Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

FC#5293			**Date: November 21, 2013**
Mental Health Institute		**Survey Dates: October 21-24, 29, November 4-5, 2013**	
1800 N. 16th	**Surveyors: Patty Barnhart RN, Wendy Lemke RN**		
Clarinda, Iowa 51632	**Ds/ss/ks**		

		Class	Fine Amount	Correction Date
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.	**I**	**$10,000 (Held in Suspension)**	**Upon Receipt**
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). **DESCRIPTION:** Based on clinical record review, observations and staff interviews, the facility failed to provide adequate supervision to ensure against hazards from self and failed to provide a modified diet as ordered by the physician in order to prevent choking (Resident #1). The sample consisted of 8 residents and the facility reported a census of 18 residents. Three residents			

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	required pureed diets. Resident #1 received a regular diet and had consumed an entire peanut butter sandwich without staff supervision and the identification the resident required a pureed diet. Findings include: 1. Resident #1 had a Minimum Date Set (MDS) assessment with a reference date of 6/19/13. The MDS identified Resident #1 had pertinent diagnosis of anemia, diabetes mellitus, non-Alzheimer's dementia, anxiety, schizophrenia, orofacial dyskinesia (repetitive facial movements of face and mouth). The assessment reflected Resident #1 required limited assistance of one person for eating meals/snacks. The MDS identified limited assistance as the resident highly involved in the activity but staff provided guided maneuvering of limbs. The MDS reflected Resident #1 had moderately impaired daily decision making skills. Review of the resident's Care Plan dated 4/18/13 initially and resolved on 9/4/13, revealed the resident had the potential for alteration in nutrition related to dementia, schizophrenia, eating to fast and history of emesis/gagging or coughing at meals. Interventions include the following: 1. Assure mouth is in optimal condition. Oral care as will allow. 2. Encourage consumption of meal and fluids. 3. Provide a consistent carb pureed diet. May leave food on the green tray to define the eating area. History of stealing others food. Allow time to complete meal. 4. Monitor for choking and follow protocol. Review of the Physician's Order dated 8/31/13 through 10/1/13 identified an order for consistent carbohydrates			

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	and a pureed diet which began 10/24/07. Review of the Progress Note dated 9/1/13 at 2203 (11:03 PM), revealed Resident #1 was found slumped over at the table. When the nurse approached, she found the resident's face pale and gray in color and not responding to her verbal command. The same nurse noted the same resident had regular food in front of him/her and assumed the resident had choked. Staff B, Licensed Practical Nurse (LPN) began the Heimlich Maneuver and a third nurse, Staff H, Registered Nurse (RN) began to suction the resident using the v-vac to clear the resident's airway and found it to be unsuccessful. The resident remained unresponsive, staff called a code blue at 5 PM and then 911. The facility's physician arrived at 5:10 PM. First responders arrived at the same time and took over the code. The physician ordered to stop CPR (cardiopulmonary resuscitation) since the resident had an advance directive. The resident was pronounced dead at 5:35 PM. Review of the Iowa EMS Report dated 9/1/13 revealed the chief complaint of choking caused cardiac arrest. The document further revealed the resident's airway showed a lot of mushy peanut butter. During observation on 10/23/13 at 4:55 PM, dietary staff used dietary tags to fill resident trays for supper. During observation on 10/24/13 at 11:15 AM, dietary staff used dietary tags to fill resident trays for lunch. On 10/21/13 at 1:20 PM, Staff F, (dietary aide) was interviewed and stated the meal was changed to a sack lunch since it was a hot summer day. Staff F stated she just forgot to use the dietary cards/tags on the night of the incident (9/1/13) at the supper meal.			

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	Staff F stated the tags are kept on top of the steam table and when they did not use the steam table, she just forgot to use the tags. Staff F stated a nurse (Staff A) obtained the tray for one of the residents receiving a pureed diet because the resident required feeding. Another nurse (Staff B) obtained the second pureed diet. Staff C and Staff D distributed regular food trays in the dining room to the other residents which included Resident #1. The meal consisted of a peanut butter and jelly sandwich, potato chips, peaches and a buddy bar. A typed and signed interview with Staff F reflected she had prepared 6 pureed meals, just in case the facility should have needed them. On 10/21/13 at 12:30 PM, the dietician was interviewed and stated on 9/1/13, the temperature in the kitchen was over 100 degrees and she wanted to help her staff so she changed the evening meal to a sack lunch. The dietician stated the residents had food from a sack lunch but served on a dinner tray. The dietician stated the dietary staff forgot to take the resident tags with them [before serving]. She stated, "they just forgot". The dietician stated the aides said they were ready to pass [distribute] the resident of the trays which means only regular food trays were left [to distribute]. She further stated they did serve pureed diets to all the residents that required it except for Resident #1. On 10/23/13 at 5:20 PM, Staff E, (dietary aide) was interviewed and stated she worked the night of the incident and assisted Staff F taking the supper meal to the unit. Staff E stated a nurse (Staff A) took a pureed diet tray and another nurse (Staff B) took a pureed tray. Then Staff C stated she would pass [distribute] the other trays, which meant regular diet trays. The regular trays were prepared and passed. The trays were being passed when she heard Staff J, RTW say, he/she is choking. Staff A then stated, that's not the			

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	right tray (referring to Resident #1's diet tray). She further stated before taking the food to the floor, she saw the tags were not on the cart, she asked Staff F if she needed the tags and Staff F stated no that's alright. She then stated, now thinking back on it, she wished she had just placed them on the cart. On 10/23/13 at 3:20 PM, Staff C, RTW/CMA (certified medication aide) was interviewed and stated she had worked at the facility for 15 years. Staff C stated she did not see the pureed trays passed because she had been putting ice cream away in the kitchen. She stated Staff F said to her that everybody gets the same thing now, so she assisted to pass the regular trays and she stated she gave Resident #1 his/her regular diet tray. She stated the sandwich is the only thing she saw gone from the tray. She further stated the dietary staff prepares the trays and the tags were never placed on the trays for the nursing staff to review for accuracy. On 10/23/13 at 3:40 p.m., Staff A (registered nurse) was interviewed and stated when it's time to serve the residents' their food, they take the tray, hand it to the dietary staff, they prepare the tray using the tag (has the residents name on it and the diet ordered), the tag would be placed back in the basket or shown to the nursing staff for verification for accuracy. She further stated she would just ask for a resident's tray that she would help feed. She stated these trays are pureed. She stated she had been helping a resident to eat when she heard a staff member say, he/she was choking. She turned to look and went immediately to assess. She stated she noticed the resident had potato chips in front of him/her. The resident had poor coloring with arm down to his/her side. Staff A stated she attempted the Heimlich Maneuver. On 10/23/13 at 4:10 PM, Staff B (licensed practical			

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	nurse) was interviewed and stated the standard is to always use the diet tags and verify it is the prescribed diet, before giving it to a resident. He further stated the diet tags had not always been used, but they are used now. On 10/24/13 at 2:25 PM, Staff H (registered nurse) was interviewed and stated he saw evidence of peanut butter in the resident's mouth. During an interview on 10/23/13 at 4:20 PM, Staff D, RTW (resident treatment worker) stated the standard is to set up trays by using the dietary tags and nursing is expected to check it for accuracy. She stated the night of the incident; the dietary tags had not been used. During an interview on 10/29/13 at 11 AM, Staff I, (registered nurse and acting Interim Director of Nursing) stated it was staff failure for not using the dietary cards when passing trays on 9/1/13. The Director of Nursing stated everyone is to observe and be responsible for the monitoring of residents and what is going on at meal time. **FACILITY RESPONSE:**			

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