STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056301	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Modesto Care Center	1900 Coffee Road Modesto, CA 95355

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review, the facility failed to provide supervision and services for the prevention of accidents for two of five sampled residents (Resident 1 and Resident 2) when Resident 1 and Resident 2 were both admitted with diagnoses that included dysphagia (difficulty swallowing or chewing) and were not evaluated or treated in accordance with professional standards of practice and the comprehensive care plan. Speech Therapy was not consulted, swallow evaluations (to determine the presence and severity of dysphagia as well as to determine the need for further testing) not conducted, meals were not supervised, modified meals to prevent the risk of choking and risk of aspiration (sucking food into the airway) were not served. These failures resulted in the risk of choking and aspiration for both Residents 1 and 2; and for Resident 1 could have contributed to the event on [DATE] where Resident 2 was found pulseless while eating and coroner's preliminary report indicated cause of death as asphyxia (condition caused by an injury or obstruction of the airway passages like choking) due to aspiration from food. Findings: 1. During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 1 was admitted to the facility on [DATE] with diagnosis, Dysphagia. During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 2 out of 15 (0 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 15) cognitively intact) which indicated Resident 1 was cognitively impaired. During a review of Resident 1's Nursing Situation, Background, Assessment and Recommendation (SBAR) dated [DATE], the SBAR indicated, . Resident found unresponsive in his wheelchair (w/c) . Resident had food in his mouth and airway had to be cleared out . (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Meal Tray Ticket (MTT), dated [DATE], the MTT indicated, . Lunch . consistent carbohydrate diet (CCD) Dysphagia advanced . Italian sausage . brown gravy . parmesan noodles . sauteed spinach with garlic . dinner roll/bread . sliced pears . 8 oz skim milk . During a review of Resident 1's nutritional Care plan (CP) dated [DATE], the CP indicated, . monitor/document/report when needed (PRN) any s/sx (sign/symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals . During an interview on [DATE] at 11:51 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she responded to Resident 1's room on [DATE] due to a call for help from CNA 1. LVN 1 stated that upon entering Resident 1's room, Resident 1 was observed sitting up in his wheelchair, head tilted backward, arms resting on arm rest, facing his bed with back turned to roommate and bedside table was positioned to the front of Resident 1. LVN 1 stated Resident 1's meal tray was on top of the bedside table, there was no food on the plate, and it appeared Resident 1 had consumed the entire lunch meal. LVN 1 stated Resident 1's head was straightened up and carotid pulse (pulse felt on the front of the neck below the angle of the jaw) was checked and LVN 1 determined Resident 1 did not have a pulse. LVN 1 stated CPR was initiated. During an interview on [DATE] at 12:18 p.m. with the Assistant Director of Nursing (ADON), the ADON stated on [DATE] there was a code (life threatening emergency) called for Resident 1. The ADON stated upon entering Resident 1's room LVN 2 was observed performing chest compressions (also called cardiopulmonary resuscitation [CPR] action used to push down hard and fast in a specific way on the person's chest) on Resident 1 who was lying on his back on the floor. The ADON stated the artificial manual breathing unit bag (ambu bag a device used to provide respiratory support) was placed over Resident 1's nose and mouth. The ADON stated when the ambu bag was compressed to assist with respirations it was noted, the ambu bag was not delivering oxygen appropriately as Resident 1's chest, because Resident 1's chest did not rise. The ADON stated Resident 1's head was repositioned and Resident 1's tongue was observed hanging to the side of his mouth. The ADON stated she inserted two fingers into Resident 1's mouth to feel for any residual food and felt tongue was swollen. The ADON stated there was no food felt in Resident 1's mouth but observed the DON scooping Resident 1's bilateral cheeks. The ADON stated she observed the Director of Nursing (DON) scoop out pocketed food from Resident 1's cheek which was size of a quarter, the food appeared to be spinach and pasta. The ADON stated the suction machine was used to remove remaining food particles from Resident 1's mouth. The ADON stated once the food was removed from Resident 1's mouth, the ambu bag was repositioned and Resident 1's chest began to rise when oxygen was delivered. The ADON stated Resident 1 required set up help for meals and did not have previous concerns with meal consumption. During an interview on [DATE] at 12:50 p.m. with the Registered Nurse Supervisor (RNS), the RNS stated he was called to Resident 1's room for a Code. The RNS stated that upon entering the room he observed the DON using the ambu bag and LVN 2 delivering compressions to Resident 1. The RNS stated when the ambu bag was used it was noted not delivering oxygen appropriately as Resident 1's chest was not rising. The RNS stated the DON scooped Resident 1's bilateral cheek and removed approximately 30 mL's (unit of measure) of food from Resident 1's mouth. The RNS stated the suction machine was used to remove remaining food particles from Resident 1's mouth. The RNS stated the food appeared chewed and looked like spinach mixed with an unknown white substance. The RNS stated there were no known food or drug allergies for Resident 1. The RNS stated, when the food was removed from Resident 1's mouth, the ambu bag was repositioned and oxygen was delivered effectively. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:11 p.m. with the DON, the DON stated she was called to Resident 1's room for a code. The DON stated when she entered Resident 1's room, LVN 2 was observed administering chest compressions to Resident 1 who was observed lying on the floor on his back. The DON stated Resident 1's skin appeared pale, he was fully dressed, eyes were open, and body was flaccid. The DON stated she assessed Resident 1's carotid pulse and concluded there was no pulse. The DON stated she was in charge of the ambu bag during cardiopulmonary resuscitation and noted there was a leak in the ambu bag seal when Resident 1's chest did not rise. The DON stated she removed the ambu bag and proceeded to scoop Resident 1's bilateral cheek for food. The DON stated there was food removed from the left cheek that appeared to have been spinach and there was food removed from the right cheek that appeared as ground meat. The DON stated she was unsure how much food was removed from Resident 1's mouth but that it was a small amount. The DON stated Resident 1 had an unusually heavy tongue that required for it to be pulled out of Resident 1's mouth to suction the back of the throat for remaining food particles. The DON stated once Resident 1's mouth was cleared of food, the ambu bag was repositioned and effectively delivered oxygen when Resident 1's chest was observed to rise. The DON stated Resident 1 required set up help only for meals and had a diagnosis of dysphagia without prior complications. During an interview on [DATE] at 1:39 p.m. with the Regional Director of Rehab (RDR), the RDR stated Resident 1 was not evaluated or treated in the facility since admission by the Speech Therapy department. The RDR stated there were no speech therapy notes in Resident 1's electronic medical record (EMR). During a concurrent interview and record review on [DATE] at 1:43 pm with the DON, Resident 1's EMR and nutritional care plan dated [DATE], were reviewed. The EMR indicated Resident 1 was not evaluated or treated by a speech therapist (ST) since admission to the facility on [DATE]. The CP indicated, . monitor/document/report when needed (PRN) any s/sx of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals . The DON stated the facility staff was not monitoring Resident 1 specifically for pocketed food or choking. The DON stated the expectation was for a monitoring order to have been put in place to monitor Resident 1 during and after meals as there was a potential for pocketing food to become a choking hazard. During an interview on [DATE] at 1:52 pm with CNA 1, CNA 1 stated she was assigned to care for Resident 1 on [DATE]. CNA 1 stated Resident 1 was served his lunch tray in his room while he sat in his wheelchair with bedside table positioned in front of him and then she exited the room. CNA 1 stated when she entered Resident 1's room to retrieve the lunch tray, Resident 1 was observed sitting in wheelchair with head tilted back, eyes open but wasn't responding to verbal stimuli. CNA 1 stated she was not aware that Resident 1 had a history of pocketing or choking on food. CNA 1 stated it was important to monitor Resident 1 as there was a potential for choking during meals. During a review of Resident 1's dietary profile dated [DATE], the dietary profile indicated, . Resident does not speak English, so his Family Member (FM) was called for preferencing interview. She said her father has a hard time chewing some meals due to dental issues. Will tell speech therapist about it . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 9:29 a.m. with the speech therapist (ST), Resident 1's EMR and nutritional care plan dated [DATE], were reviewed. The EMR indicated Resident 1 was not evaluated or treated by a ST since admission to the facility on [DATE]. The CP indicated, . monitor/document/report when needed (PRN) any s/sx of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals . The ST stated that based on Resident 1's history, the facility should have downgraded Resident 1's diet to a puree texture and should have referred to ST services to ensure resident was given the appropriate diet. The ST stated that based on Resident 1's history, diagnosis and care plan it was her professional opinion that Resident 1 should have been referred, evaluated and treated as indicated by a ST. During a concurrent interview and record review on [DATE] at 10:18 a.m. with the facility's registered dietitian (RD), Resident 1's diet order dated, [DATE], and dietary profile dated [DATE], were reviewed. The diet order indicated, Consistent Carb Diet dysphagia advanced texture thin liquids. The dietary profile indicated, . Resident does not speak English, so his daughter was called for preferencing interview. She said her father has a hard time chewing some meals due to dental issues. Will tell speech therapist about it . The RD stated Resident 1 was admitted to the facility with a diet order for Dysphagia advanced texture and continued without a diet change until Resident's death on [DATE]. The RD stated that a dysphagia advanced texture consisted of finely chopped foods, dinner rolls and pasta and should have been soft and did not require chopping. The RD stated the dietary manager (DM) in the facility at the time of the documented dietary profile was no longer an employee of the facility. The RD stated the process was for the dietary manager to attend all resident's interdisciplinary team (IDT team of healthcare professionals who work together toward the goals of their clients) meetings and report any findings. The RD stated the DM should have notified the ST and the IDT team of the family's concern at the time of the dietary profile to evaluate Resident 1's diet. During a telephone interview on [DATE] at 3:10 p.m. with the coroner's office sheriff (COS), the COS stated, Resident 1's preliminary report indicated cause of death was asphyxia due to Aspiration of food. During a telephone interview on [DATE] at 2:50 pm with the family member (FM) 1, the FM 1 stated Resident 1 had a history of dysphagia that presented by difficulty swallowing foods. FM 1 stated Resident 1 had episodes of pocketing food during meals and required supervision and redirection during meals. FM 1 stated the facility staff was informed that Resident 1 was pocketing food and FM1 requested staff follow up with Resident 1 during meals. During a telephone interview on [DATE] at 3:38 p.m. with LVN 3, LVN 3 stated Resident 1 had a diagnosis of dysphagia since admission. LVN 3stated dysphagia was interpreted as trouble swallowing food. LVN 3 stated the facility process was for the admitting nurse to look at Resident's history and determine which diet order was in place and notify the physician. LVN 3 stated Resident 1 was administered crushed medications in applesauce during medication administration because Resident 1 had a hard time swallowing. LVN 3 stated Resident 1 did not have a physician order in place to crush medications. LVN 3 stated the facility process was for the facility nurses to notify MD and speech therapy if Resident 1 was having trouble swallowing and this was not done for Resident 1 . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Emergency Medical Services (EMS) Patient Care Report, dated [DATE]. The EMS report indicated, . Oropharyngeal Airway (OPA device used to maintain an open airway by assisting in moving the tongue or other possible obstructions and improving the airway, placed, but rejected by patient due to intact gag reflex. Initial video laryngoscopy (procedure in which a fiberoptic camera is used to visualize the upper airway for intubation) utilized for use in clearing airway, where bits of noodle and greens were removed. 2. During a review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included Dysphagia. During a review of Resident 2's Minimum Data Set (MDS a resident assessment tool used to identify cognitive and physical functional level assessment) dated [DATE], the MDS indicated Resident 2's BIMS score was 13 out of 15 which indicated Resident 2 was cognitively intact. During a review of Resident 2's Dietary Order, dated [DATE], the Diet order indicated, . Regular diet, regular texture, thin consistency . During a review of Resident 2's Dental Consult, dated [DATE], the dental consult indicated, . Resident strongly refusing extractions today, stated why pull them if they don't hurt me, patient does not want extractions . During a concurrent interview and record review on [DATE] at 1:20 p.m. with the DON, Residents 2's EMR was reviewed. The EMR indicated Resident 2 was not evaluated or treated by ST since admission to the facility. The DON stated that upon review of the EMR, Resident 2 had no documented history of speech therapy services. During a concurrent observation and interview on [DATE] at 12:05 p.m. with Resident 2 in Resident 2's room, Resident 2 was observed lying in bed. Resident 2 stated the facility speech therapist, as far as she was aware, had not evaluated her. 2 stated she was not having issues chewing or swallowing food at the time of the interview but was experiencing facial nerve pain. Resident 2 stated the facial nerve pain was located on her left side of the face. Resident 2 stated that there were times when she had to put her head up to swallow food due to the nerve pain. Resident 2 was observed lifting head backward to show position for swallowing. During an interview on [DATE] at 12:33 p.m. with the physical therapy assistant (PTA), the PTA stated after review of Resident 2's physical therapy documentation, Resident 2 had not been evaluated or treated by speech therapy since admission. During a concurrent interview and record review on [DATE] at 12:55 p.m. with the social services assistant (SSA), Resident 2's dental consult, dated [DATE] was reviewed. The dental consult indicated, . Resident strongly refusing extractions today, stated why pull them if they don't hurt me, patient does not want extractions . The SSA stated Resident 2 was last seen by the dentist on [DATE] and had refused any further treatment. The SSA stated Resident 2 had a lot of dental issues that needed to be addressed including multiple tooth extractions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on [DATE] at 9:22 a.m. with the facility ST, Resident 2's EMR, diet order dated [DATE] and dental consult dated [DATE] were reviewed. The EMR indicated Resident 2 had not been referred, evaluated, or treated by a ST since admission to the facility. The Diet order indicated, . Regular diet, regular texture, thin consistency . The ST stated, it was her professional opinion that based on Resident 2's diagnosis of dysphagia, resident reports of left sided facial pain, inability to swallow and documented dental issues, Resident 2 should have been referred to ST for an evaluation, MD notified of concern and diet changed. During a telephone interview on [DATE] at 4:24 p.m. with Registered Nurse Manager (RNM), the RNM stated the facility process for residents with dysphagia was for the admitting nurse to notify the physician and refer to speech therapy for evaluation. The RNM stated all residents with dysphagia should have been monitored and referred to speech therapy services for an evaluation. The RNM stated if Resident 2 had a history of difficulty swallowing, it was expected that Resident 2 be referred to speech therapy. During a telephone interview on [DATE] at 4:26 p.m. with the DON, the DON stated it was the facility process when a resident is admitted with a diagnosis of dysphagia, to request a speech therapy evaluation. The DON stated it was the expectation for the admitting nurse to clarify with physician and follow the diet orders sent from the hospital upon admission. The DON stated it was the expectation that nursing staff monitor the resident for any changes in eating habits. The DON stated it was not an acceptable practice to not monitor a resident with a diagnosis of dysphagia including Resident 1 and Resident 2. During a telephone interview on [DATE] at 4:28 p.m. with the facility administrator (ADM), the ADM stated it was the expectation that the admitting nurse notify MD and obtain an order for speech therapy services for residents with dysphagia upon admission. The ADM stated if the facility staff identified difficulty with eating or swallowing it was the expectation that the charge nurse evaluate and asses the resident and refer to speech therapy for evaluation. During a review of the facility's policy and procedure (P&P) titled, Speech Therapy, dated ,d+[DATE]. The P&P indicated, . The purpose of this procedure is to identify, assess and treat speech and language problems including swallowing disorders . Speech therapists treat . Dysphagia difficulty in chewing or swallowing . the speech therapists work to provide a comprehensive evaluation and treatment plan for residents . the speech therapists complete an evaluation of the following speech and language skills . ability to swallow . During a review of the facility's policy and procedure (P&P) titled, Dysphagia, dated ,d+[DATE], the P&P indicated, . the staff and the physician will identify individuals with a history of swallowing difficulties or related diagnosis such as dysphagia . based on the information collected and correlated by various disciplines, the staff and practitioner, in conjunction with the SLP (speech language pathologist), will define the situation carefully . and whether the situation needs additional evaluation and clarification . if a swallowing problem is identified or suspected, a healthcare practitioner, in conjunction with nursing and SLP, will identify and document pertinent information, including the resident's level of consciousness, ability to swallow 3 ounces of water without drooling, coughing, or choking . previous and recent history of swallowing capability and difficulty . it is important to clarify the symptoms and the history in detail in order to help identify causes, since symptoms related to chewing or swallowing may have modifiable causes .