

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Edgemoor Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 Park Center Drive Santee, CA 92071	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three residents (Resident 1) reviewed for feeding assistance and weight loss was supervised during meals.</p> <p>This failure placed Resident 1 at risk for aspiration (inhaling food particles into the lungs), choking, and weight loss.</p> <p>Findings:</p> <p>During a record review on 1/16/25, Resident 1 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing) following cerebral infarction (stroke).</p> <p>During a record review on 1/16/25, the Minimum Data Set (MDS, an assessment tool) dated 11/20/24 indicated, Resident 1 had a BIMS (a tool to measure cognition) of 13, which indicated intact cognition.</p> <p>A review of the Interdisciplinary Progress Notes indicated on 11/20/24, At 8:30Am [sic], staff witnessed resident is coughing and started turning red. One staff went to notify the RN and another help [sic] resident with back thrust and encouraged him to cough, resident cleared his throat with cough and little tap on his back. Nothing had visibly come out but looked like resident chew [sic] food and swallow it again .</p> <p>A review of the In-House Referral dated 11/20/24 indicated, CONSULTANT'S COMMENTS: 11/20/24 Resident seen during skilled ST [Speech Therapy] session to discuss this episode of choking. Resident reported that he was eating quickly [and] taking larger bites of his eggs and a piece of egg went towards airway, causing expressive coughing .</p> <p>on 1/16/24 a review of the Interdisciplinary Progress Notes (IPN) was conducted. The IPN dated 12/18/24 at 2:26 P.M. indicated, Resident noted to have episode of choking during lunch time with [NAME] [sic] pasta and ground meat, noted with coughing and turning so red. Heimlich maneuver done and got relief .</p> <p>A review of Resident 1's Plan of Care effective 12/18/24 indicated At risk for choking/aspiration .with re-curent choking episode during lunch time . The interventions indication, Follow Eating safe strategy at [facility's name] per facility policy .Do 1:1 supervision (one staff member dedicated to sit with/supervise the resident) during meals.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/25 at 12:54 P.M., an interview was conducted with Restorative Nursing Assistant (RNA) 1. RNA 1 stated Resident 1 is able to feed himself, and staff does not sit with Resident 1 during meals. RNA 1 stated, . we just watch him sometimes. He eats fast, he needs to slow down. Sometimes he coughs, but nobody sits with him. As far as I know nobody watches him during meals .</p> <p>On 1/16/25 at 1:08 P.M , an observation was conducted in the dining room during lunch. Resident 1 was sitting at a table with his lunch, by himself. Resident 1 picked up a spoon and took a bite of food.</p> <p>During an observation in the dining room on 1/16/25 at 1:23 P.M., Licensed Nurse (LN) 1 sat next to Resident 1, picked up a spoon and fed Resident 1 a bite of food.</p> <p>On 1/17/25 at 10:06 A.M., a joint interview and record review was conducted with Licensed Nurse (LN) 2. LN 2 stated .there's always a licensed nurse present during meals. Someone watches [Resident 1] but doesn't sit with him. We just do spot checks because he has episodes of choking. He tends to eat fast and cough . LN 2 stated she was unaware of Resident 1's care plan to have 1:1 supervision during meals.</p> <p>On 1/21/25 at 9:38 A.M., a telephone interview was conducted with the Speech Language Pathologist (SLP). The SLP stated Resident 1 required 1:1 supervision during meals, due to dysphagia and a history of choking while eating without assistance. The SLP stated, .he tends to eat fast. He has limited upper extremity movements and does require feeding assistance . The SLP stated Resident 1 was at risk for further choking because, .he doesn't want to comply with the diet orders [for mince and moist diet with mildly thickened liquids] .he enjoys .cookies, but doesn't have the lingual coordination or oral coordination to swallow it safely. The SLP stated Resident 1 required 1:1 supervision so staff could watch him eat, and to provide verbal cues when necessary. The SLP stated, From what I see with him I agree, someone should sit with him [during meals].</p> <p>On 2/3/25 at 5:09 P.M., a telephone interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation for Resident 84 to receive 1:1 supervision if it was indicated in the care plan. The DON stated, .We have to be compliant on what the resident needs. Safety is our priority, so if the resident is 1:1 [supervision] he should be 1:1 [supervision] .</p> <p>A review of the facility's policy titled Assisting Residents With Eating/Dining/Feeding Techniques dated 10/19/23 indicated, .h. Trays are not placed in front of a resident who requires feeding help until help is available .l. Watch swallowing to determine if one bite is swallowed prior to offering another .m. Stop/slow down feeding if resident is having difficulty swallowing/coughing .</p>		