| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075257 | A. Building<br>B. Wing | 04/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Riverside Health & Rehabilitation | 745 Main St<br>East Hartford, CT 06108 |

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) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for accidents, the facility failed to ensure the resident received supervision assistance during mealtime in accordance with the plan of care which resulted in a choking incident. The findings include:<br><br>Resident #2 's diagnoses included hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (death of brain tissue/stroke) affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (language disorder), apraxia (motor disorder), epilepsy and dementia without behavioral disturbances.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a staff assessment for Mental Status conducted identifying both short-term and long-term memory problems indicative of severely impaired cognition and required setup and cleanup assistance with eating, substantial assistance with bed mobility and was dependent on staff for transfers.<br><br>The Resident Care Plan (RCP) dated 3/4/25 identified Resident #2 had dysphagia related to a stroke. Interventions included ensuring all meals and fluid intake occurred under staff supervision and providing speech therapy services as ordered.<br><br>A Speech Therapy Discharge summary dated [DATE] identified that Resident #2 had been on speech services starting 3/12/25 and was discharged on 3/27/25. The summary identified Resident #2 required supervision/assistance at mealtime due to swallowing safety 0-25 percent (%) of the time and to facilitate safety and efficiency. The summary identified that the Resident #2 ' s prognosis (expected outcome) was good with consistent staff follow-through<br><br>A nurse's note dated 4/1/25 at 4:30 PM identified Resident #2 began coughing and choking while eating lunch, the Heimlich maneuver was performed and a code was called for immediate assistance to the room.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The facility Reportable Event (RE) Form dated 4/1/25 identified that at 12:15 PM, Resident #2 had a choking episode, during lunch, in his/her room. The RE identified that upon entry to Resident #2 ' s room, NA #5 observed Resident #2 coughing and turning red in color. The RE identified that another NA went to notify the nurse and that the Advanced Practice Registered Nurse (APRN #2) was nearby during the incident and intervened by successfully performing the Heimlich maneuver. The RE identified Resident #2 ' s diet was downgraded immediately, speech therapy was notified to screen Resident #2, orders were obtained for vital signs and lung sounds every four (4) hours, to obtain bloodwork and a chest x-ray, and for supplemental oxygen as needed and a hospice consult.<br><br>The facility Summary Report dated 4/2/25 identified the RCP directed supervision during meals but the supervision requirements were not effectively communicated by the Speech Therapist (ST) to the care team and was not implemented. Following the incident, the ST would be required to document all dietary and supervision changes in the therapy Activities of Daily Living (ADL) evaluation immediately and then the Assistant Director of Nursing Services (ADNS) would be responsible for reviewing and locking the evaluation confirming the receipt of updates from the ST. The summary identified there would be written communication/documentation from the ST to nursing for changes made to the RCP and nursing would communicate the changes to the NA's every shift for 24-hours following the changes.<br><br>Interview with APRN #2 on 4/15/25 at 12:28 PM identified that on 4/1/25 Resident #2 appeared to be choking. She indicated Resident #2 was rigid and it took multiple staff to lean him/her forward in his/her customized wheelchair, to assist with the Heimlich maneuver, and Resident #2 continued to cough and expel copious amounts of secretions. APRN #2 identified that a code was called, and a male staff member responded and stood Resident #2 up. Resident #2 then coughed up chicken, continued to cough, and his/her lung sounds were still not clear. She reported Resident #2 was encouraged to continue coughing and he/she eventually coughed up another piece of chicken which ceased the coughing.<br><br>Interview with ST #1 on 4/15/25 at 1:18 PM identified that Resident #2 was referred to ST in March 2025 for weight loss and to ensure his/her diet was appropriate. She reported Resident #2 was discharged from ST services on 3/27/25 with an unchanged regular texture diet and thin liquids, and indicated she had no concerns. She identified that if new diet orders were placed, she would have verbally communicated the new orders to the charge nurse but since the diet remained unchanged and the RCP already identified Resident #2 required supervision for meals, she did not verbally notify the charge nurse of the strategy recommendations. She identified that when she re-evaluated Resident #2 following the 4/1/25 choking incident, Resident #2 had an evident decline to include new left sided weakness, facial droop, and Resident #2 was not triggering a swallow at all.<br><br>Interview with NA #6 (accompanied by the DNS) on 4/15/25 at 1:30 PM identified that on 4/1/25, she was in the hallway passing lunch trays when NA #5 called her from Resident #2's doorway stating Resident #2 was choking and needed help. NA #6 reported she observed Resident #2 coughing and turning red and she then alerted LPN #1. NA #6 identified she knew Resident #2 well and he/she had always been a setup for meals, not requiring staff supervision.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview with NA #5 (accompanied by the DNS) on 4/15/25 at 1:41 PM identified she was responsible for providing care for Resident #2 during the 7:00 AM to 3:00 PM shift on 4/1/25 and was regularly assigned to provide care for Resident #2. NA #5 identified that, according to the Resident Care Card (RCC) (quick-reference sheet used by NAs which lists information about daily care needs), Resident #2 was a setup only for meals. NA #5 reported that on 4/1/25, she went to check on Resident #2, after feeding another resident, and when she observed Resident #2 from the hallway, he/she was sitting in the wheelchair with his/her mouth open and tongue sticking out. NA #5 reported that LPN #1 came into the room immediately and they attempted looking into Resident #2 ' s mouth, but he/she would not allow them to perform a finger sweep. NA #6 identified that APRN #2 came in to assist and LPN #1 then performed the Heimlich maneuver from the front of Resident #2, which dislodged a one-inch cubed shaped piece of chicken but Resident #2 continued to cough so they called a code for additional assistance.<br><br>Interview with NA #4 on 4/15/25 at 2:33 PM identified she delivered Resident #2's lunch tray on 4/1/25, and Resident #2 wanted to eat in his/her room while in his/her customized wheelchair. NA #4 reported Resident #2 was a meal setup per the RCC, so she cut the chicken into one-inch pieces, ensured Resident #2 had everything he/she needed and then left the room.<br><br>Interview with LPN #1 on 4/16/25 at 11:41 AM identified that on 4/1/25 NA #5 reported to her that Resident #2 was choking. She identified that she floats to work on all the facility units and was unsure of Resident #2 ' s meal assistance level at the time of the incident.<br><br>Interview with the DNS on 4/15/25 at 1:55 PM identified that the RCP directed Resident #2 required supervision for meals. The DNS indicated she thought Resident #2 was a setup only, as he/she was on a regular texture diet with thin liquids.<br><br>Interview with ADNS #2 on 4/15/25 at 2:04 PM identified she was unaware that Resident #2 required supervision assistance with meals prior to the 4/1/25 choking incident and was also unaware that the RCP directed supervision with meals since 2017. She identified that during the incident investigation it was identified that the RCP interventions, to include supervision with eating, were initially entered incorrectly, so did not appear on the RCC. She reported that subsequent to that finding, the facility did a whole house audit to ensure all RCPs were reflected on RCCs.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interview with the DNS, ADNS #1, ADNS #2 and RN #6 (Regional nurse) on 4/15/25 at 2:21 PM identified that they initiated a Plan of Correction (POC) immediately on 4/1/25 regarding the choking incident with Resident #2 including reviewing emergency response procedures, both Speech Therapy and nursing staff responsibilities involving the 'Therapy ADL evaluation', a written Care Plan revision communication tool to be implemented to ensure critical care plan changes are communicated effectively, mandatory training for all direct care staff to include dysphagia management, dietary modifications and meal supervision, the implementation of competency assessments to ensure that staff understand choking prevention protocols and intervention strategies and meal supervision audits. The facility will also monitor clinical alerts in the electronic health record and review NA documentation regarding meal consumption and any changes/difficulties that residents have exhibited, review residents with a diagnosis of dysphagia to ensure Care Plans and Speech Therapy recommendations match and re-educate staff as needed and refer to Speech Therapy any residents in question. Additionally, they identified that for the pre-populated dysphagia Care Plan, under the interventions, it automatically says supervision for eating, but it doesn't automatically carry over to the Care Plan, stating that in their new Therapy ADL evaluation, when meal assistance/supervision is checked off, it automatically carries over to the [NAME].<br><br>Although requested, a facility policy for providing assistance with meals was not provided. |