STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075437	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health Care Center at Stoneridge	186 Jerry Browne Road Mystic, CT 06355

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policies, and interviews for 1 of 4 residents (Resident #4) reviewed for accidents, the facility failed to develop a comprehensive care plan to include interventions to address observed behaviors during eating such as eating fast and putting too much food in his/her mouth. Subsequently, the resident choked while eating and required the Heimlich, transfer to the hospital and laryngoscopy to remove a 3-inch piece of lamb from the airway. The findings include: Resident #4 was admitted to the facility in June 2025 with diagnoses that included mild intellectual disabilities and obesity. Review of the Nursing Clinical admission Evaluation, nutrition section, dated 6/10/25 failed to identify documentation of Resident #4's intake or signs and symptoms of a possible swallowing disorder; review of the MDS section did not indicate Resident #4 had a loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, complaints of difficulty or pain when swallowing, or a swallowing disorder. The Plan of Treatment for Rehabilitation dated 6/12/25 identified Resident #4 had treatment diagnoses that included dysphagia and mixed receptive-expressive language disorder. The reason for referral identified that Resident #4 was referred following recent changes in status due to a recent fall at his/her prior assisted living facility, resulting in a functional decline in expressive language, oral motor function, receptive language, safety awareness, and swallow function. Resident #4 was seen for a skilled Speech Therapy (ST) swallow and speech evaluation and was somewhat uncooperative and not sitting up while in bed, he/she tolerated the SLP feeding him/her while he/she held his/her own cup. Resident #4 consumed regular food with 1 slight outward cough, but did evidence an increased rate of eating, and reduced ability to swallow after each intake. It would be medically necessary for Resident #4 to be seen for skilled ST to improve his/her ability to communicate effectively with others and to use safe swallowing compensatory strategies consistently.Oral/Pharyngeal Function-ROM Oral/Pharyngeal Function was moderately/severely impaired (17-29% accuracy), deficits limiting functional performance included Resident #4's decreased swallow function related to extended oral transit time, decreased range of motion of the oral musculature was leading to increased pocketing and oral transit time, tongue base retraction deficits were leading to decreased oral transit and bolus formation, and oral motor weakness was negatively impacting swallow function.Standardized Test-[NAME]- [NAME] Assessment of Swallowing Ability Standardized Test notes identified Resident #4 was with reluctant cooperation, some breath control first swallow, mild impairment in range for tongue movement, minimal tongue weakness, and mild tongue in coordination. During oral preparation stage, Resident #4 was with minimal chew thrust gravity assisted, and some clearance for bolus clearance, oral transit time was delayed over one second, laryngeal elevation mildly restricted with slow initiation and incomplete clearance for pharyngeal phase and cough after swallow for pharyngeal response.Swallowing-Compensatory Strategy Use Swallowing: 10 % accuracy with no cueing, deficits limiting functional performance included Resident #4 demonstrated decreased ability to utilize compensatory strategies for oral (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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Interview with NA #1 on 5/4/26 at 12:40 PM identified that Resident #4 was a fast eater prior to the choking incident and would need reminding to take smaller bites. NA #1 indicated that Resident #4 would sometimes put 4-5 pieces of meat in his/her mouth at a time, and that nurses were aware. NA #1 identified that he/she would say, in general to the nursing supervisor RN #4, that Resident #4 needed to be reminded to take smaller bites or Resident #4 was taking large bites again. NA #1 indicated that he/she was not sure if there had been any follow-up. Interview with NA #3 on 5/4/26 at 1:44 PM identified that Resident #4 did not require supervision or assistance with cutting food prior to the choking incident, and that he/she had no observations of Resident #4 putting too much food in his/her mouth at once, but that Resident #4 would sometimes eat fast, but that was probably when he/she was first admitted and that Resident #4 had been working with ST. Interview with NA #4 on 5/4/26 at 1:53 PM identified that Resident #4 was a very fast eater, and it was his/her norm, so NA #4 never thought to discuss it with anyone. Resident #4 would usually be done with his/her meal in about 2-5 minutes of being served. NA #4 indicated that he/she had not observed Resident #4 taking too large of a bite or putting too much food in his/her mouth at once. Interview with RN #4 on 5/4/26 at 2:15 PM identified that he/she did not recall reports being brought to her attention that Resident #4 had been observed eating quickly or putting large amounts of food in his/her mouth at one time and indicated had concerns been reported to her she would have notified the SLP. During an interview with PTA #1 and SLP #1 on 5/4/26 at 2:25 PM, SLP #1 indicated that she did not recall any concerns of Resident #4 eating too fast or putting too much food in his/her mouth being brought forward to her and indicated if there had been she would have evaluated him/her and implemented interventions, if appropriate. PTA #1 indicated that if any concerns had been brought forth to her by the nursing staff, she would have documented the concern and notified SLP. Interview with the Dietitian (RD #1) on 5/5/26 at 8:58 AM identified that when she completes her admission and quarterly nutrition evaluations, she also completes a meal observation. RD #1 identified that during meal observations of Resident #4 she did not observe any swallowing difficulty, concerns with pacing, impulsive behaviors, or a need for cueing. Interview with the medical APRN (APRN #1) on 5/5/26 at 10:10 AM identified that she was not aware of any concerns from the interdisciplinary team that Resident #4 was eating too fast or putting too much food in his/her mouth, and that if she was aware of those concerns, she would have expected a notification and a referral for a SLP evaluation. APRN #1 further indicated that she could not speak to why Resident #4 choked on 3/2/26, but in general putting too much food in your mouth at a time would be a risk factor for choking. Interview with the MDS Coordinator (RN #2) on 5/5/26 at 10:20 AM identified that he was not made aware of concerns that Resident #4 had demonstrated fast eating habits or was putting too much food in his/her mouth at a time, even prior to the choking event. RN #2 indicated that if those behaviors were present the RN supervisor could initiate a care plan or once an evaluation was completed by the SLP and new orders were placed, he would have created a comprehensive care plan with interventions that were based off the providers orders. Interview with the DNS on 5/5/26 at 11:19 AM identified that she was unaware that nursing staff had observed Resident #4 eating fast or putting a lot of food in his/her mouth at one time, prior to 3/2/26, and that information was not disclosed to her during her investigation interviews, either, following Resident #4's choking incident. The DNS indicated that she would expect the nurse aide to report those observations to the nurse, and if the nurse aide felt like nothing was being done, she would have expected the nurse aide to bring their concerns directly to her; she would have ensured a (continued on next page)

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