STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16E702	A. BUILDING _____ B. WING _____	C 11/05/2013

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MENTAL HEALTH INSTITUTE	1800 N 16TH STREET CLARINDA, IA 51632

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F 000	INITIAL COMMENTS Correction date _____ Investigation of facility-reported incident # 45889-I resulted in the following deficiencies. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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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The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and communication with the facility, the facility failed to submit an investigation into an allegation of possible neglect for 1 of 8 residents reviewed (Resident #1). The facility identified a census of 18 current residents.
Findings include:
On 9/3/13, the facility submitted an online Incident Report to the Department of Inspections and Appeals (DIA) that informed DIA of a resident choking death. The online report documented that the facility had an unexplained death. Staff found Resident #1 to be unresponsive and slumped over at a meal table on 9/1/13. Staff assumed that patient had choked, performed the Heimlich maneuver and then proceeded with CPR (cardio pulmonary resuscitation), notified 911 and the doctor on call. Facility staff could not revive Resident #1 with resuscitation measures.
The facility reported that starting 9/1/13, they were requesting written statements from nursing and dietary staff that were in attendance during the incident.
Staff from DIA contacted the facility on 9/13/13, requesting the facility provide information regarding the incident. The facility ' s Director of Nursing (DON) responded that other questions

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F 225	Continued From page 2 had come up during the investigation and they hoped the investigation would be completed on 9/16/13. The facility ' s Superintendent would receive it and staff from Department of Human Services (DHS) would look at the report before sending it on to DIA. Staff from DIA contacted the facility again on 10/11/13 requesting information regarding the incident and the DON replied that the report had been finished on10/11/13 and she would request it to be mailed to DIA staff. DIA received the facility ' s written investigative report on 10/17/13, 44 days after receipt of the initial online Incident Report.	F 225		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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 required pureed diets. Resident #1 received a regular diet and had consumed an entire peanut butter sandwich	F 323		

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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

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carbohydrates 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.

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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. 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)

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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 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

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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 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.

Note: At the time of the investigation, the

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F 323	Continued From page 8 complaint was coded at a "J" immediate and serious jeopardy. By 10/30/13 it was determined the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "D" level. The facility inserviced employees of the revised policy/procedure for serving meal trays. The revised policy/procedure included staff responsibility for knowledge of diets, location and use of diet cards, dietary will have a card for every tray, nursing staff must observe the dietary card before serving a resident. The facility began monitoring staff for the implementation of the revised policy/procedure. As of the 11/5/13 exit conference, the facility needed to continue to: .finish inservicing all employees regarding the revised policy/procedure for passing food trays. .Monitor staff to ensure the facility policy/procedure is being implemented correctly.	F 323		
F 492 SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on employee personnel file reviews and staff interview, the facility failed to complete an annual job performance review for licensed nursing staff as outlined in Iowa Administrative	F 492		

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Rule 58.20(13) for 5 of 8 staff reviewed (Staff H, J, and K). The facility identified a census of 18 current residents.

Findings include:

1. The undated Seniority Report documented a hire date of 4/24/06 for Staff H, licensed practical nurse (LPN). Review of the personnel file for Staff H revealed the most current Performance Plan and Evaluation covered the employee's job performance from 10/24/10 - 10/24/11.

2. The undated Seniority Report documented a hire date of 9/10/93 for Staff J, LPN. Review of the personnel file for Staff J revealed the most current Performance Plan and Evaluation covered the employee's job performance from 6/25/11 to 6/26/12.

3. The undated Seniority Report documented a hire date of 3/11/94 for Staff K, registered nurse (RN). Review of the personnel file for Staff K revealed the most current Performance Plan and Evaluation covered the employee's job performance from 5/10/10 to 5/10/11.

4. The undated Seniority Report documented a hire date of 7/15/05 for Staff L, resident treatment worker (RTW). Review of the personnel file for Staff L revealed the most current Performance Plan and Evaluation covered the employee's job performance from 7/25/11 to 7/25/12.

5. The undated Seniority Report documented a hire date of 1/23/06 for Staff M, RTW. Review of the personnel file for Staff M revealed the most current Plan and Evaluation covered the employee's job performance from 7/26/11 to

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F 492	Continued From page 10 7/26/12. During interview on 9/5/13 at 8:50 AM Staff I, RN Nursing Supervisor stated employee evaluations have not been completed on a yearly basis because she and the other 2 nursing supervisors had to assume more job duties due the lack of a director of nursing at this time.	F 492		