STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065179	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hildebrand Care Center	1401 Phay Ave Canon City, CO 81212

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews, the facility failed to ensure one (#1) out of three sample residents received the care and services necessary to maintain her highest practicable level of well-being. Specifically, the facility failed to serve Resident #1 the correct physician-ordered mechanical soft texture diet which contributed to her mental and physical decline. Resident #1, who had a history of dysphagia (difficulty swallowing) and dementia, had a physician-ordered texture diet of mechanical soft. On [DATE], Resident #1 was served large pieces of steak, mashed potatoes, and a bread roll for dinner. The resident began choking in the dining room, the Heimlich maneuver (a first aid procedure utilized to dislodge an obstruction from the throat) was performed and emergency services were called. In the emergency room , a large piece of meat was dislodged from her trachea (the airway that leads from the vocal box to the lungs). The resident was admitted to the hospital for acute hypoxic (low levels of oxygen in the body's tissues) respiratory failure due to choking. The resident's mental status did not recover and she was unresponsive to verbal stimuli. She was diagnosed with severe acute hypoxic encephalopathy (a type of brain damage from lack of oxygen in the brain). Resident #1 returned to the facility under hospice care on [DATE] and passed away on [DATE] at the facility, seven days after the choking incident. Findings include: Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. I. Situation of serious harm The facility failed to ensure Resident #1, who had a history of swallowing difficulties, was served the appropriate physician-ordered mechanical soft texture diet, which included ensuring food was chopped in small pieces and soft. This resulted in Resident #1 experiencing a choking episode in the dining room on [DATE]. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to serve the resident the physician-ordered diet led to the resident being sent to the hospital where a large piece of meat was removed from her trachea in the emergency room . The resident was admitted to the hospital for acute hypoxic respiratory failure due to choking; however, she was unable to recover and was readmitted to the facility on [DATE] with hospice services. Resident #1 passed away at the facility on [DATE], seven days after the choking incident. Record review and interviews during the complaint investigation confirmed the deficient practice had been corrected and the facility was in substantial compliance at the time of the survey from [DATE] to [DATE]. II. Facility plan of correction A. Immediate action The corrective action plan the facility implemented in response to Resident #1's choking incident on [DATE] was provided by the nursing home administrator (NHA) on [DATE] at 2:00 p.m. On [DATE], a huddle was conducted with the dietary staff to discuss the incident of Resident #1's choking. On [DATE], an educational in-service was conducted for all dietary staff regarding the importance of ensuring residents received the correct physician-ordered diet texture. The education included a review of all diet textures. B. Systemic changes On [DATE], the facility implemented a new system of diet cards for all residents. The facility implemented one card (instead of two pieces of paper) that included the diet texture, resident preferences, resident allergies, and the resident's food order for each meal. Education was provided to all staff, including dietary and nursing staff, on the new system put in place to ensure residents received the correct diet texture. On [DATE], an education write-up was completed for a dietary staff member. On [DATE] and [DATE], annual skills testing was conducted for all staff on diet textures, modified liquids and the importance of following physician-ordered diet textures. The facility conducted direct observations of staff serving meals with the correct diet tickets following the skills testing. C. Monitoring On [DATE], meal service audits were started and continued daily at different meals. Audits would be continued indefinitely. All audits were to be reviewed daily by the dietary manager, discussed weekly in the interdisciplinary team meetings (IDT), and reviewed during monthly QAPI (quality assurance and performance improvement) meetings. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews and record review during the complaint investigation revealed corrective actions to identify the resident and other residents who had the potential to be affected by the deficient practice, systematic changes to prevent its recurrence, and monitoring to ensure sustained corrections were in place. III. Facility policy and procedure The NHA provided the Mechanical Soft Diet policy and procedure, dated 2011, on [DATE] at 1:30 p.m. It revealed in pertinent part, A mechanical soft diet is used for individuals who have difficulty chewing regular textured foods. Foods that are difficult to chew are chopped, ground, shredded and/or soft cooked to facilitate chewing and ease of swallowing. Protein foods (fish, seafood, lean meat, poultry, eggs, cooked dry beans/peas/lentils as tolerated, soy products, etc): soft, tender, ground, shredded or chopped. IV. Incident of choking A. Resident status Resident #1, age greater than 65, was admitted on [DATE], readmitted on [DATE], and expired at the facility on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included dementia without behavioral disturbance, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, interstitial pulmonary disease, and dysphagia. The [DATE] minimum data set (MDS) assessment revealed the resident had short-term memory impairment with modified independence in making decisions regarding tasks of daily life. She required set-up assistance with eating. B. Record review The cognition care plan, initiated on [DATE], documented the resident had a cognitive deficit with signs and symptoms of memory loss and dementia. The interventions included allowing the resident to participate in daily decisions to the best of her ability, contacting the resident's family to assist in major decision-making, encouraging the resident to share memories past and present, explaining procedures to the resident, and allowing her time to process and respond. The nutrition care plan, initiated on [DATE], documented the resident's diet was changed on [DATE] due to a previous choking incident from a regular texture to a mechanical soft texture. The interventions indicated the resident should be served the mechanical soft texture diet as ordered by the physician. The [DATE] CPO documented the following physician order: Regular diet, mechanical soft texture, chin tuck with swallowing, and no straws for diet. Order date [DATE]. The [DATE] nutrition/dietary progress note documented the resident was ordered by the physician to be served a mechanical soft texture diet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] nursing progress note documented Resident #1 was observed choking in the dining room during dinner. The resident was not breathing, was unable to communicate verbally and her skin was noted to be severely cyanotic (bluish or purplish discoloration of the skin due to deficient oxygenation of the blood). The Heimlich maneuver was performed without success. Oral suction was performed with an output of a thick tan-colored substance, possibly bread, after several minutes. Resident #1 was taking slow and shallow breaths when emergency services arrived at the facility. The resident's oxygen saturation was 67% (percent) on 6 L (liters) of oxygen with a non-rebreather mask (oxygen mask that delivers high concentrations of oxygen). The resident was transferred to the emergency room . On [DATE] at 6:28 p.m., the facility nurse contacted the emergency room for an update on Resident #1's condition. Resident #1 was intubated (a tube inserted into the airway to assist with breathing) and moved to the intensive care unit (ICU). The [DATE] emergency room physician's progress note documented in pertinent part, Presented with respiratory distress in the setting of a possible foreign body aspiration. The resident arrived in respiratory distress with marked inspiratory stridor (abnormal, high-pitched respiratory sound produced by irregular airflow in a narrowed airway) while on 100 % oxygen via a non-rebreather mask. EMS (emergency medical services) reported that she was at a local nursing facility eating dinner and possibly choked on a dinner roll. On arrival, she has an oxygen saturation of 84% while on the non-rebreather mask. Her tongue was depressed, which revealed a foreign body in the oropharynx (middle part of the throat, behind the mouth). At the time of direct visualization, a large piece of meat was visualized with complete occlusion (blocking) of the trachea at the level of the vocal cords. Forceps were used to remove this piece of meat. After successful removal of this large piece of meat obstructing the patient's airway, it was collectively decided that the patient needed to be intubated for airway protection. She remained hypoxic on a 100% non-rebreather mask. The [DATE] nursing progress note documented Resident #1 remained in the ICU and intubated. It indicated the resident was still intubated due to the physical trauma to her airway. Resident #1 was readmitted to the facility on [DATE] with hospice services. The [DATE] facility physician progress note, written after the resident's readmission to the facility on [DATE], documented that on [DATE], Resident #1 had a choking episode in the dining hall. The progress note read in pertinent part: Nursing staff state efforts were made to dislodge a large piece of meat from her throat. At the same time, other staff were alerting emergency services to take her to the hospital. Staff indicated she was becoming cyanotic as she left the facility and was transported to the hospital. She was brought to the hospital emergency roiagnom on a non-rebreather mask and was gasping for air per the emergency room report. A large piece of meat was dislodged from the trachea in the emergency room . She was admitted for acute hypoxic respiratory failure secondary to choking. (continued on next page)

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