STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Healthcare & Wellness Centre, LP	415 South Garfield Alhambra, CA 91801

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 1) was provided with cardiopulmonary resuscitation (CPR-a lifesaving emergency procedure for a victim who has signs of cardiac arrest [a situation when a victim becomes unresponsive, no normal breathing, and no pulse]), in accordance with the standard of practice on basic life support and the facility's cardiopulmonary resuscitation policy by failing to: 1. Ensure facility staff immediately start CPR when Resident 1 was found unresponsive (no movement or response to stimuli and no pulse or respirations). Instead, Licensed Vocational Nurse 1 (LVN 1) walked to the nurses' station, which was about 30 feet away from the resident to check on the resident's code status (type of emergent treatment a resident would or would not receive if their heart or breathing were to stop) before starting CPR. 2. Ensure facility staff immediately start CPR when Resident 1 was found unresponsive. Instead, Resident 1 was moved from outside his room to the resident's room, which was about 10 feet away, and placed on the bed prior to starting CPR. As a result of these failures, Resident 1 did not receive immediate CPR and was pronounced dead by the paramedics (healthcare professional that respond to emergency calls and performs CPR to the victims) on [DATE] at 9:23 PM, 35 minutes after Resident 1 became unresponsive, due to cardiac and respiratory arrest (heart and lungs stopped functioning) related to asphyxia (the state or process of dying from not having enough air or unable to breathe). Findings: On [DATE] at 11:50 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding quality-of-care services. The survey team notified the Director of Nursing (DON), the Administrator (ADM), the [NAME] President of Operation (VPO), and Quality Assurance (QA) consultant of the IJ situation due to delay in the initiation of CPR to Resident 1. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:52 PM, the IJ was removed in the presence of the ADM, VPO, Chief of Business Development (CBD), QA, and the DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present. The IJ Removal Plan dated [DATE], included the following: 1. On [DATE], the DON/Designee immediately provided an in - service education to the Nursing Staff regarding Aspiration/Choking Precautions. 2. On [DATE], DON initiated an in - service education to the Nursing Staff, and sitters regarding meals/snacks distribution, aspiration/choking precautions, emergency response - code blue, supervision, validation of diet prior to distribution. This in-service will be completed by [DATE]. Nursing Staff and sitters on leave or unscheduled will receive education upon return to work. 3. On [DATE], an American Heart Association accredited outside vendor for CPR Classes (CPR-911), came to the facility and provided an in - service education and competency assessment for Licensed Nurses, CNAs, and other staff on CPR and Heimlich Maneuver. 4. On [DATE], an American Heart Association accredited outside vendor for CPR Classes (CPR-911), came to the facility and initiated an in - service education and competency assessment for Licensed Nurses, CNAs and other staff on CPR and Heimlich Maneuver. This in-service will be completed by [DATE] to ensure that a CPR certified staff is available at all times to provide CPR immediately when needed. 5. On [DATE], the DON provided an in - service education to the Licensed Nurses regarding Emergency Response, Change of Condition, Unusual Occurrence, and Resident Supervision. 6. On [DATE], the DON provided an in - service education to the Licensed Nurses, CNAs, and other staff from other departments regarding the policy and procedures for Cardiopulmonary Resuscitation/Emergency Response. 7. On [DATE], the DON provided an in - service education to the Licensed Nurses, CNAs, and other staff from other departments regarding the policy and procedures for Cardiopulmonary Resuscitation/Emergency Response. Staff on leave or unscheduled will receive education upon return to work. 8. On [DATE], the DON/Designee conducted an audit of residents who had code blue emergencies and became unresponsive after choking within the last 30 days, to ensure that licensed nurses-initiated CPR immediately without delay. There were no other residents identified to have been affected by the same deficient practice. 9. On [DATE], the DON/Designees conducted an audit and observation of current residents during meals to ensure that residents received accurate diet texture as ordered. 10. On [DATE], the DON/Designees conducted an audit and observation of current residents that received HS snacks to ensure that residents received accurate food texture as ordered. There are 30 residents that received HS snacks and all residents identified received accurate diet texture. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. On [DATE], the DON/Designees conducted an audit of current residents and reviewed the most recent MDS, ST Notes/Discharge Summaries within the last 30 days to identify residents' required level of assistance with eating, residents at risk for aspiration/choking, to ensure that a care plan for risk for aspiration/choking are developed and implemented accordingly. 35 residents out of total current census of 94 were identified to be at risk for aspiration/choking based on their current diagnoses, diet orders, recent changes of condition, and/or speech therapy evaluation and discharge summary. 12. An ADHOC (for this) meeting is scheduled to be conducted on [DATE], with Administrator and QAA Members, to review the recent incident of choking, current practices and policies related to aspiration, and emergency response. 13. On [DATE], the DON/Designee conducted an audit and observation of current residents with resident/family preference of being assisted with eating by private caregivers to ensure that the private caregiver(s) have received adequate training. There are six other residents identified to have the preference of being assisted with eating by private caregivers and none were affected by the same deficient practice. 14. The Speech Therapist (ST) is scheduled to initiate an in-service education to the nursing staff regarding different diet textures. This in-service will be completed by [DATE]. Nursing Staff on leave or unscheduled will receive education upon return to work. 15. Upon identification or request by a resident or caregiver/family member to provide assistance with eating, the ST will provide training to the interested caregiver and document the training in residents' records. PROCESS: a. Evening (3 PM-11 PM) Shift Nursing Supervisor will print a copy of diet orders and dietary supplements to be used in validation of meals and snacks served for the day. Any new orders/changes in orders will be communicated by the receiving licensed nurse to the CNA, and a new copy of diet orders will be printed out for reference. b. The Dietary Supervisor/Designee will print and place a copy of Diet Orders in a folder in the meal cart during mealtimes for reference. c. Licensed Nurses will check and validate meal trays and snacks prior to distribution to residents. d. Any snacks or food items picked up by CNAs will be checked by a Licensed Nurse prior to distribution to residents. e. Meal Trays and snacks will be distributed to the residents by nursing staff. f. Diet Orders, Dietary Supplement Orders, and Required Level of Assistance with Eating will be made available in the Diet Binder at each nurse's station and dining room for reference. The DON/Designee will be responsible for updating these lists. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	g. Snacks provided by the kitchen that are not resident-specific will be sorted and labeled according to texture (i.e., Regular, Mechanical Soft, Puree, etc.) h. On [DATE], the DON/Designee conducted competency assessments to nursing staff to ensure that residents receive their prescribed diet orders with appropriate verification of food texture and fluids consistency prior to meal distribution. CPR Procedure: Responding to Cardiopulmonary Emergency 1. Check the victim for responsiveness, respiration, and pulse. a. If the victim responds but is injured, follow the facility protocol for first aid or call 911. b. Verify, or instruct a staff member to verify the code status of the individual. c. If the resident shows signs of irreversible death, cardiopulmonary resuscitation may be withheld. The physician shall be contacted immediately. 2. If the victim is unresponsive (no movement or response to stimuli, and no pulse or respirations, activate the Emergency response team). a. Call for help and send someone to contact the EMS or 911 for emergency medical assistance. b. Send someone for the emergency cart and supplies, and to announce your facility code for medical emergencies. c. Initiate CPR in accordance with AHA guidelines. d. CPR will be initiated at the place of incident if area is safe; if area is not safe, resident will be moved to a safe area immediately and CPR will be initiated. e. Continue CPR until the EMS arrives and assumes care of the resident. 16. The DON/DSD will conduct Code Blue Drills every 3 months to ensure that staff are aware and trained in all emergency procedures, administering CPR, and responding to Residents who are choking and who become unresponsive. 17. The DON/Designee will conduct a review of residents weekly for 4 weeks then bi-monthly for 2 months who had code blue emergencies and became unresponsive after choking to ensure that licensed nurses-initiated CPR immediately without delay. Identified concerns will be immediately addressed and reported to DON for follow-up and resolution as warranted. 18. The DON/Designee will conduct an audit of residents' records and observation of current residents with resident/family preference of being assisted with eating by private caregivers, weekly for 4 weeks then bi-monthly for 2 months, to ensure that the private caregiver(s) have received adequate training. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	19. The Administrator will conduct a review and audit of CODE Blue Drill Records monthly for 3 months to ensure that current staff have participated in the drills. Any issues identified will be addressed by the Administrator immediately. 20. The DON will present the results of CODE Blue Emergency Response audits, and Caregiver Training audits to the Quality Assurance and Performance Improvement for review and recommendations monthly for 3 months or until substantial compliance is achieved. 21. The Administrator will present the results CODE Blue Drill records audits to the Quality Assurance and Performance Improvement for review and recommendations monthly for 3 months or until substantial compliance is achieved. 22. The Administrator and DON will be responsible for monitoring and sustaining compliance. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia oropharyngeal phase (difficulty transferring food from the mouth into the pharynx [passage leading from the mouth and nose to the esophagus {organ that food travels through to reach the stomach for further digestion] and the larynx [voice box]) and esophagus to initiate an involuntary swallowing process) and generalized muscle weakness. A review of Resident 1's Physician's Order, dated [DATE], indicated a diet order for no added salt (NAS, food is seasoned as regular food), consistent (or controlled) carbohydrate (one of several substances such as sugar or starch that provide the body with energy) diet (CCHO, a restrictive diet that involves eating the same numbers of carbohydrate daily) mechanical soft texture (food item that has been blended, mashed, mixed, or processed into a smooth and uniform texture), nectar thick consistency (easily pourable and are comparable to heavy syrup found in canned fruits). A review of Resident 1's Physician's Order, dated [DATE], indicated a CPR order. A review of Resident 1's History and Physical (H&P), dated [DATE], indicated Resident 1 does not have the capacity to understand and make decisions. A review of Resident 1's ST Notes, dated [DATE], included diet precautions for the resident to receive NAS CCHO mechanical soft texture, nectar thick consistency. A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated [DATE], indicated the resident had severely impaired cognitive skills (ability to understand and make decision) for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cues) with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with toileting, hygiene, shower, lower body dressing, and putting on/taking off footwear. Resident 1 required partial assistance (helper does less than half the effort) with upper body dressing. A review of Resident 1's Change in Condition (COC) Evaluation, dated [DATE] at 1:20 AM, indicated on [DATE] at 8:48 PM, CNA 1 called for assistance to check on Resident 1 who had a COC. COC evaluation indicated Resident 1 did not have a pulse. CPR was initiated by facility staff until paramedics arrived. Resident 1 was pronounced dead by the paramedics on [DATE] at 9:23 PM. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:25 PM, Certified Nurse Assistant 1 (CNA 1) stated on [DATE] at around 8:40 pm, she was sitting next to Resident 1, just outside of his room. Resident 1 was on a recliner wheelchair eating a sandwich when the resident started coughing. CNA 1 stated she saw a third of the sandwich inside Resident 1's mouth so CNA 1 removed it. CNA 1 stated she asked Uncertified Assistive Personnel 1 (UAP 1) who was sitting near her to assist in getting Resident 1 up so CNA 1 can perform the Heimlich maneuver (a procedure used to force a foreign object from a choking victim's airway [organ that allow airflow to the lungs] by performing abdominal thrusts) because Resident 1 did not respond when CNA1 asked him if he was okay. CNA 1 stated she then performed the Heimlich maneuver to Resident 1. CNA 1 stated Registered Nurse 1 (RN 1) arrived and saw the resident unresponsive with his lip turning blue. CNA 1 stated Resident 1 was moved back to room onto the bed, which was 10 feet away from the hallway, in accordance with RN 1's instructions. During an interview on [DATE] at 2:57 PM, UAP 1 stated, CNA1 instructed her to pick up a sandwich for Resident 1 from the residents' refrigerator around 8:15 PM on [DATE]. UAP 1 stated she grabbed extra sandwiches to hand out to other residents. UAP 1 stated she gave Resident 1's sandwich of regular texture with unknown content to CNA 1. UAP 1 stated CNA 1 gave Resident 1 the sandwich. UAP 1 further stated she saw Resident 1 eating the sandwich and after a few minutes, saw Resident 1 coughing. UAP 1 stated CNA 1 removed a piece of sandwich from Resident 1's mouth and performed the Heimlich maneuver because the resident was unresponsive. During an interview on [DATE] at 3:54 PM, LVN 1 stated she rushed to check on Resident 1 who was just outside his room. LVN 1 stated Resident 1 was unresponsive, so she went back to the nurses' station to check on Resident 1's code status. LVN 1 stated as soon as she found out that Resident 1 was a full code (if a resident's heart stopped beating or stopped breathing, all resuscitation procedures will be provided to keep the resident alive), she went back to the resident who was being wheeled by the staff back to his room. LVN 1 stated she called 911 (number to contact for emergency services) at this time. LVN 1 stated as soon as Resident 1 became unresponsive and without a pulse, CPR should have been initiated by the staff because every second counts. LVN 1 stated staff should have left Resident 1 where he was, which was outside his room, instead of moving him back in his room on to his bed. During an interview on [DATE] at 3:56 PM, LVN 1 stated Resident 1 was on dysphagia (difficulty swallowing) mechanical soft diet with nectar thick consistency and should not have been given a sandwich because of the resident's difficulty with swallowing. LVN 1 stated Resident 1 could not swallow a sandwich because it is considered a regular texture. LVN 1 also stated, according to CNA 1, UAP 1 gave the sandwich to Resident 1. During an interview on [DATE] at 5 PM, RN 1 stated on [DATE] around 8:48 PM, LVN 1 called her to check on Resident 1 due to change of condition. RN 1 stated that when she arrived outside Resident 1's room, RN 1 observed Resident 1 was already cyanotic (bluish skin color due to inadequate oxygen in the blood) and unresponsive. RN 1 further stated she tried to check Resident 1's mouth but did not see any obstruction or foreign body and instructed CNA 1 and the other CNAs helping out to transfer Resident 1 back to his room and placed on to his bed. RN 1 stated she then instructed LVN 1 to get Resident 1's chart at the nurses' station to check on the resident's advanced directives (a legal document that indicates resident's wishes about receiving medical care if the resident is no longer able to) and to verify code status. RN 1 stated she then initiated CPR to Resident 1 after LVN 1 arrived in the resident's room confirming Resident 1 was a full code. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:03 PM, RN 1 stated they did not initiate CPR outside Resident 1's room, where he was found unresponsive but instead initiated it when Resident 1 was moved back in his room to his bed, for privacy because there were other residents around watching. During an interview on [DATE] at 10:26 PM, CNA 1 stated Resident 1 turned blue and became unresponsive while she was doing the Heimlich maneuver. CNA 1 stated she was instructed by RN 1 to move Resident 1 back in his room and place on his bed when Resident 1 turned cyanotic and unresponsive. CNA 1 stated RN 1 initiated CPR when Resident 1 was placed back on his bed. During a concurrent observation and interview on [DATE] at 8:10 PM, the Director of Nursing (DON) stated there was about 30 feet from the nurses' station to Resident 1's room. A review of the facility's Policy and Procedure titled, Cardiopulmonary Resuscitation, dated [DATE], indicated steps in responding to cardiopulmonary emergencies to include checking the victim for responsiveness, respirations, and pulse. The policy also indicated that if the victim was unresponsive to activate the emergency response team by: 1. Calling for help and sending someone to contact the Emergency Medical Services (EMS) or 911 for emergency medical assistance. 2. Sending someone for the emergency cart (used to transport and dispense emergency medications and supplies) and supplies, and to announce your facility code for medical emergencies. 3. Initiate CPR in accordance with the American heart Association (AHA) guidelines. A review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: High-quality CPR with minimal interruptions and early defibrillation (administering a controlled electric shock to allow restoration of the normal rhythm.) are the actions most closely related to good resuscitation outcomes. High quality CPR if started immediately after cardiac arrest combined with early defibrillation can double or triple the chances of survival. These time-sensitive interventions can be provided both by members of the public and by healthcare providers. Bystanders who are not trained in CPR should at least provide chest compressions (act of applying pressure to someone's chest in order to help blood flow through the heart in an emergency situation). Even without training, bystanders can perform chest compressions with guidance from emergency telecommunicators over the phone; the signs of severe airway obstruction included clutching the throat with the thumb and fingers, making the universal choking sign, unable to speak or cry, weak/ineffective cough or no cough at all, and the rescuer actions included: to take step immediately to relieve the obstruction, if severe airway obstruction continues and the victim becomes unresponsive, start CPR. A review of Basic Life Support Provider Manual by American Heart Association, dated 2020, indicated: a choking victim's condition may worsen, and the victim may become unresponsive. If the rescuer is aware that a foreign-body airway obstruction is causing the victim's condition, you will know to look for a foreign body in the throat. To relieve choking in an unresponsive adult, follow these steps: 1. Shout out for help. Send someone to activate the emergency response system. 2. Gently lower the victim to the ground if you see that they are becoming unresponsive (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Begin CPR, starting with chest compressions. Do not check for a pulse. Each time you open the airway to give breaths, open the victim's mouth wide. Look for the object. 4. If you see an object that looks easy to remove, remove it with your fingers 5. If you do not see an object, continue CPR. 6. After about five (5) cycles or two (2) minutes of CPR, activate the emergency response system if someone has not already done so.

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to follow the physician's order to give mechanical soft texture (food item that has been blended, mashed, mixed, or processed into a smooth and uniform texture) diet for one (1) of three (3) sampled residents (Resident 1) in accordance with the facility's policy on nutrition management of dysphagia (difficulty swallowing) by facility staff failing to : 1. Ensure Certified Nursing Assistant (CNA 1) did not instruct Uncertified Assistive Personnel 1 (UAP 1) to obtain a sandwich from the facility's refrigerator for Resident 1 to consume on [DATE]. 2. Verify Resident 1's diet order for the resident to receive no added salt (NAS, food is seasoned as regular food), consistent or controlled carbohydrate (one of several substances such as sugar or starch that provide the body with energy) diet (CCHO, a restrictive diet that involves eating the same numbers of carbohydrate daily) mechanical soft texture, nectar thick consistency (easily pourable and are comparable to heavy syrup found in canned fruits) prior to handing the resident a sandwich of regular texture and unknown content as a snack on [DATE]. These deficient practices resulted in causing Resident 1 to choke (difficulty breathing because of constricted or obstructed throat or a lack of air) on [DATE] resulting in loss of consciousness. Resident 1 was pronounced dead by the paramedics (trained to give emergency medical care to residents who are injured or ill) on [DATE] at 9:23 PM. Findings: On [DATE] at 11:50 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding food and nutrition services. The survey team notified the Director of Nursing (DON), the Administrator (ADM), the [NAME] President of Operation (VPO), and Quality Assurance (QA) consultant of the IJ situation due to Resident 1 who was on dysphagia (difficulty swallowing) mechanical soft texture, nectar thick consistency diet was served with a sandwich of regular texture and unknown content on [DATE], which caused Resident 1 to choke resulting in loss of consciousness. Resident 1 was pronounced dead on [DATE] at 9:23 PM. On [DATE] at 9:52 PM, the IJ was removed in the presence of the ADM, VPO, Chief of Business Development (CBD), QA, and the DON after the facility submitted an acceptable IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) and the surveyor verified/confirmed onsite the facility's implementation of the IJ Removal Plan and the IJ situation was no longer present. The IJ Removal Plan dated [DATE], included the following: On [DATE], the DON/Designee immediately provided an in-service education to the Nursing Staff regarding Aspiration/Choking Precautions. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the DON immediately provided an in-service education to the sitter regarding scope of practice/job description. On [DATE], DON initiated an in-service education to the Nursing Staff and sitters regarding meals/snacks distribution, aspiration/choking precautions, emergency response, supervision, validation of diet prior to distribution. This in-service will be completed by [DATE]. Nursing Staff and sitters on leave or unscheduled will receive education upon return to work. On [DATE], the DON provided an in - service education to the Nursing Staff regarding the facility's policy and procedures for Comprehensive Care Planning, with emphasis on implementation of interventions, such as aspiration and choking precautions in cases where the resident is assessed to need supervision and on choking precautions. On [DATE], the DON/Designee developed a list of residents at risk for aspiration/choking, and supervision during meals and placed it in the Special Needs List binder at each Nursing Station and Dining Room. An ADHOC (for this situation) meeting is scheduled to be conducted on [DATE], with Administrator and QAA Members, to review the recent incident of choking, current practices and policies related to aspiration, and emergency response. On [DATE], the DON/Designees conducted an audit and observation of current residents during meals to ensure that residents received accurate diet texture as ordered. On [DATE], the DON/Designees conducted an audit and observation of current residents that received bedtime (HS) snacks to ensure that residents received accurate food texture as ordered. There were 30 residents that received HS snacks and all residents identified received accurate diet texture. On [DATE], the DON/Designees conducted an audit of current residents and reviewed the most recent MDS, Speech Therapy (ST, the treatment of communication and swallowing disorders) Notes/Discharge Summaries within the last 30 days to identify residents' required level of assistance with eating, residents at risk for aspiration/choking, to ensure that a care plan for risk for aspiration/choking are developed and implemented accordingly. 35 residents out of total current census of 94 were identified to be at risk for aspiration/choking based on their current diagnoses, diet orders, recent changes of condition, and/or speech therapy evaluation and discharge summary. On [DATE], the Speech Therapist (ST) was scheduled to initiate an in-service education to the nursing staff regarding different diet textures. This in-service will be completed by [DATE]. Nursing Staff on leave or unscheduled will receive education upon return to work. PROCESS: a. Night Shift Nursing Supervisor will print a copy of diet orders and dietary supplements to be used in validation of meals and snacks served for the day. Any new orders/changes in orders will be communicated by the receiving licensed nurse to the CNA, and a new copy of diet orders will be printed out for reference. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Healthcare & Wellness Centre, LP	415 South Garfield Alhambra, CA 91801

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. The Dietary Department will also place a copy of Diet Orders in a folder and made in the meal cart during mealtimes for reference. c. Licensed Nurses will check and validate meal trays and snacks prior to distribution to residents. d. Any snacks or food items picked up by CNAs will be checked by a Licensed Nurse prior to distribution to residents. e. Meal Trays and snacks will be distributed to the residents by nursing staff. f. Diet Orders, Dietary Supplement Orders, and Required Level of Assistance with Eating will be made available in the Diet Binder at each nurse's station and dining room for reference. The DON/Designee will be responsible for updating these lists. g. Snacks provided by the kitchen that are not resident-specific will be sorted and labeled according to texture (i.e., Regular, Mechanical Soft, Puree, etc.) by the dietary department. The snacks will be hand delivered by dietary staff to a licensed nurse and will be stored in the med room. The licensed nurse receiving the snacks from dietary staff will validate the accuracy of texture of snacks provided. h. Licensed Nurses with access to the med room will distribute the snacks to the CNAs to ensure that residents receive the appropriate/accurate snacks as ordered. i. On [DATE], the DON/Designee initiated competency assessments to nursing staff to ensure that residents receive their prescribed diet orders with appropriate verification of food texture and fluids consistency prior to meal distribution. 1. The DON/Designee will conduct rounds and observations during mealtimes and/or during distribution of snacks, seven (7) times/week for four (4) weeks then weekly for two (2) months, to ensure that residents are receiving accurate diet as ordered. Any issues identified will be addressed by the DON immediately. 2. Quality Assurance and Performance Improvement (QAPI) a. The DON will present the results of the Meal/Snacks Observation to the Quality Assurance and Performance Improvement for review and recommendations monthly for 3 months or until substantial compliance is achieved. b. The DON will be responsible for monitoring and sustaining compliance. A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia oropharyngeal phase (difficulty transferring food from the mouth into the pharynx [passage leading from the mouth and nose to the esophagus {organ that food travels through to reach the stomach for further digestion] and the larynx [voice box]) and esophagus to initiate an involuntary swallowing process) and generalized muscle weakness. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Physician's Order, dated [DATE], indicated a diet order for the resident to receive NAS, CCHO, mechanical soft texture, nectar thick consistency. A review of Resident 1's History and Physical (H&P), dated [DATE], indicated Resident 1 does not have the capacity to understand and make decisions. A review of Resident 1's ST Notes, dated [DATE], included diet precautions and for the resident to receive NAS CCHO, dysphagia mechanical soft texture, nectar thick consistency. A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated [DATE], indicated the resident had severely impaired cognitive skills (ability to understand and make decision) for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cues) with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with toileting, hygiene, shower, lower body dressing, and putting on/taking off footwear. Resident 1 required partial assistance (helper does less than half the effort) with upper body dressing. A review of Resident 1's Care Plan titled, Potential for Nutritional Problem related to Aging, Dysphagia, and Dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a resident's daily functioning), revised [DATE], indicated staff interventions were to monitor, document, report signs and symptoms of dysphagia, explain and reinforce to resident the importance of maintaining the diet ordered, and to provide and serve diet as ordered. A review of Resident 1's Change in Condition (COC) Evaluation, dated [DATE] at 1:20 AM, indicated on [DATE] at 8:48 PM, CNA 1 called for assistance to check on Resident 1 who had a COC. COC evaluation indicated Resident 1 did not have a pulse. CPR was initiated by facility staff until paramedics arrived. Resident 1 was pronounced dead by the paramedics on [DATE] at 9:23 PM. During an interview on [DATE] at 2:25 PM, CNA 1 stated on [DATE] at around 8:40 PM, she was sitting next to Resident 1, just outside of his room. Resident 1 was on a recliner wheelchair eating a sandwich when the resident started coughing. CNA 1 stated she saw a third of the sandwich inside Resident 1's mouth so CNA 1 removed it. CNA 1 stated she asked UAP 1 who was sitting near her to assist in getting Resident 1 up so CNA 1 can perform the Heimlich maneuver (a procedure used to force a foreign object from a choking victim's airway [organ that allow airflow to the lungs] by performing abdominal thrusts) because Resident 1 did not respond when CNA1 asked him if he was okay. CNA 1 stated she then performed the Heimlich maneuver to Resident 1. CNA 1 stated Resident 1 was moved to his bed, which was 10 feet away, when Registered Nurse 1 (RN 1) arrived and saw the resident unresponsive with his lip turning blue. During an interview on [DATE] at 2:57 PM, UAP 1 stated, CNA1 instructed her to pick up a sandwich for Resident 1 from the residents' refrigerator. UAP 1 stated she grabbed a few more sandwiches to hand out to other residents. UAP 1 stated she gave Resident 1's sandwich of regular texture with unknown content to CNA 1. UAP 1 stated CNA 1 gave Resident 1 the sandwich. UAP 1 further stated she saw Resident 1 eating the sandwich and after a few minutes, saw Resident 1 coughing. UAP 1 stated CNA 1 removed a piece of sandwich from Resident 1's mouth and performed the Heimlich maneuver. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:56 PM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 was on dysphagia mechanical soft diet with nectar thick consistency and should not have been given a sandwich because of the resident's difficulty with swallowing. LVN 1 stated Resident 1 could not swallow a sandwich because it is considered a regular texture. LVN 1 also stated, according to CNA 1, UAP 1 gave the sandwich to Resident 1. During an interview on [DATE] at 4:43 PM, the Dietary Service Supervisor (DSS) stated Resident 1's diet order for NAS, consistent or controlled carbohydrate mechanical soft texture, nectar thick consistency was between pureed (smooth, crushed or blended food) and mechanical soft. DSS stated Resident 1 should not have been given a sandwich because sandwiches were not to be given for residents on dysphagia mechanical soft diet. During an interview on [DATE] at 5:57 PM, the DON stated CNA 1 should have checked the diet of Resident 1 before the resident was given a sandwich for the resident's safety. A review of the facility's Snack Spreadsheet indicated that sandwiches was not recommended for residents on dysphagia with thick liquid diet. A review of the facility's Policy and Procedure titled, Dysphagia Diets and Thickened Liquids, revised [DATE], indicated its purpose was to provide appropriate food and fluid consistencies to residents with dysphagia or swallowing problems, to ensure adequate hydration and diminish the risk of asphyxiation (deprivation of oxygen that can result in unconsciousness and often death). A review of the facility's Policy and Procedure titled, Nutrition Management of Dysphagia, dated 2023, indicated that dysphagia mechanical diet is a diet that consists of food that are moist, mechanically altered, easily mashed, or pureed. The policy also indicated that the dysphagia mechanical diet was necessary to form a cohesive bolus (breakdown of solid material into a size suitable for subsequent propulsion through the coordinated actions of the tongue, teeth, and cheeks while mixing the partially prepared matter with saliva) requiring little chewing and food must not be sticky or bulky increasing the risk of airway obstruction.