip the loose lip of the catheter into the water. This will help the catheter glide more easily. Put your thumb on the port and suck up some of the water to make sure the suction is working. Then release your thumb from the port and empty the water. 6. Put a saline solution mist or up to 3 cc of saline in your stoma. This will loosen secretions. 7. Take a few deep breaths and gently insert the moist catheter between 5 and 8 inches into the trachea through your Lary tube or stoma until you feel resistance. Caution: Take care not to injure yourself. Be careful not to cover the catheter's suction port during insertion. The suction pressure that results can damage the tissues that line your trachea.	F 695		

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F 695	Continued From page 10 8. With your thumb, cover and uncover the suction portion, start and stop the suction. As you do this, slowly take the catheter out of the trachea, rolling it between your thumb and finger as you go. This should take no more than 10 seconds. (Longer than that steals oxygen from your lungs.) 9. Repeat if needed for a lot of secretions. 10. You may see a small amount of blood, This is normal and not a cause for concern. 11. Put the catheter tip in the water to clean the suction catheter and the connection, then turn off the suction machine and disconnect tubing. Throw the disposable catheter in a plastic-lined wastebasket.	F 695		