| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495291 | A. Building<br>B. Wing | 11/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Shalom Gardens Health & Rehabilitation | 1600 John Rolfe Parkway<br>Richmond, VA 23233 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28288<br><br>Based on observations, medical records review, and staff interviews, the facility failed to ensure one of five residents (Resident #3) received emergency treatment and care in accordance with professional standards of practice.<br><br>The findings include:<br><br>Resident #3 was admitted to the facility on [DATE] with a diagnosis of diabetes, cerebral infractions (stroke), dysphagia (difficulty swallowing), Muscle and Facial Weakness, Transient Cerebral Ischemic Attack, DNR, Contracture of Muscles (Right Upper Arm), and Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side.<br><br>Resident #3's Care Plan dated [DATE] documented the resident as having an Activity of Daily Living (ADL) self-care performance deficit determined by impaired mobility due to right hemiplegia related to Cerebral Vascular Accident (CVA). Resident requires assistance with personal care due to weakness. Resident #3's intervention established by the facility was to offer cues, supervision and a meal tray to be set up at mealtime. Resident #3's Quarterly Minimum Data Set (MDS) dated [DATE], the resident was coded as needing supervision or touch assistance for eating (The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident).<br><br>An interview was conducted with Family Member #1 on [DATE] at 2:35 PM. He stated the DON contacted the family with details regarding Resident #3 choking incident. He expressed the DON told him the nurses were unable to perform Abdominal Thrusts because Resident #3 was in a wheelchair. He said the DON told him when Resident #3 became unconscious, there was nothing the nurses could do due to the resident's DNR order. Family Member #1 stated he requested several documents from the facility pertaining to Resident #3 cause of death.<br><br>Resident #3's nursing notes dated [DATE] at 11:58 AM noted, Resident's tooth came out while eating an apple. No bleeding was noted at the time. Resident denies any pain or discomfort. Resident will continue to be monitored for changes. LPN #1 documented on [DATE] at 12:45 pm, she was notified by the CNAs that Resident #3 was coughing and choking. Resident was removed from the dining room, and large amount of food was retrieved from Resident's mouth. Resident #3 became unresponsive once the food was removed. Resident was assisted to bed by staff. The resident was noted to have no pulse, respiration, or blood pressure (BP). The supervisor and Hospice are aware. The resident expired at 1:08 PM on [DATE].<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A Phone Interview was conducted with LPN #1 on [DATE] at 12:08 PM. LPN #1 stated that on [DATE], she was working on Unit 4 for the first time and was unfamiliar with the residents. LPN #1 said she was the only nurse working with three (3) Certified Nurse Assistants (CNAs) caring for 28 residents. LPN #1 stated that prior to lunch, Resident #3 lost a tooth while attempting to eat an apple. Resident #3 had no bleeding or complained of pain from the lost tooth.<br><br>LPN #1 further stated that she was at the nurse's station with the CNAs when another resident's family member approached and made them aware that Resident #3 was in the dining room choking. No licensed or certified nursing staff monitored the dining room during the lunch meal. CNAs entered the dining room, removed the resident, using the resident's wheelchair, and pushed the resident directly to the nurse's station. LPN #1 stated she remained at the nurse's station, and Resident #3 was observed coughing and choking by the CNAs. LPN #1 said she could remove large amounts of food from the resident's mouth with her fingers. She said Resident #3, at this time, became unresponsive, and his head dropped forward. LPN #1 explained she was alone then, so she started pushing the resident down the hallway towards his room. She stated she attempted to perform abdominal thrusts while pushing the resident's wheelchair. LPN #1 stated she used one hand to push the resident's wheelchair while placing her other hand on the resident's chest, attempting to push down. LPN #1 stated, I really wasn't doing much.<br><br>During the above interview, LPN #1 stated the CNAs arrived at Resident #3's room and assisted her with transferring the resident into bed. She said Resident #3 was lying in bed, non-responsive, with no pulse, and 911 was called at 12:49 PM. LPN #1 stated the nursing supervisor was notified and came to assist at 1:00 PM. RN #1 Nursing Supervisor, entered Resident #3's room and reassessed the resident to confirm no signs of life were present. Emergency Technicians arrived, and the facility confirmed the resident's hospice/DNR status. Resident #3 was pronounced deceased by the Hospice Nurse at 2:09 PM.<br><br>LPN #1 stated that the Emergency Cart on the unit, which stored the emergency suction machine and oxygen equipment, was not retrieved during Resident #3's choking emergency. She said was current with her Cardiopulmonary Resuscitation (CPR) certification, which includes basic life support and abdominal thrusts for a conscious choking individual.<br><br>LPN#1 said she could not confirm which tooth the resident lost just before lunch, and Resident #3 was not assessed for his ability to continue chewing. The surveyor reviewed Resident #4's lunch menu for [DATE], which consisted of Baked Glazed Ham, Baked Sweet Potato, [NAME] Beans, Chilled Pear, and Beverage.<br><br>A phone interview was conducted on [DATE] at 11:08 AM with RN #1, who was the Nurse Supervisor on duty. RN #1 stated she was at lunch when the Code Blue was called on Unit 4. She was surprised the code was called for Unit 4 because all the residents in Unit 4 are Do Not Resuscitate (DNRs). RN #1 said that when she arrived in Unit 4, no additional staff were present for the emergency. Resident #3 was lying in bed unresponsive. She instructed the staff that Resident #3 was hospice and DNR. She said the emergency cart was not in Resident #3's room. RN #1 stated, If a 'Code Blue' is called, all available staff from other units must come to assist, and the emergency cart should be retrieved.<br><br>The surveyor reviewed the Facility Emergency Procedure-Choking Policy dated [DATE]. Guidance for Conscious Resident Standing or Sitting:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 1. Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately.<br><br>2. Ask the resident to cough or speak, if at all possible, to determine if his or her airway is obstructed.<br><br>3. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign objects.<br><br>4. Call for help but stay with the resident.<br><br>5. Quickly assure the resident that you are going to stay and assist him or her.<br><br>6. If the resident cannot cough, only then should the abdominal thrusts be performed as follows:<br><br>a. Stand behind the resident.<br><br>b. Wrap your arms around the resident waist.<br><br>c. Make a fist with one hand<br><br>d. Place the thumb side of your fist against the resident's upper mid-abdomen, below the ribcage and above the navel.<br><br>e. Grasp your clenched fist with your other hand.<br><br>f. Press your fist into the resident's upper abdomen with a quick upward thrust.<br><br>g. Do not squeeze the ribcage. Contain the force of the thrust to your hands.<br><br>h. Repeat the thrusts until the foreign body is expelled or the resident loses consciousness.<br><br>The surveyor was not provided any documentation to support why the facility did not immediately offer emergency treatment to Resident #3 while in the dining room per their policy. The facility did not provide any documentation to explain why Resident #3 was removed from the dining room, and his emergency care for a change in condition was delayed. The surveyor found no evidence in Resident #3's medical records supporting the fact that the facility's staff performed abdominal thrusts correctly in accordance with the facility's policy.<br><br>The Surveyor conducted a tour of the facility Emergency Cart (EC) on Unit 4 with the Unit Manager (UM #1) on [DATE] at 12:15 PM. UM #1 stated not all the residents in Unit 4 were hospice or DNRs. UM #1 showed the Surveyor where Unit 4 EC was stored. UM #1 removed the protective covering from over the cart and started to identify what supplies were on the cart. The surveyor observed the suction machine canister was detached from the suction machine and positioned on the other side of the cart. UM #1 set up the suction machine for use which took approximately 5 minutes.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A meeting was conducted with the Director of Nurses (DON) on [DATE] at 10:18 AM. The DON stated the facility utilizes agency nurses to assist with staffing needs. DON stated LPN #1 was an agency nurse who had worked at the facility numerous times. She wasn't aware if LPN #1 worked on Unit 4 previously. DON said that all agency nurses receive their training online and are ready to work when they arrive at the facility. She stated that Resident #3 had a DNR status, and the facility's nurses did everything possible. DON stated Resident #3 became unconscious after choking, and treatment was stopped because of the resident's DNR order.<br><br>During the meeting, the DON presented the surveyor with undated, unsigned, typed statements regarding the incident from LPN #1 and RN #1. DON stated that the staff had provided the statements after the incident. The surveyor reviewed Resident #3 medical records and found the statements incongruent with the incident documentation in Resident #3's electronic medical records. The medical records did not reveal emergency treatment for the resident who was actively choking, including the implementation of abdominal thrusts that were evident in the typed statements. No CNA statements regarding the incident were presented to the surveyor.<br><br>The surveyor requested a copy of all nursing staff's CPR cards for verification and the emergency cart facility assessment. All nursing staff had valid and up-to-date BLS cards.<br><br>The exit meeting was conducted on [DATE] at 3:20 PM with the DON, Director of Clinical Operation (DCO), UM #2, and Facility Administrator. Surveyor informed the facility of concerns regarding Resident #3's treatment and documentation. DCO stated that the facility emergency cart (EC) should be used for any resident emergency because it stores oxygen and suction. She said that if a resident was crashing, it should be used anytime. DCO could not provide the surveyor with an explanation regarding why the CNAs pushed Resident #3 out of the dining room instead of immediately starting treatment. DCO requested a brief break to speak with her team and provided additional information.<br><br>The exit meeting continued on [DATE] at 3:53PM with the DON, DCO, UM #2, and Facility Administrator. Although there was no documentation to support the actions of the CNAs during this choking incident, the DOC stated she felt that the facility policy for choking was followed. The CNAs were unavailable for interviews at this time. No additional information was provided to the surveyor regarding this matter. The surveyor requested the Facility Assessment regarding the Emergency Cart usage. The Facility Administrator was unable to provide the documentation. |