STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525383	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMERICAN LUTHERAN HOME-MONDOVI	**200 MEMORIAL DR MONDOVI, WI 54755**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not immediately consult with the resident's physician upon a significant change in resident condition for 1 of 3 sampled residents, Resident (R) R1. The facility did not notify or consult with R1's physician when R1 had a choking/coughing episode, followed by an episode of weakness and dysphagia. This is evidenced by: R1's [DIAGNOSES REDACTED]. R1's Brief Interview for Mental Status (BIMS) is 11, indicating moderate cognitive deficits. On 07/15/20 at 9:30 a.m., Surveyor interviewed Registered Nurse (RN) C. RN C told Surveyor on 07/02/20, at 5:30 p.m., the Certified Nursing Assistants (CNAs) came to the nurses' desk and informed her R1 was choking. RN C stated when she entered the dining room, R1 was coughing a little and slouching in her wheelchair. R1 was unable to keep her eyes open or hold her head up. RN C stated, That was kind of concerning. RN C brought R1 to the nurses' station, where Director of Nursing (DON) B was sitting, and informed DON B that, Something wasn't right with R1. R1 could not keep her head up. RN C told Surveyor DON B told her that R1's neurological signs were normal, even though R1 could not hold up her head, and was slouching in her wheelchair. RN C told Surveyor that RN C and DON B, Thought maybe R1's MS ([MEDICAL CONDITION]) was acting up. RN C told Surveyor that she instructed the CNAs to assist R1 with lying down. RN C stated the CNAs informed her that R1 was unable to transfer via pivot transfer due to this onset of weakness. The CNAs used a partial lift to assist R1 with lying down. RN C told Surveyor that she did not inform or consult with R1's physician about the choking/coughing incident or R1's subsequent symptoms. At 10:30 a.m., Surveyor interviewed CNA D. CNA D stated CNA I came to her and said, I need you in the dining room. R1 is choking. CNA D stated when she entered the dining room, R1 was not choking. R1 was slouched down in her wheelchair, and could not hold up her head. CNA D stated, We kept asking her to hold her head up, but she couldn't. CNA D stated this was not normal for R1, and she reported this to the nurse. At 11:50 a.m., Surveyor interviewed CNA F. CNA F stated, Me and CNA J were in the dining room helping with the residents when R1 starting coughing. We asked her if she was okay and she was not able to talk. We ended up patting her on the back, and she coughed up the food .I think it was a green bean. CNA F stated the episode lasted about 2 minutes. CNA F told Surveyor that R1, Was out of it (after the choking/coughing episode). She was not at baseline. We had to use a lift to transfer her. She kept saying she was okay, but she wasn't. I told the nurse. At 1:00 p.m., Surveyor interviewed R1. R1 was sitting up in her wheelchair with normal posture. R1 told Surveyor that she remembers choking but the staff helped her when this happened. R1 stated, I was so scared. At 3:00 p.m., Surveyor interviewed CNA J. CNA J stated, CNA F and I were in the dining room for the evening meal when R1 said she was choking. R1 was sliding down in her chair during this time and when we boosted her up, she spit out a green bean. We tried to feed her some mandarin oranges and water, but she could not hold her head up. R1's eyes kept closing. The oranges and water just slid out of her mouth. She couldn't hold her head up or keep her eyes open. I told DON B this and she stated, 'She is fine.' At 3:15 p.m., Surveyor reviewed R1's clinical record. The Minimum Data Set ((MDS) dated [DATE] indicated R1 does not have chewing or swallowing problems. R1 requires set up and supervision with eating a regular diet. R1 transfers with assist of one. The clinical notes state, in part, that on 07/02/20, at 4:49 p.m.: Resident was eating dinner when she choked on a green bean. Writer was alerted by staff. Writer assessed resident. Resident coughed up green bean. VSS (Vital Signs Stable). O2: 96% on room air. Lung sounds clear throughout. Neuros within baseline. Resident unable to stand, keep eyes open or head up. Hand grasps equal. Resident then requested to use the restroom. Resident unable to stand with one assist, so she transferred via sit to stand with assist of one. Resident stated she was ok, but nauseated. Blood sugar was 160. Resident was also assessed by DON. DON stated resident was baseline. At 3:45 p.m., Surveyor interviewed DON B. Regarding the above incident, DON B stated, R1 really didn't choke. She swallowed a green bean and it went down the wrong pipe. RN C did an assessment. After R1 was able to cough it up, she was alert and oriented and back to her old self. DON B reviewed the clinical notes from 07/02/20 at 4:49 p.m. DON B stated that RN C should have notified R1's physician if R1 was unable to stand, keep her eyes open, hold up her head and was nauseated. DON B stated, I went back and looked at the notes .RN C should have notified the physician. Yes, it was a change of condition.

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.