STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106088	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLYDE E LASSEN STATE VETERANS NURSING HOME	4650 STATE RD 16 SAINT AUGUSTINE, FL 32092

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 0658 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and record review the facility failed to ensure qualified staff assess residents with change in respiratory status and to properly perform [MEDICATION NAME] maneuver during a choking episode resulting in death of 2 of 2 sampled residents. (Resident #2, 3) The findings include: Professional Standard of Care is defined in Chapter 766.102 as the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which in light of all relevant surrounding circumstances is recognized as acceptable and appropriate by reasonably prudent similar health care providers. The Florida Nurse Practice Act, Chapter 464.003 defines the practice of professional nursing as the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include, but not limited to: the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner ' practice of practical nursing as the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured or infirmed and the promotion of wellness, maintenance or health, and the prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician or a licensed dentist. Review of the records for Resident #2 revealed a choking episode on [DATE]. Record review for Resident #3 revealed a choking incident on [DATE]. Employee A, (Registered Nurse) was involved in both incidents, the incident on [DATE] she was directly involved and the other on [DATE] she was the RN supervisor who oversaw Employee B (Licensed Practical Nurse) attempting to perform [MEDICATION NAME] maneuver and offered no assistance. On [DATE] Employee A did not appropriately assess Res #2's respiratory status, perform [MEDICATION NAME] maneuver properly and instead of immediately contacting 911 and notifying the physician she waited and called family for direction. The family requested he be sent to the hospital. Res #2 was transferred to the hospital but died shortly after arriving. On [DATE], Employee A did not participate in attempts to help Res #3 when he was choking, nor did she offer any guidance to Employee B, LPN, who did not assess respiratory status, failed to ensure [MEDICATION NAME] maneuver was executed properly, notify the physician and immediately summons EMS when choking could not be resolved. Resident #3 died at the facility. Per Mayo Foundation of Medical Evaluation and Research ,[DATE] (Mayo Clinic) Mayo.org: Choking occurs when a foreign object lodges in the throat or windpipe, blocking the flow of air. In adults, a piece of food often is the culprit. Young children often swallow small objects. Because choking cuts off oxygen to the brain, give first aid as quickly as possible. The universal sign for choking is hands clutched to the throat. If the person doesn't give the signal, look for these indications: Inability to talk Difficulty breathing or noisy breathing Squeaky sounds when trying to breathe Cough, which may either be weak or forceful Skin, lips and nails turning blue or dusky Skin that is flushed, then turns pale or bluish in color Loss of consciousness If the person is able to cough forcefully, the person should keep coughing. If the person is choking and can't talk, cry or laugh forcefully, a five-and-five approach to delivering first aid: Give 5 back blows. Stand to the side and just behind a choking adult. Place one arm across the person's chest for support. Bend the person over at the waist so that the upper body is parallel with the ground. Deliver five separate back blows between the person's shoulder blades with the heel of your hand. Give 5 abdominal thrusts. Perform five abdominal thrusts (also known as the [MEDICATION NAME] maneuver). Alternate between 5 blows and 5 thrusts until the blockage is dislodged. To perform abdominal thrusts ([MEDICATION NAME] maneuver) on someone else: Stand behind the person. Place one foot slightly in front of the other for balance. Wrap your arms around the waist. Tip the person forward slightly. Make a fist with one hand. Position it slightly above the person's navel. Grasp the fist with the other hand. Press hard into the abdomen with a quick, upward thrust - as if trying to lift the person up. Perform between six and 10 abdominal thrusts until the blockage is dislodged. If you're the only rescuer, perform back blows and abdominal thrusts before calling 911 or your local emergency number for help. If another person is available, have that person call for help while you perform first aid. To clear the airway of a pregnant woman or obese person: Position your hands a little bit higher than with a normal [MEDICATION NAME] maneuver, at the base of the breastbone, just above the joining of the lowest ribs. Proceed as with the [MEDICATION NAME] maneuver, pressing hard into the chest, with a quick thrust. Repeat until the food or other blockage is dislodged. If the person becomes unconscious, follow the next steps. To clear the airway of an unconscious person: Lower the person on his or her back onto the floor, arms to the side. Clear the airway. If a blockage is visible at the back of the throat or high in the throat, reach a finger into the mouth and sweep out the cause of the blockage. Don't try a finger sweep if you can't see the object. Be careful not to push the food or object deeper into the airway. .
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to appropriately assess a resident's respiratory status following a choking incident, appropriately perform the [MEDICATION NAME] maneuver and promptly notify Emergency Medical Services for two residents requiring assistance by staff for meals (Resident #2 and Resident #3). On [DATE], the facility's census was 107. There were thirty-five residents identified as requiring assistance by staff with meals and were at risk. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 5:19 PM on [DATE], which is ongoing. On [DATE] at 6:45 PM, the Administrator was notified of the IJ determination. The findings include: A review of the medical record for Resident #2 was conducted which revealed a readmission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. The resident's cognition was impaired and he required assistance by staff with activities of daily living, to include meals. The resident received a mechanically altered diet for swallowing difficulties. A nursing note entry by Employee A, Registered Nurse (RN) dated [DATE] at 3:17 PM indicated that the resident was in distress by explaining that he appeared blue with wide eyes open and presented with a blood pressure of ,[DATE] and a heart rate of 87. However, the note failed to indicate whether the resident's respiratory status was assessed, whether the [MEDICATION NAME] maneuver was performed, and contained no timeline of the actions the facility took in response to the choking incident. A nursing note entry by Employee K, RN - House Supervisor dated [DATE] at 3:38 PM indicated the resident was having trouble breathing and was turning blue. The note indicated the RN supervisor proceeded to check the resident's code status and it was determined the resident was a do-not-resuscitate (DNR). The resident's wife was then called who requested the resident be transferred to the hospital. The resident's physician was then called to obtain an order to send the resident to the hospital. Finally, Emergency Medical Services (EMS) was called. The note indicated no attempts to appropriately assess the resident's respiratory status or perform the [MEDICATION NAME] maneuver but did demonstrate delays in notification to EMS. The resident expired in the facility on [DATE]. An interview was conducted with Employee A, RN on [DATE] at 4:00 PM. The nurse indicated that as she was exiting another resident's room, Resident #2's CNA summoned her from across the hall. She

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.

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F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) explained that when she entered the room the resident was lying in bed and was noted to be blue and that his eyes were wide open. She explained that she instructed the CNA to call the supervisor and applied oxygen via nasal cannula at a rate of 2 liters per minute. She explained that she did not attempt the [MEDICATION NAME] maneuver because of the resident's position in bed. She was asked whether she attempted to reposition the resident to facilitate the [MEDICATION NAME] maneuver and she stated No. The nurse was asked whether she assessed the resident's respiratory status (to include breath sounds) and she stated No. The nurse explained that the, because the resident was a DNR, the supervisor called the resident's family and the physician prior to notifying EMS as this was the facility's protocol. She then stated had it been up to me I would have called 911. When asked to expand on the answer the nurse explained that, prior to this incident, the facility's policy had been to notify the family and physician for any resident that was a DNR prior to calling EMS for emergencies. She explained that this policy was without regard to whether the resident still presented with signs of life (a blood pressure and/or pulse). The nurse acknowledged that a delay in performing the [MEDICATION NAME] maneuver and notifying EMS had the potential to result in harm or death to residents. An interview was conducted with Employee C, Certified Nursing Assistant (CNA) on [DATE] at 4:13 PM. She was asked to explain what she could recall about the incident and resident #2. The CNA explained that as she was assisting the resident with his lunch the resident's eyes got very big and that he opened his mouth as if to try and say something. She acknowledged that the resident was in bed at the time. The CNA explained that she called the nurse immediately. She stated the nurse came in and instructed her to call the supervisor so she left the room. She explained that the supervisor responded to the resident's room but that she was unable to recall whether the supervisor or the primary RN attempted the [MEDICATION NAME] maneuver. She explained that EMS arrived a little while later and pronounced the resident deceased . An interview was conducted with the risk manager on [DATE] at 4:28 PM. She acknowledged that she was responsible for conducting an internal investigation into Resident #2's choking incident and provided an investigative file. The investigative file was reviewed with the risk manager. She explained that the resident had experienced a decline in function in the weeks prior to the incident and that his needs for assistance had increased as a result. She also explained that, because the resident was a DNR, the investigation concluded the facility had followed it's policies with regard to emergency care for choking incidents. A copy of the policy/procedure was requested. Several minutes later the risk manager returned and acknowledged that no specific policy/procedure for choking incidents was available and explained that the facility would revert to professional standards of practice in that instance. During a review of Resident #2's most recent speech therapy discharge summary dated [DATE], it was noted that his discharge recommendations were to be up to his wheelchair for all meals. The resident was being assisted with his meal in bed at the incident. A review of the resident's nutritional care plan indicated interventions to assist the resident with meals as needed and encourage meals in the dining room. The care plan did not reflect the speech therapist's recommendations from the [DATE] discharge summary. An interview was conducted with Employee E, Speech Therapist on [DATE] at 11:00 AM regarding Resident #2. She explained that she evaluated the resident for weight loss and that the resident did require assistance with meals. She explained that the resident's decline in condition had progressed and that he hadn't been eating as much. The speech therapist was asked about the discharge summary dated [DATE] in which recommendations were made for the resident to be up to his wheelchair for all meals. The therapist confirmed that this was her recommendation to facilitate swallowing and confirmed that the resident may have been at a higher risk for choking if he was eating in the bed. A review of the medical record for Resident #3 was conducted which revealed a readmission date of [DATE] with a primary medical [DIAGNOSES REDACTED]. The resident's cognition was impaired and he required extensive to total assistance by staff for activities of daily living (to include meals). The resident received a mechanically altered diet for difficulties swallowing. A review of the resident's nursing notes revealed an entry by Employee B, Licensed Practical Nurse (LPN) dated [DATE] at 10:26 AM which indicated that the nurse was summoned to the dining room by the CNA at 9:20 AM. The nurse observed the resident's eyes open and he was moving his lips as if to say something. The resident was breathing but appeared pale. Two staff members assisted the resident to lean forward while the nurse attempted to perform abdominal thrusts which were unsuccessful. Subsequently, the resident's breathing stopped. He was assessed by the RN supervisor and pronounced deceased . The note did not indicate any respiratory assessments or notifications to EMS were conducted. The resident expired in the facility on [DATE]. A nursing note entry by Employee A, RN, dated [DATE] at 9:51 AM was reviewed. The nurse was functioning as the house supervisor at the time of the incident. The note indicated the nurse responded to an overhead page and upon arriving to the unit the resident was noted to be sitting in a broda chair with staff attempting abdominal thrusts. Shortly thereafter, the RN assessed the resident and was unable to obtain vital signs. The note did not indicate any respiratory assessments or notifications to EMS were conducted. An interview with Employee A, RN was conducted on [DATE] at 4:05 PM regarding Resident #3. She explained that she was functioning as the house supervisor at the time of the incident. She noted that the resident's assigned caregivers were attempting abdominal thrusts while the resident was seated in his Broda chair and that they were unsuccessful due to the resident's abdominal girth. The nurse was asked whether any attempts to perform back blows or attempts to reposition the resident were made and she stated No. The RN explained that EMS was never called and voiced concerns that the facility had not provided her with enough training or support. The nurse explained that she had been instructed to call a resident's family and physician prior to notifying EMS even in emergency incidents such as choking. An interview was conducted with Employee C, LPN on [DATE] at 9:43 AM regarding Resident #3. She explained that she assisted the resident with his morning oatmeal and left the table to administer treatment to another resident. She explained that when she returned to the dining area she observed the CNA with the resident at that the resident appeared to be choking. The resident mouthed help me but no sound came out. Staff attempted to perform abdominal thrusts in the Broda chair but they were unsuccessful. The nurse explained that the RN supervisor responded to the unit but proceeded to the nursing station to review the medical record and offered to assistance or direction during the choking incident. The nurse confirmed that no respiratory assessment was conducted and that no notification was made to EMS. An interview was conducted with Employee D, CNA on [DATE] at 10:00 AM regarding Resident #3. She explained that after assisting the resident with a bite of eggs the resident's eyes enlarged. She explained that she called the nurse thinking maybe he's choking. The CNA explained that the nurse started to perform abdominal thrusts from the front of the resident's chair. The CNA was unable to recall whether EMS was notified but confirmed that they never responded to the incident. An interview was conducted with the resident's attending physician on [DATE] at 2:28 PM. The physician also serves as the facility's medical director. During the interview the physician confirmed that Resident #3 expired from an acute choking episode and confirmed that he believed it would have been appropriate to notify EMS in this instance. The physician indicated he did recall that some remedial training had been conducted with the nurses as a result of this incident. .
F 0726 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure licensed nurses had the specific competencies and skill sets necessary to care for resident at risk of chocking by failing to ensure consistent nursing practice and provision of education/training as it related performing [MEDICATION NAME] Maneuver on chocking residents. Failure to appropriately assess the residents' respiratory status following a choking incident, appropriately perform the [MEDICATION NAME] maneuver based on a resident's size and promptly notify Emergency Medical Services, resulted in Resident #2 and #3's death. There were thirty-five residents identified as requiring assistance by staff with meals and were at risk. Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 5:19 PM on [DATE], which is ongoing. On [DATE] at 6:45 PM, the Administrator was notified of the IJ determination. The findings include: A review of the medical record for Resident #2 revealed he was admitted to the facility on [DATE] with a primary medical [DIAGNOSES REDACTED]. A review of the most recent comprehensive assessment revealed the resident required supervision with his meals. The diet order was a regular diet with a mechanical soft texture. Brief Interview of Mental Status (BIMS) score was 9. A record review of the nurses' notes for Resident #2 dated [DATE] at 3:17 PM read, Finished care with a resident and came out of room when the Certified Nursing Assistant (CNA) came out of this resident's room. Went into room and found resident appeared blue with wide eyes opened. Yelled out to staff to call supervisor, while assessing resident's mouth. There was a small amount of food noted between gum and cheek. No food noted in back of mouth or throat. Blood Pressure (BP) ,[DATE] Millimeters of Mercury (mm Hg Heart Rate (HR) 87 Oxygen at 2 Liters per minute via nasal cannula was in place. Further review of the nurses' notes revealed an entry by the registered nurse (RN) supervisor (Employee A) dated [DATE] at 3:38 PM. She wrote Writer was called STAT

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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) (immediately) to the unit. CNA (Employee C) reported Resident #2 was experiencing respiratory distress. Upon entering the room, resident was observed having difficulty breathing and turning blue, was able to make weak sound. Employee A checked resident's code status. He was a Do Not Resuscitate (DNR). Called wife/Power of Attorney (POA). POA requested to send resident to the hospital. The attending physician was called who ordered to send resident to hospital. When Emergency medical technicians (EMT) arrived and assessed Resident #2, he was pronounced deceased . An interview was conducted with Employee A, RN supervisor on [DATE] at 4:00 PM. The nurse explained that she was the supervisor on duty on [DATE]. She responded to the R2 room after being summoned by the CNA (Employee C) who was assisting the resident with lunch (lunch was delivered between 12:00 -12:10 PM). She explained that, upon entering the room, the resident was lying in bed with his head elevated and that he appeared blue. She explained that the resident's eyes were very wide. The nurse checked the resident's mouth for food and observed food pocketed between the cheek and tongue on both sides. The nurse stated she attempted the [MEDICATION NAME] maneuver but was unsuccessful due to the resident's position in bed. She explained that EMT was notified around 1:15 pm, they responded and pronounced the resident deceased in the facility. An interview on [DATE] at 4:30 pm, Employee C, Certified Nursing Assistant (CNA) stated that she was the assigned to care for Resident #2 on [DATE] when the incident happened. She explained that the he had recently been transferred to her unit and that she was assisting him with his meal. She stated, All of a sudden his eyes got very big and he opened his mouth as if he was trying to say something. She responded by calling the nurse immediately. The nurse responded and instructed the her to call the supervisor. She explained that the paramedics came in and stated, There is nothing we can do. He probably had a [MEDICAL CONDITION] or a stroke. A review of the medical record for Resident #3 revealed he was admitted to the facility on [DATE] with a primary medical [DIAGNOSES REDACTED]. A review of the most recent comprehensive assessment, dated [DATE], revealed the resident required extensive to total assistance with activities of daily living. The diet order included a mechanical soft consistency with nectar-thickened liquids. Brief Interview of Mental Status (BIMS) of 12. A review of the nurses' progress notes for Resident #3 dated [DATE] at 10:26 AM read, Writer assisted resident with consuming oatmeal. Resident completed oatmeal. While awaiting main entre, writer prepared and administered medication for another resident. At 9:20 AM writer was called to main dining area by CNA (Employee H). Upon arriving resident's eyes were open. Resident was chewing his food and at the same time he was moving his lips as if to say something. Resident was breathing but looked pale. Resident then stopped breathing. Two staff assisted resident in leaning forward while writer performed abdominal thrusts. Abdominal thrusts were unsuccessful. Due to resident size, a second staff member with longer arms performed abdominal thrusts. Abdominal thrusts were unsuccessful. During this time, non-rebreather at 12 liters applied to resident. Staff attempted to obtain 02 sat and blood pressure. Unable to obtain. RN supervisor assessed resident. Resident did not have a heartbeat. Notified daughter. An interview on [DATE] at 4:05 PM, Employee A, RN supervisor stated that she entered the unit dining room and observed Resident #3 seated in his Broda chair with two or three staff members positioning the resident and attempting to perform the [MEDICATION NAME] maneuver. She indicated that she then proceeded to the nurse's station to check the resident's code status and confirmed he was a DNR. When asked whether emergency medical personnel were notified the nurse indicated they were not. She stated, If it was my choice, I would have notified them. When asked to elaborate on the facility's procedures she stated, There's not enough training or support here. I've heard from one person that we have to call the family and get permission to call 911 first. I've also heard that now we can call 911 immediately if we need to. The nurse explained that she was unclear of the facility's emergency response procedures and that, in response to the death of Resident #3, the facility conducted training to clarify its procedures for notifying emergency medical personnel. Employee B stated in an interview on [DATE] at 9:55 am, that she had worked in the facility since February 2020. She added that had not received training on facility protocol for chocking She further mention that there was a recent training on [DATE]rd where she was informed to contact 911 for all emergencies. Interview on [DATE] at 10:15 am, Employee J Licensed Practical Nurse (LPN) stated that she is an Agency Nurse. She stated that she works an average of ,[DATE] days a week for the last two years. She stated that she received four-hour onboarding computer training. When asked to walk the surveyor through a chocking incident, the nurse could not mention all the appropriate steps for [MEDICATION NAME] Maneuver. Additionally, the nurse was unfamiliar with the facility chocking protocol. Interview [DATE] at 4:15 pm, Employee H, CNA that she has worked in the facility for the last 9 years. Every year during the hire month they are offered a training packet. After the training is completed the packet is handed over to the staff development specialist. She mentioned that she had not had any in-service on chocking. When asked about the competency checklist. She stated that they complete it themselves depending on the skill which one is comfortable completing. She mentioned that here is no one who checks the skills as the CNA completes the check list. Interview on [DATE] at 8:30 am revealed that Employee I LPN had worked at the facility for four years. She added that the facility provided a packet containing all he mandatory annual trainings. She stated that she had not received any training on chocking or emergency protocol. She added that recently (could not remember the exact date) she was informed about calling 911 in all emergencies and confirmed that she signed the in-service. When asked to walk the surveyor through a chocking incident, the nurse could not mention all the appropriate steps for [MEDICATION NAME] Maneuver. In addition, the nurse could not state different [MEDICATION NAME] maneuvers depending on residents' sizes. Per Mayo Foundation of Medical Evaluation and Research ,[DATE] (Mayo Clinic) Mayo.org: Choking occurs when a foreign object lodges in the throat or windpipe, blocking the flow of air. In adults, a piece of food often is the culprit. Young children often swallow small objects. Because choking cuts off oxygen to the brain, give first aid as quickly as possible. The universal sign for choking is hands clutched to the throat. If the person doesn't give the signal, look for these indications: Inability to talk Difficulty breathing or noisy breathing Squeaky sounds when trying to breathe Cough, which may either be weak or forceful Skin, lips and nails turning blue or dusky Skin that is flushed, then turns pale or bluish in color Loss of consciousness If the person is able to cough forcefully, the person should keep coughing. If the person is choking and can't talk, cry or laugh forcefully, a five-and-five approach to delivering first aid: Give 5 back blows. Stand to the side and just behind a choking adult. Place one arm across the person's chest for support. Bend the person over at the waist so that the upper body is parallel with the ground. Deliver five separate back blows between the person's shoulder blades with the heel of your hand. Give 5 abdominal thrusts. Perform five abdominal thrusts (also known as the [MEDICATION NAME] maneuver). Alternate between 5 blows and 5 thrusts until the blockage is dislodged. To perform abdominal thrusts ([MEDICATION NAME] maneuver) on someone else: Stand behind the person. Place one foot slightly in front of the other for balance. Wrap your arms around the waist. Tip the person forward slightly. Make a fist with one hand. Position it slightly above the person's navel. Grasp the fist with the other hand. Press hard into the abdomen with a quick, upward thrust - as if trying to lift the person up. Perform between six and 10 abdominal thrusts until the blockage is dislodged. If you're the only rescuer, perform back blows and abdominal thrusts before calling 911 or your local emergency number for help. If another person is available, have that person call for help while you perform first aid. To clear the airway of a pregnant woman or obese person: Position your hands a little bit higher than with a normal [MEDICATION NAME] maneuver, at the base of the breastbone, just above the joining of the lowest ribs. Proceed as with the [MEDICATION NAME] maneuver, pressing hard into the chest, with a quick thrust. Repeat until the food or other blockage is dislodged. If the person becomes unconscious, follow the next steps. To clear the airway of an unconscious person: Lower the person on his or her back onto the floor, arms to the side. Clear the airway. If a blockage is visible at the back of the throat or high in the throat, reach a finger into the mouth and sweep out the cause of the blockage. Don't try a finger sweep if you can't see the object. Be careful not to push the food or object deeper into the airway. An interview was conducted with Staff Development Nurse (SDN) on [DATE] at 9:55 am. She was asked if she conducted competencies including skills for the nursing staff. She stated no the house supervisors do the annual competencies and sign off the skills check lists completed by the nurses and certified nursing assistants. She stated that the facility has had a high staff turnover and it was a challenge to capture all the staff. When asked how often in-service training was provided, she stated she had not conducted any in-services for the past six months. Annually all nursing staff are given a packet that contains all mandatory in-services. The nursing staff completed the trainings including the tests and turn them in. She was asked if the supervisors had been provided any training or instruction as to how to conduct the annual competencies and monitor staff for proper skills techniques, she said not to her knowledge. She was asked if she had been made aware by nursing management or the administrator regarding how nurses were responding to choking episodes. She said she was asked by the administrator to conduct an in-service for nurses on [DATE] regarding Patient health emergency. When asked what was included in the in-service, she said calling 911 in all emergencies. She as asked if the in-service addressed choking or change in resident condition, she said no. Review of the sign in sheets dated [DATE] revealed Detailed Description of the in-service: This in service discusses the protocol for a patient health emergency. Nursing staff will be

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F 0726 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) educated that all patient health emergencies require a call to 911 and evaluation from a physician. 18 out of 36 nurses in the facility had not received the inservice. In addition, 2 of the 4 nurses involved in the two choking incidences has not received the in-service. On [DATE] at 5:30 pm an interview was conducted with the administrator. She was asked about the choking incident of Resident #3 on [DATE]. She stated she was not in the facility at the time, she was out on sick leave. She was asked how the facility addressed adverse incidents. She said that all emergency incidents are discussed in the next business day clinical meeting. At that time the risk manager and the director of nursing (DON) determines what actions to take e.g. staff education. She confirmed that she was informed about the incident with R3 however, there were no measures/ training put in place since it was determined that the resident expired so quickly, and the staff did what they could keeping in mind the resident was a DNR. The DON who was present during the interview stated that he was not informed of the incidence. He added that he was the assistant director of nursing (ADON) at the time. The administrator was asked who was responsible for ensuring all nursing staff have annual competencies and skills checks, she stated SDN. .
F 0867 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews and the facility's policy and procedure for Quality Assurance Performance Improvement (QAPI), the facility failed to ensure quality assurance monitoring of facility processes related to adverse events and to ensure identification of potential significant problems. The lack of follow up to adverse events related to choking incidents resulted in the death of two residents. (Resident #2 , 3) Immediate Jeopardy (IJ) at a scope of J (isolated) was identified at 11:07 a.m On [DATE] at 6:45 PM, the Administrator and Director of Nursing was notified of the IJ determination. The findings include: Review of the records for Resident #2 revealed a choking episode on [DATE]. Record review for Resident #3 revealed a choking incident on [DATE]. Employee A, (Registered Nurse) was involved in both incidents, the incident on [DATE] she was directly involved and the other on [DATE] she was the RN supervisor who oversaw Employee B (Licensed Practical Nurse) attempting to perform [MEDICATION NAME] maneuver and offered no assistance. On [DATE] Employee A did not appropriately assess Res #2's respiratory status, perform [MEDICATION NAME] maneuver properly and instead of immediately contacting 911 and notifying the physician she waited and called family for direction. The family requested he be sent to the hospital. Res #2 was transferred to the hospital but died shortly after arriving. On [DATE], Employee A did not participate in attempts to help Res #3 when he was choking, nor did she offer any guidance to Employee B, LPN, who did not assess respiratory status, failed to ensure [MEDICATION NAME] maneuver was executed properly, notify the physician and immediately summons EMS when choking could not be resolved. Resident #3 died at the facility. Following the incident the facility risk manager documented a summary and submitted to Veterans affair. There was no investigation regarding the details of the incident or actions needed to be taken. During an interview with the Risk Manager (RM) on [DATE] at 11:30 am, she was asked if there had been any adverse incident reports or federal one and five day reports filed in past 3 months. She stated there were no adverse incidents, however there were some federal reports. She was asked to provide copies of the reports and facility investigations. She also added the facility reports adverse events(AE) reports to the Veterans, however those reports did not meet criteria of adverse incidents for reporting to the State agency. An interview was conducted with RM on [DATE] at 4:20pm. She was asked what was the definition of a sentinel event found in the AE reports, she said did not want to misspeak and would bring a copy of definition. Sentinel event was defined as an adverse event that results in the loss of life or limb or permanent loss of function The RM was asked why adverse incidents were not filed with State agency, she said the criteria for reporting was not the same. She was asked if the investigations of the incidents of Res #2 and Res #3 resulted in any change of practice, additional education or nursing competencies, she said no. She was asked who was responsible to determine what further actions were needed, she said administrator, director of nursing, risk manager and Veteran affairs consultants. During an interview on [DATE] at 3:35pm with the Nursing Home Administrator(NHA) and Director of Nursing (DON) (acting) they were asked what did they know about the incident on [DATE] involving Resident #2. The DON stated that at the time he was the ADON/infection control nurse and had not been involved in the investigation. The Administrator stated when a situation like this occurs we all speak about what happened, review the care plan, discuss current interventions and hold interdisciplinary team meeting for new interventions. If we felt any concerns we would implement immediate actions whether it be competency skills, corrective actions and we would begin implementing the plan that day. She said she really did not have a recollection of the event of [DATE] or anything that we did moving forward. Regarding the incident on [DATE] involving Resident #3, NHA said she was not in the facility at the time, she was quarantined due to being positive for COVID-19. She was asked who was designated as NHA when you were out on sick leave, she said the former DON was in the building at the time and was designated as in charge. Also a regional NHA came in for a week. The RM investigated the incident on [DATE] and reported findings to regional office. When asked what measures were taken. she said all nursing staff would be educated that all health emergencies require call to 911 and evaluation from a physician. When asked if nursing competencies were performed after the incident, she stated no. Review of the in-service training sign in sheet dated [DATE] revealed as of [DATE] only half of the nurses had received the training (18 of 36). At the time of the survey, the facility had no consistent monitoring/audit process for ensuring nursing staff were appropriately trained and competent to provide necessary care to the facility residents. Staff interviews revealed a packet was received annually to independently complete training. No oversight, monitoring or auditing of training completion or competency was completed by nursing management. .