STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105029	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Convalescent Center	2202 W Oak Ave Plant City, FL 33563

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on observations, interviews with the nursing staff, Nursing Home Administrator, the Director of Nursing, the resident's primary care physician, and review of the resident's medical record and facility policies, the facility failed to protect the resident's right to be free from neglect by not ensuring one resident (#2) of three residents dependent upon staff to feed at meal times, was provided supervision and services related to the resident's difficulty swallowing and history of cerebral infarction and dementia. The facility staff failed to ensure the safety of Resident #2; on [DATE] at approximately 5:15 p.m., Resident #2 was provided a covered food tray in the resident's room by facility staff. Resident #2 consumed a portion of her dinner meal unsupervised and without assistance. The facility failed to take action to prevent the resident from choking by not providing supervision during the resident's meal and not checking the resident's plan of care prior to providing the meal to the resident. At approximately 5:38 p.m., Staff A, Licensed Practical Nurse discovered Resident #2 unresponsive after being alerted by Resident #2's roommate. Resident #2 required use of the Heimlich maneuver and cardiopulmonary resuscitation (CPR) by facility staff and Emergency Medical Services (EMS) staff due to suspected choking and being found without a pulse or respirations. Resident #2 was transported to the hospital where she expired. The failure created a situation that resulted in Resident #2's death and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D. Findings included: A review of the facility policy titled Abuse Prevention Program, last reviewed in [DATE], revealed under the section titled Policy, the facility had designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. The policy defines neglect as failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's medical record Resident #2 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; muscle weakness; and dysphagia, oropharyngeal phase. A review of Resident #2's preadmission Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, with a Physician Certification date of [DATE] revealed under Section C: Decision Making Capacity (Patient) Resident #2 required a surrogate for medical decision making. The transfer form revealed under Section U: Nutrition/Hydration, Resident #2 required assistance with eating. Section U: Mental/Cognitive Status at Transfer revealed Resident #2 was alert and disoriented but could follow simple instructions. A review of Resident #2's Admission/Readmission Data Collection assessment dated [DATE] revealed under section C: Body System Review, Resident #2 had no natural teeth or dentures and was on a mechanically altered diet. The assessment revealed under section D: Mobility/ADL/ROM (Activities of Daily Living/Range of Motion), Resident #2 was dependent on staff with eating. Resident #2's care plan was updated with a Focus: (Resident #2) has an ADL Self Care Performance Deficit. Interventions included assist of one staff with eating and dependent upon staff to feed. A review of the facility policy titled Admission/Readmission Data Collection, effective [DATE] revealed the Resident's Admission/Readmission Data Collection will provide a comprehensive description of the Resident's status on admission. The assessment is designed to identify past history, current findings, and factors that may put the Resident at risk. A review of Resident #2's [DATE] Order Summary Report revealed the following orders: - Renal diet mechanical soft/soft and bite-sized texture, regular (thin) consistency. Dated [DATE]. - Full resuscitation. Dated [DATE]. - Speech Therapy Clarification resident to be seen 5 times per week for 6 weeks for focus on dysphagia management, resident/caregiver education, discharge planning with group treatment when appropriate/and do planning. Dated [DATE]. - Renal diet, regular texture, regular (thin) consistency. Dated [DATE] and discontinued on [DATE]. A review of Resident #2's care plan revealed a Focus area of the resident has an ADL self-care performance deficit. Interventions included an assist of 1 for eating and dependent upon staff to feed. Resident #2's care plan revealed a Focus are of the resident has impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included to provide orientation and validation, and cue, reorient, and supervise as needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The assessment revealed under Section GG - Functional Abilities, Resident #2 required substantial/maximal assistance (helper does more than half the effort) with eating. The assessment revealed under Section K - Swallowing/Nutritional Status, Resident #2 had coughing or choking during meals or when swallowing medications and had a mechanically altered diet on admission and while a resident in the facility. A review of Resident #2's Change in Condition Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated [DATE] and authored by Staff A, Licensed Practical Nurse (LPN), revealed under the section titled Mental Status Evaluation (compared to baseline; check all changes that you observe), Unresponsiveness, was checked. Under the section titled Functional Status Evaluation (compared to baseline; check all changes that you observe), Other (describe) was checked with a description symptom or sign of aspirated documented. The form revealed the following under Appearance: Writer was across the hall at [room number] providing medication. Writer turned to go to [Resident #2's room], [Resident #2's roommate] said to writer that, you need to look at [Resident #2]. Writer assessed resident, resident was unresponsive, writer called a code blue and grabbed the crash cart. Other nurses arrived and we began CPR, because the resident was eating dinner before going unconscious, we then began the Heimlich maneuver. The [Emergency Medical Services personnel] arrived and took over. A review of an ambulance run report dated [DATE] revealed two EMS personnel (E2 and R1) were dispatched and responded to the facility after notification of Resident #2 being unresponsive. The run report included the following: E2 and R1 responded to a medical call. E2 was first on scene and found a 76 [year old] female in a nursing home in cardiac arrest. E2 began ACLS [Advanced Cardiac Life Support] procedures and CPR was initiated. E2 began CPR and ventilations per AHA [American Heart Association] guidelines. [Patient] was positioned in bed with [cervical] spine board to support CPR. Staff on scene state the [patient] appeared to be choking and they began the Heimlich maneuver. [Patient] became unresponsive and was laid supine as E2 walked into the room. E2 performed CPR and ventilations per AHA until R1 arrived . No pulse Asystole. R1 arrived and assisted E2 in establishing ALS [Advanced Life Support] interventions. A suction was provided and utilized to removed emesis and food from the patients airway. A pulse check rhythm check was performed again after 2 minutes with no pulse, [patient] in asystole. CPR and ventilations were resumed per AHA throughout the duration of the call with a pulse check rhythm check every 2 minutes . Around 10 cycles of CPR were performed throughout the duration of the arrest. After the current cycle finished, a pulse check was performed, pulse present with sinus rhythm. ROSC [Return of Spontaneous Circulation] procedures were initiated. [Patient] was prepped for transport and transferred to the stretcher and secured. [Patient] placed into the rescue and emergency transport to [local hospital] started. [Patient] interventions were reassessed and intact. Pulse still present. A blood pressure was obtained and recorded. Pulse check performed on arrival of ER [emergency room], pulse present . The section of the run report titled Specialty Patient - CPR revealed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cardiac Arrest Etiology: Respiratory/Asphyxia Estimated time of arrest: ,d+[DATE] Minutes The run report revealed the following Incident Times: Call received: 17:41 (5:41 p.m.) En Route: 17:44 (5:44 p.m.) On scene: 17:50 (5:50 p.m.) Depart scene: 18:18 (6:16 p.m.) At destination: 18:26 (6:26 p.m.) According to the Cleveland Clinic, the Heimlich maneuver is a first-aid method for choking that you can use on adults and children. Another name for the Heimlich maneuver is abdominal thrusts, because it involves thrusting into the abdominal area. It is a quick and life-saving method, but you should only use it on conscious people who can not breathe on their own. https://my.clevelandclinic.org/health/treatments/21675-heimlich-maneuver According to the Mayo Clinic, choking occurs when a foreign object lodges in the throat or windpipe, blocking the flow of air. In adults, a piece of food often is the culprit. Because choking cuts off oxygen to the brain, give first aid as quickly as possible. The universal sign for choking is hands clutched to the throat. If the person does not give the signal, look for these indications: - Inability to talk - Difficulty breathing or noisy breathing - Squeaky sounds when trying to breathe - Cough, which may either be weak or forceful - Skin, lips, and nails turning blue or dusky - Skin that is flushed, then turns pale or bluish in color - Loss of consciousness (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	https://www.mayoclinic.org/first-aid/first-aid-choking/basics/art- 637#:~:text=To%20perform%20abdominal%20thrusts%20([MEDICATION(S)]%20maneuver)%20on%20yourself%2C%20place, do%20in%20a%20choking%20emergency A review of Resident #2's Emergency Department Documents dated [DATE] revealed EMS reported Resident #2 was found unresponsive in her room with vomiting and fluid all over. Upon EMS arrival, Resident #2 was pulseless and in PEA (Pulseless Electrical Activity) cardiac arrest. On arrival to the ER, initial evaluation and pulse check demonstrated recurrent cardiopulmonary arrest. Resident #2 had a significant amount of oropharyngeal and aspiration output after ET (endotracheal) tube placement. The section of the documents titled Medical Decision Making revealed Resident #2 had no signs of significant neurofunction and had prolonged oxygen deprivation due to either prolonged downtime or severe aspiration. The section of the documents titled Assessment/Plan revealed Resident #2 had diagnoses of cardiopulmonary arrest and aspiration into airway (unspecified foreign body in respiratory tract, part unspecified causing other injury, initial encounter). An interview was conducted on [DATE] at 1:14 p.m. with Resident #6, former roommate of Resident #2. Resident #6 stated she was Resident #2's roommate during the duration of her stay at the facility and would regularly see the resident's daughter coming in to feed the resident, but never witnessed facility staff assisting the resident with her meals. Resident #6 stated on [DATE] during the dinner meal, she witnessed Resident #2 feeding herself and the resident, was eating as fast as she could get it in there. Resident #6 noticed Resident #2 had food coming out of her mouth and was no longer swallowing food, which is when she notified the nurse who was across the hallway Resident #2 needed help. Resident #6 stated the nurse entered the room to check on Resident #2 and ran down the hallway. Resident #6 stated she heard code blue followed by their room number on the overhead speaker and the entire room filled up with people. Resident #6 stated the following day she was informed by Resident #2's daughter the resident passed away. A review of Resident #6's MDS assessment with an ARD of [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15, which indicated the resident was cognitively intact. An interview was conducted on [DATE] at 3:11 p.m. with the facility's Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional [NAME] President of Operations (VPO). The NHA stated on [DATE], an allegation of neglect was reported to her by Resident #2's daughter when she came to the facility to gather Resident #2's belongings. The NHA stated she was told by Resident #2's daughter, I know she choked on her food and that's why she was sent to the emergency room , prompting them to initiate an investigation. The DON stated they conducted interviews with the staff involved during the incident and discovered staff performed CPR on Resident #2 as well as the Heimlich maneuver because there was concern the resident may have had something in their airway and there was vomit in the resident's mouth during the CPR. The NHA stated Resident #2 aspirated during the incident and was suctioned by staff. The DON stated facility developed the following timeline of events through interviews with staff: - On [DATE] around 3:00 p.m., Resident #2 was observed by facility staff in her room, with no signs of distress and at her baseline level. Resident #2's care was assigned to Staff A, LPN and Staff B, Certified Nursing Assistant (CNA). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] around 5:15 p.m., Staff B, CNA and her hall partner Staff C, CNA passed meal trays in Resident #2's hall while Staff A, LPN performed blood glucose checks and medication administration for other residents in the hall. Resident #2 was provided a dinner tray in her room by Staff C, CNA, which was left on the bedside table in front of her after the resident stated she did not want it. After passing meal trays, Staff B, CNA, looked into Resident #2's room and saw her upright in bed and eating without difficulty. Staff B, CNA went to another resident's room to assist the resident with dining. - On [DATE] at 5:38 p.m., Staff A, LPN entered Resident #2's room to administer medications to Resident #6. Resident #6 told Staff A, LPN she needed to first check on Resident #2. Resident #2 was observed upright in the bed with her head to the side and unresponsive. At that time, Staff A, LPN ran from the room to call a Code Blue overhead and grabbed the emergency cart. Staff A, LPN verified Resident #2's code status as a Full Code and responded back to the room. Staff D, CNA responded to the resident's room and began life saving measures, including CPR, on Resident #2. Staff E, LPN, Staff F, LPN, and Staff G, LPN all responded to Resident #2's room and assisted in providing CPR. During the CPR, Resident #2 had an episode of vomiting and regained a pulse and respirations, verified by Staff E, LPN by palpation and by attaching a pulse oximeter to the resident's finger. Staff sat Resident #2 up in the bed and performed the Heimlich maneuver on the resident. No food or vomit came out of Resident #2's mouth during the performance of the Heimlich maneuver. During the event, at 5:43 p.m., a staff member called 911. - On [DATE] at approximately 5:58 p.m., Emergency Medical Services (EMS) arrived. Resident #2 became unresponsive without a pulse or respirations shortly after arrival of EMS and CPR was initiated by EMS. Per interview with Staff H, LPN, who was near the facility entrance when EMS left with Resident #2, Resident #2 had a pulse on the monitor and was intubated by EMS when she was being taken out of the facility and to the hospital. The DON stated the next day on [DATE], all information relating to the incident was collected to ensure the Code Blue process was properly executed and all CPR certifications of the involved staff were verified. The DON stated Resident #2's dinner meal was verified and the resident received the appropriate diet, but not the food she was supposed to receive per her diet slip. Resident #2 received potato salad on her dinner tray instead of rice with thick gravy. The DON addressed Resident #2's care plan revealed she required assistance of one staff member with dining, but the care plan did not indicate the resident could not feed herself. The DON stated Resident #2 was evaluated by the Speech Language Pathologist (SLP), who determined the resident was able to feed herself, but would consume food too quickly at times. The DON addressed Resident #2's care plan did not include anything related to the resident consuming food too quickly and stated none of the staff interviewed spoke about the resident consuming food too fast. The DON stated upon investigation and interview with staff, they determined Staff C, CNA was the staff member who passed the meal tray to Resident #2 and did not check the resident's plan of care prior to passing the meal tray and was not told the resident required assistance. The DON stated they could not verify if Resident #2 choked on her food during the meal due to documentation stating the resident had aspirate, which could have been from the CPR performed on the resident. The NHA stated after the facility investigation the concern, they substantiated the allegation of neglect due to Resident #2 receiving the wrong food on her meal tray and not being provided assistance with the meal per the plan of care. The DON stated the facility separated employment from Staff A, LPN, Staff B, CNA, Staff C, CNA, and Staff I, [NAME] following the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was attempted on [DATE] at 9:48 a.m. with Staff D, CNA, who performed CPR on Resident #2 when she was found unresponsive on [DATE]. Staff D, CNA did not answer the phone call and a message was left for call back. The phone call was not returned by Staff D, CNA. A telephone interview was attempted on [DATE] at 10:10 a.m. with Staff C, CNA, who provided Resident #2's dinner meal tray on [DATE]. Staff C, CNA did not answer the phone call and a message was left for call back. The phone call was not returned by Staff C, CNA. A telephone interview was attempted on [DATE] at 10:21 a.m. with Staff I, Cook, who prepared Resident #2's dinner meal tray on [DATE]. Staff I, [NAME] did not answer the phone call and a message was left for call back. The phone call was not returned by Staff I, Cook. A telephone interview was attempted on [DATE] at 10:28 a.m. with Staff J, Dietary Aide, who verified the contents of Resident #2's dinner meal tray on [DATE]. Staff J, Dietary Aide did not answer the phone call and a message was left for call back. The phone call was not returned by Staff J, Dietary Aide. A telephone interview was conducted on [DATE] at 10:45 a.m. with Staff B, CNA, who was Resident #2's assigned CNA on [DATE]. Staff B, CNA stated the dinner meal arrived on her floor around 5:15 p.m. while she was assisting another resident with a shower. Two other CNA's came to the floor to pass dinner meals to the residents, including Resident #2. Staff B, CNA stated after seeing Resident #2 was set up with her dinner meal, she went to another resident's room to assist the resident with eating. While feeding the other resident, the staff member heard a Code Blue over the facility's intercom system and ran to Resident #2's room. Staff B, CNA observed Resident #2 laid flat in the bed with food on her gown and around her mouth and other staff members began CPR on the resident. Staff B, CNA stated when she asked what happened with the resident, Staff A, LPN told her Resident #2 was choking on her food. Staff A, LPN called 911 from her cell phone and passed the phone to Staff B, CNA while she continued CPR on Resident #2. Staff B, CNA stated once EMS arrived at the facility, they continued CPR on the resident. Staff B, CNA stated Resident #2 usually fed herself at meal times and was not fed by the facility staff. Review of the facility policy titled Dining Program, effective [DATE], revealed under Policy, the nursing staff assists residents in need of assistance during mealtimes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 11:28 a.m. with Staff K, Speech Language Pathologist (SLP). Staff K, SLP stated when Resident #2 was admitted to the facility she was on a regular diet but did not have any teeth and did not wear dentures. Staff K, SLP verified from Resident #2's previous facility the resident received a mechanical soft diet. Staff K, SLP stated a trial was conducted, which determined a mechanical soft diet with bite size food was an appropriate diet for the resident. Staff K, SLP stated she educated Resident #2's direct care staff regarding providing set-up assistance for the resident, sitting the resident up 90 degrees in bed for meals prior to the resident eating, and monitoring the resident to ensure she was eating safely. Staff K, SLP stated she did not witness the resident choking or having difficulty swallowing during trials, but the resident would occasionally take consecutive sips of liquids before swallowing what was already in her mouth. Staff K, SLP recommended the resident have supervision during her meals due to the resident's dementia and safe swallowing reminders might not be retained be the resident. Staff K, SLP stated she wanted nursing staff present in the room during meals to ensure the resident was safe during her meals, which was the level of supervision the resident had at her previous facility. Staff K, SLP stated she would expect nursing staff to put interventions in the care plan and communicate any recommendations she provides so all other nursing staff were aware. Staff K, SLP informed Resident #2's physician of the recommendations, who signs and approves the resident's orders. An interview was conducted on ,d+[DATE] at 11:53 a.m. with Staff G, LPN. Staff G, LPN stated on [DATE], she was working on the first floor of the facility when she heard a Code Blue on the overhead speaker. Staff G, LPN responded to Resident #2's room, which was on a different floor, and witnessed about four people already in the resident's room assessing the resident. Staff G, LPN stated Resident #2 appeared sitting upright in bed, was unresponsive, and appeared to be losing color. She was asked by Staff E, LPN for assistance in providing the Heimlich maneuver to Resident #2, so Staff G, LPN got onto the bed and behind the resident to perform the Heimlich maneuver. Staff G, LPN stated she put her hands in front of Resident #2's upper abdominal region and performed thrusts in an upward position. After a few thrusts, Resident #2 had an episode of vomiting, which the staff member described as watery and without solids. Staff G, LPN stated they performed the Heimlich maneuver on the resident because they suspected the resident may have had something in their airway and the resident's oxygen level was dropping. Staff G, LPN stated once she became fatigued, another staff member, who she was unable to state the name of, performed the Heimlich maneuver on the resident with no results. Staff G, LPN stated EMS arrived shortly after and stated, we kind of got out of the way. Staff G, LPN stated she returned to her floor after EMS arrived. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:21 p.m. with Staff A, LPN, who was Resident #2's assigned nurse on [DATE]. Staff A, LPN stated when Resident #2 was first admitted to the facility, she was on a regular diet. After speaking with Resident #2's daughter, she found out the resident was previously receiving a mechanical soft diet and changed the resident's diet order. Staff A, LPN stated on [DATE], she was passing medications and went into Resident #2's room to administer medications to Resident #6. Resident #6 informed her to check on Resident #2 because she saw the resident eating and point to her mouth as if she could not breathe. Staff A, LPN stated Resident #2 appeared unresponsive with food all over her chest. Staff A, LPN put a pulse oximeter on Resident #2's finger and did not get a pulse reading, so she ran to call a Code Blue and retrieve the emergency cart. Staff A, LPN stated when she returned to the resident's room, a CNA was already doing CPR on the resident. Staff A, LPN retrieved a bag valve mask and applied it to Resident #2 while attempting to maintain the resident's airway. Staff A, LPN stated other nursing staff responded to the room and they eventually discovered a pulse using the pulse oximeter. Once they determined the resident had a pulse, they stopped CPR and began to perform the Heimlich maneuver on Resident #2 until EMS personnel arrived at the room. Staff A, LPN stated Resident #2 had an episode of emesis during the Heimlich maneuver, which was of a watery consistency. EMS personnel checked for the resident's pulse and the resident was still unresponsive, so they laid the resident back onto the bed and began CPR. Staff A, LPN stated EMS took Resident #2 to the hospital. The staff member stated Resident #2 fed herself and no staff assisted the resident since her admission. Staff A, LPN stated she did not look at Resident #2's care plan to determine if the resident required assistance and was told in the shift report the resident did not require assistance with dining. Staff A, LPN stated you just know, because this resident was an independent eater and had never needed help before. An interview was conducted on [DATE] at 10:08 a.m. with Staff L, LPN and Clinical Reimbursement Specialist (CRS) and Staff M, Clinical Reimbursement Consultant (CRC). Staff L, LPN CRS stated resident care plans are developed using physician orders, hospital documentation, and interviews with the resident and/or the resident's family members, and would include anything needed to provide care to the resident. Staff L, LPN CRS stated everybody has access to the resident's care plan and can see the interventions in the care plans. Staff M, CRC stated staff should be following resident care plans if the care plan shows a resident was dependent on dining with an assist of one staff member. An assist of one staff member means the staff member would be physically assisting the resident with eating. Staff M, CRC stated interventions from the care plan are pulled over into the CNA charting system, which can be viewed by the CNA staff providing care to the resident. An interview was conducted on [DATE] at 12:17 p.m. with the facility's Medical Director (MD), who was Resident #2's primary care provider. The MD stated Resident #2 was initially admitted to the facility for a fractured hip and was receiving physical and occupational therapy. The resident had dementia, diabetes, mild congestive heart failure, and pulmonary hypertension, among other comorbidities. The MD stated the resident was not able to get out of the bed safely due to the hip fracture, so the resident had all of her meals in the bed and the MD, would guess she would need assistance with all of them. The MD stated he was aware the resident had a previous cerebral vascular accident (CVA), but did not think she had a problem with her swallowing because the CVA was not a recent issue. The MD stated he was not aware the resident required supervision with her meals and would think the resident was a self-feeder. The MD stated his knowledge of the event on [DATE] came from the NHA, who told him the resident was found unresponsive in bed and required CPR and use of the Heimlich maneuver before being transported to the hospital. He said he did not review any of the resident's hospital documentation but there was concern the resident could have aspirated. (continued on next page)

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	105029	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Convalescent Center	2202 W Oak Ave Plant City, FL 33563

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:35 p.m. with Resident #2's daughter and emergency contact (EC). The EC stated in 2021, Resident #2 suffered a massive stroke and required nursing home care due to the resident's inability to care for herself. After suffering a fall with hip fracture at a previous facility, she decided to place the resident at this facility. The EC stated when at the previous facility, Resident #2 was provided a mechanical soft diet and needed supervision during meals because the resident could not feel food on the left side of her mouth and would pocket food. The EC observed Resident #2's meal tray left in the resident's room on several occasions and never observed staff assisting the resident or providing supervision to the resident during meals, even after informing the facility of the resident's needs several times. The EC stated when Resident #2 would attempt to feed herself, she would get food all over her and was not aware of how much food she was putting in her mouth. The EC was at work when she received a call from the facility informing her Resident #2 was unresponsive. When the EC asked the facility staff if the resident choked, they told her she was unresponsive and they were assessing the situation. The facility called the EC back appropriately five minutes later and was informed EMS personnel were taking Resident #2 to the hospital. During the phone call, the EC asked facility staff if Resident #2 choked on her food and the facility staff responded, I believe so. The EC stated Resident #2 passed away later that night on [DATE]. The facility's immediate actions to remove the Immediate Jeopardy included: - On [DATE], Resident #2 discharged to the hospital and has not returned to the facility. - The facility incorporated an additional notification on resident meal tickets through the meal tracker system to ensure facility staff are aware of the care and services needed by residents to include supervision and/or assistance during mealtimes in order to prevent further instances of neglect. The addition of this tray ticket notification indicator was complete on [DATE]. - The DON and NHA received directed education by the Regional Nurse Consultant on [DATE] regarding abuse, neglect, and misappropriation as they relate to ensuring proper resident supervision and/or assistance during meals. - A total of 109 out of 109 facility staff were provided education by the DON or designee regarding abuse, neglect, and misappropriation as they relate to ensuring proper resident supervision and/or assistance during meals. Education was provided to 28 out of 28 contracted staff members regarding abuse, neglect, and misappropriation. A total of 104 out of 104 nursing and therapy staff were provided education by the DON or designee on ensuring proper resident supervision and/or assistance during meals. Education regarding the added notification on resident meal tickets was provided including the meaning of the indicator and what to do when they see it. This education was 100% completed on [DATE]. - An ad hoc Quality Assurance Meeting was held with the MD regarding removal plan activities. This meeting was held on [DATE]. Verification of the facility's removal actions was conducted by the survey team on [DATE]. Review of facility education was conducted. Staff roster provided by NHA and DON. All facility staff were educated related to abuse, neglect, exploitation, and misappropriation, completed on [DATE]. All nursing, therapy staff, and department heads were educated related to tray ticket indication of need for dining assistance/dependent diners/staff role during meal times and the all hands dining process, completed on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations were conducted [DATE] at 11:30 a.m. and on [DATE] at 5:00 p.m. of the facility's meal service process. Nursing staff were observed verifying meal tickets with the resident tray before handing the tray to CNA staff to provide to residents, who verified the meal tickets match the resident tray. Nursing st[TRUNCATED]

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 40775 Based on observations, interviews with the nursing staff, Nursing Home Administrator, the Director of Nursing, the resident's primary care physician, and review of the resident's medical record and facility policies, the facility failed to implement care plan interventions to provide supervision and assistance during meals for one resident (#2) of three residents dependent upon staff to feed at meal times, related to the resident's difficulty swallowing and history of cerebral infarction and dementia. The facility staff failed to ensure the safety of Resident #2; on [DATE] at approximately 5:15 p.m., Resident #2 was provided a covered food tray in the resident's room by facility staff. Resident #2 consumed a portion of her dinner meal unsupervised and without assistance in accordance with the plan of care. The facility failed to take action to prevent the resident from choking by not providing supervision during the resident's meal and not checking the resident's plan of care prior to providing the meal to the resident. At approximately 5:38 p.m., Staff A, Licensed Practical Nurse discovered Resident #2 unresponsive after being alerted by Resident #2's roommate. Resident #2 required use of the Heimlich maneuver and cardiopulmonary resuscitation (CPR) by facility staff and Emergency Medical Services (EMS) staff due to suspected choking and being found without a pulse or respirations. Resident #2 was transported to the hospital where she expired. The failure created a situation that resulted in Resident #2's death and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D. Findings included: A review of Resident #2's medical record Resident #2 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; muscle weakness; and dysphagia, oropharyngeal phase. A review of Resident #2's preadmission Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, with a Physician Certification date of [DATE] revealed under Section C: Decision Making Capacity (Patient) Resident #2 required a surrogate for medical decision making. The transfer form revealed under Section U: Nutrition/Hydration, Resident #2 required assistance with eating. Section U: Mental/Cognitive Status at Transfer revealed Resident #2 was alert and disoriented but could follow simple instructions. A review of Resident #2's Admission/Readmission Data Collection assessment dated [DATE] revealed under section C: Body System Review, Resident #2 had no natural teeth or dentures and was on a mechanically altered diet. The assessment revealed under section D: Mobility/ADL/ROM (Activities of Daily Living/Range of Motion), Resident #2 was dependent on staff with eating. Resident #2's care plan was updated with a Focus: (Resident #2) has an ADL Self Care Performance Deficit. Interventions included assist of one staff with eating and dependent upon staff to feed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Admission/Readmission Data Collection, effective [DATE] revealed the Resident's Admission/Readmission Data Collection will provide a comprehensive description of the Resident's status on admission. The assessment is designed to identify past history, current findings, and factors that may put the Resident at risk. A review of Resident #2's care plan revealed a Focus area of the resident has an ADL self-care performance deficit. Interventions included an assist of 1 for eating and dependent upon staff to feed. Resident #2's care plan revealed a Focus are of the resident has impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included to provide orientation and validation, and cue, reorient, and supervise as needed. A review of Resident #2's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The assessment revealed under Section GG - Functional Abilities, Resident #2 required substantial/maximal assistance (helper does more than half the effort) with eating. The assessment revealed under Section K - Swallowing/Nutritional Status, Resident #2 had coughing or choking during meals or when swallowing medications and had a mechanically altered diet on admission and while a resident in the facility. A review of Resident #2's [DATE] Order Summary Report revealed the following orders: - Renal diet mechanical soft/soft and bite-sized texture, regular (thin) consistency. Dated [DATE]. - Full resuscitation. Dated [DATE]. - Speech Therapy Clarification resident to be seen 5 times per week for 6 weeks for focus on dysphagia management, resident/caregiver education, discharge planning with group treatment when appropriate/and do planning. Dated [DATE]. - Renal diet, regular texture, regular (thin) consistency. Dated [DATE] and discontinued on [DATE]. A review of Resident #2's Change in Condition Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated [DATE] and authored by Staff A, Licensed Practical Nurse (LPN), revealed under the section titled Mental Status Evaluation (compared to baseline; check all changes that you observe), Unresponsiveness, was checked. Under the section titled Functional Status Evaluation (compared to baseline; check all changes that you observe), Other (describe) was checked with a description symptom or sign of aspirated documented. The form revealed the following under Appearance: Writer was across the hall at [room number] providing medication. Writer turned to go to [Resident #2's room], [Resident #2's roommate] said to writer that, you need to look at [Resident #2]. Writer assessed resident, resident was unresponsive, writer called a code blue and grabbed the crash cart. Other nurses arrived and we began CPR, because the resident was eating dinner before going unconscious, we then began the Heimlich maneuver. The [Emergency Medical Services personnel] arrived and took over. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Cleveland Clinic, the Heimlich maneuver is a first-aid method for choking that you can use on adults and children. Another name for the Heimlich maneuver is abdominal thrusts, because it involves thrusting into the abdominal area. It is a quick and life-saving method, but you should only use it on conscious people who can not breathe on their own. https://my.clevelandclinic.org/health/treatments/21675-heimlich-maneuver An interview was conducted on [DATE] at 1:14 p.m. with Resident #6, former roommate of Resident #2. Resident #6 stated she was Resident #2's roommate during the duration of her stay at the facility and would regularly see the resident's daughter coming in to feed the resident, but never witnessed facility staff assisting the resident with her meals. Resident #6 stated on [DATE] during the dinner meal, she witnessed Resident #2 feeding herself and the resident, was eating as fast as she could get it in there. Resident #6 noticed Resident #2 had food coming out of her mouth and was no longer swallowing food, which is when she notified the nurse who was across the hallway Resident #2 needed help. Resident #6 stated the nurse entered the room to check on Resident #2 and ran down the hallway. Resident #6 stated she heard code blue followed by their room number on the overhead speaker and the entire room filled up with people. Resident #6 stated the following day she was informed by Resident #2's daughter the resident passed away. A review of Resident #6's MDS assessment with an ARD of [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15, which indicated the resident was cognitively intact. An interview was conducted on [DATE] at 3:11 p.m. with the facility's Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional [NAME] President of Operations (VPO). The NHA stated on [DATE], an allegation of neglect was reported to her by Resident #2's daughter when she came to the facility to gather Resident #2's belongings. The NHA stated she was told by Resident #2's daughter, I know she choked on her food and that's why she was sent to the emergency room , prompting them to initiate an investigation. The DON stated they conducted interviews with the staff involved during the incident and discovered staff performed CPR on Resident #2 as well as the Heimlich maneuver because there was concern the resident may have had something in their airway and there was vomit in the resident's mouth during the CPR. The NHA stated Resident #2 aspirated during the incident and was suctioned by staff. The DON stated facility developed the following timeline of events through interviews with staff: - On [DATE] around 3:00 p.m., Resident #2 was observed by facility staff in her room, with no signs of distress and at her baseline level. Resident #2's care was assigned to Staff A, LPN and Staff B, Certified Nursing Assistant (CNA). - On [DATE] around 5:15 p.m., Staff B, CNA and her hall partner Staff C, CNA passed meal trays in Resident #2's hall while Staff A, LPN performed blood glucose checks and medication administration for other residents in the hall. Resident #2 was provided a dinner tray in her room by Staff C, CNA, which was left on the bedside table in front of her after the resident stated she did not want it. After passing meal trays, Staff B, CNA, looked into Resident #2's room and saw her upright in bed and eating without difficulty. Staff B, CNA went to another resident's room to assist the resident with dining. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at 5:38 p.m., Staff A, LPN entered Resident #2's room to administer medications to Resident #6. Resident #6 told Staff A, LPN she needed to first check on Resident #2. Resident #2 was observed upright in the bed with her head to the side and unresponsive. At that time, Staff A, LPN ran from the room to call a Code Blue overhead and grabbed the emergency cart. Staff A, LPN verified Resident #2's code status as a Full Code and responded back to the room. Staff D, CNA responded to the resident's room and began life saving measures, including CPR, on Resident #2. Staff E, LPN, Staff F, LPN, and Staff G, LPN all responded to Resident #2's room and assisted in providing CPR. During the CPR, Resident #2 had an episode of vomiting and regained a pulse and respirations, verified by Staff E, LPN by palpation and by attaching a pulse oximeter to the resident's finger. Staff sat Resident #2 up in the bed and performed the Heimlich maneuver on the resident. No food or vomit came out of Resident #2's mouth during the performance of the Heimlich maneuver. During the event, at 5:43 p.m., a staff member called 911. - On [DATE] at approximately 5:58 p.m., Emergency Medical Services (EMS) arrived. Resident #2 became unresponsive without a pulse or respirations shortly after arrival of EMS and CPR was initiated by EMS. Per interview with Staff H, LPN, who was near the facility entrance when EMS left with Resident #2, Resident #2 had a pulse on the monitor and was intubated by EMS when she was being taken out of the facility and to the hospital. The DON stated the next day on [DATE], all information relating to the incident was collected to ensure the Code Blue process was properly executed and all CPR certifications of the involved staff were verified. The DON stated Resident #2's dinner meal was verified and the resident received the appropriate diet, but not the food she was supposed to receive per her diet slip. Resident #2 received potato salad on her dinner tray instead of rice with thick gravy. The DON addressed Resident #2's care plan revealed she required assistance of one staff member with dining, but the care plan did not indicate the resident could not feed herself. The DON stated Resident #2 was evaluated by the Speech Language Pathologist (SLP), who determined the resident was able to feed herself, but would consume food too quickly at times. The DON addressed Resident #2's care plan did not include anything related to the resident consuming food too quickly and stated none of the staff interviewed spoke about the resident consuming food too fast. The DON stated upon investigation and interview with staff, they determined Staff C, CNA was the staff member who passed the meal tray to Resident #2 and did not check the resident's plan of care prior to passing the meal tray and was not told the resident required assistance. The DON stated they could not verify if Resident #2 choked on her food during the meal due to documentation stating the resident had aspirate, which could have been from the CPR performed on the resident. The NHA stated after the facility investigation the concern, they substantiated the allegation of neglect due to Resident #2 receiving the wrong food on her meal tray and not being provided assistance with the meal per the plan of care. The DON stated the facility separated employment from Staff A, LPN, Staff B, CNA, Staff C, CNA, and Staff I, [NAME] following the incident. A review of an ambulance run report dated [DATE] revealed two EMS personnel (E2 and R1) were dispatched and responded to the facility after notification of Resident #2 being unresponsive. The run report included the following: The section of the run report titled Specialty Patient - CPR revealed the following: Cardiac Arrest Etiology: Respiratory/Asphyxia Estimated time of arrest: ,d+[DATE] Minutes (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's Emergency Department Documents dated [DATE] revealed EMS reported Resident #2 was found unresponsive in her room with vomiting and fluid all over. Upon EMS arrival, Resident #2 was pulseless and in PEA (Pulseless Electrical Activity) cardiac arrest. On arrival to the ER, initial evaluation and pulse check demonstrated recurrent cardiopulmonary arrest. Resident #2 had a significant amount of oropharyngeal and aspiration output after ET (endotracheal) tube placement. The section of the documents titled Medical Decision Making revealed Resident #2 had no signs of significant neurofunction and had prolonged oxygen deprivation due to either prolonged downtime or severe aspiration. The section of the documents titled Assessment/Plan revealed Resident #2 had diagnoses of cardiopulmonary arrest and aspiration into airway (unspecified foreign body in respiratory tract, part unspecified causing other injury, initial encounter). According to the Mayo Clinic, choking occurs when a foreign object lodges in the throat or windpipe, blocking the flow of air. In adults, a piece of food often is the culprit. Because choking cuts off oxygen to the brain, give first aid as quickly as possible. The universal sign for choking is hands clutched to the throat. If the person does not give the signal, look for these indications: - Inability to talk - Difficulty breathing or noisy breathing - Squeaky sounds when trying to breathe - Cough, which may either be weak or forceful - Skin, lips, and nails turning blue or dusky - Skin that is flushed, then turns pale or bluish in color - Loss of consciousness https://www.mayoclinic.org/first-aid/first-aid-choking/basics/art- 637#:~:text=To%20perform%20abdominal%20thrusts%20([MEDICATION(S)]%20maneuver)%20on%20yourself%2C%20place, do%20in%20a%20choking%20emergency (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on [DATE] at 10:45 a.m. with Staff B, CNA, who was Resident #2's assigned CNA on [DATE]. Staff B, CNA stated the dinner meal arrived on her floor around 5:15 p.m. while she was assisting another resident with a shower. Two other CNA's came to the floor to pass dinner meals to the residents, including Resident #2. Staff B, CNA stated after seeing Resident #2 was set up with her dinner meal, she went to another resident's room to assist the resident with eating. While feeding the other resident, the staff member heard a Code Blue over the facility's intercom system and ran to Resident #2's room. Staff B, CNA observed Resident #2 laid flat in the bed with food on her gown and around her mouth and other staff members began CPR on the resident. Staff B, CNA stated when she asked what happened with the resident, Staff A, LPN told her Resident #2 was choking on her food. Staff A, LPN called 911 from her cell phone and passed the phone to Staff B, CNA while she continued CPR on Resident #2. Staff B, CNA stated once EMS arrived at the facility, they continued CPR on the resident. Staff B, CNA stated Resident #2 usually fed herself at meal times and was not fed by the facility staff. Review of the facility policy titled Dining Program, effective [DATE], revealed under Policy, the nursing staff assists residents in need of assistance during mealtimes. Review of the facility Job Description for Certified Nursing Assistants revealed under Summary of Position, the CNA Is responsible for assisting with direct residents/patients care within the scope of their practice as well as other work on the unit which supports the patient environment. The section titled Essential Duties and Responsibilities revealed direct care responsibilities include participating and receiving the nursing report upon reporting to duty, report and record observations of resident's/patient's conditions, and ensuring each resident's personal care needs are being met in accordance with the resident's/patient's wishes. An interview was conducted on [DATE] at 11:28 a.m. with Staff K, Speech Language Pathologist (SLP). Staff K, SLP stated when Resident #2 was admitted to the facility she was on a regular diet but did not have any teeth and did not wear dentures. Staff K, SLP verified from Resident #2's previous facility the resident received a mechanical soft diet. Staff K, SLP stated a trial was conducted, which determined a mechanical soft diet with bite size food was an appropriate diet for the resident. Staff K, SLP stated she educated Resident #2's direct care staff regarding providing set-up assistance for the resident, sitting the resident up 90 degrees in bed for meals prior to the resident eating, and monitoring the resident to ensure she was eating safely. Staff K, SLP stated she did not witness the resident choking or having difficulty swallowing during trials, but the resident would occasionally take consecutive sips of liquids before swallowing what was already in her mouth. Staff K, SLP recommended the resident have supervision during her meals due to the resident's dementia and safe swallowing reminders might not be retained be the resident. Staff K, SLP stated she wanted nursing staff present in the room during meals to ensure the resident was safe during her meals, which was the level of supervision the resident had at her previous facility. Staff K, SLP stated she would expect nursing staff to put interventions in the care plan and communicate any recommendations she provides so all other nursing staff were aware. Staff K, SLP informed Resident #2's physician of the recommendations, who signs and approves the resident's orders. A review of Resident #2's SLP Evaluation & Plan of Treatment, initiated [DATE], revealed under Plan of Treatment, treatment approaches may include treatment of swallowing dysfunction and/or oral function for feeding and evaluation of oral and pharyngeal swallow function. The Evaluation & Plan of Treatment revealed the following under Initial Assessment/Current Level of Functioning & Underlying Impairments: (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Patient was admitted to the facility on regular/thin liquids diet from the hospital, however, nursing downgraded and referred to Speech Therapy due to patient complaints of difficulty masticating. Per daughter, patient was previously receiving mechanical soft/thin diet at her previous facility. Patient presents for a BSE (Bedside Swallowing Evaluation) to assess current swallow function. The Evaluation & Plan of Treatment revealed under Objective Tests/Measures & Additional Analysis, Resident #2 displayed behaviors impacting safety of decreased safety awareness and poor self-monitoring skills. The section titled Recommendations revealed recommendations for close supervision of oral intake. The Evaluation & Plan of Treatment was signed by the resident's physician on [DATE]. An interview was conducted on ,d+[DATE] at 11:53 a.m. with Staff G, LPN. Staff G, LPN stated on [DATE], she was working on the first floor of the facility when she heard a Code Blue on the overhead speaker. Staff G, LPN responded to Resident #2's room, which was on a different floor, and witnessed about four people already in the resident's room assessing the resident. Staff G, LPN stated Resident #2 appeared sitting upright in bed, was unresponsive, and appeared to be losing color. She was asked by Staff E, LPN for assistance in providing the Heimlich maneuver to Resident #2, so Staff G, LPN got onto the bed and behind the resident to perform the Heimlich maneuver. Staff G, LPN stated she put her hands in front of Resident #2's upper abdominal region and performed thrusts in an upward position. After a few thrusts, Resident #2 had an episode of vomiting, which the staff member described as watery and without solids. Staff G, LPN stated they performed the Heimlich maneuver on the resident because they suspected the resident may have had something in their airway and the resident's oxygen level was dropping. Staff G, LPN stated once she became fatigued, another staff member, who she was unable to state the name of, performed the Heimlich maneuver on the resident with no results. Staff G, LPN stated EMS arrived shortly after and stated, we kind of got out of the way. Staff G, LPN stated she returned to her floor after EMS arrived. An interview was conducted on [DATE] at 12:21 p.m. with Staff A, LPN, who was Resident #2's assigned nurse on [DATE]. Staff A, LPN stated when Resident #2 was first admitted to the facility, she was on a regular diet. After speaking with Resident #2's daughter, she found out the resident was previously receiving a mechanical soft diet and changed the resident's diet order. Staff A, LPN stated on [DATE], she was passing medications and went into Resident #2's room to administer medications to Resident #6. Resident #6 informed her to check on Resident #2 because she saw the resident eating and point to her mouth as if she could not breathe. Staff A, LPN stated Resident #2 appeared unresponsive with food all over her chest. Staff A, LPN put a pulse oximeter on Resident #2's finger and did not get a pulse reading, so she ran to call a Code Blue and retrieve the emergency cart. Staff A, LPN stated when she returned to the resident's room, a CNA was already doing CPR on the resident. Staff A, LPN retrieved a bag valve mask and applied it to Resident #2 while attempting to maintain the resident's airway. Staff A, LPN stated other nursing staff responded to the room and they eventually discovered a pulse using the pulse oximeter. Once they determined the resident had a pulse, they stopped CPR and began to perform the Heimlich maneuver on Resident #2 until EMS personnel arrived at the room. Staff A, LPN stated Resident #2 had an episode of emesis during the Heimlich maneuver, which was of a watery consistency. EMS personnel checked for the resident's pulse and the resident was still unresponsive, so they laid the resident back onto the bed and began CPR. Staff A, LPN stated EMS took Resident #2 to the hospital. The staff member stated Resident #2 fed herself and no staff assisted the resident since her admission. Staff A, LPN stated she did not look at Resident #2's care plan to determine if the resident required assistance and was told in the shift report the resident did not require assistance with dining. Staff A, LPN stated you just know, because this resident was an independent eater and had never needed help before. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled Care Plan - Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, revealed under the section titled Policy, the facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facticity shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. An interview was conducted on [DATE] at 10:08 a.m. with Staff L, LPN and Clinical Reimbursement Specialist (CRS) and Staff M, Clinical Reimbursement Consultant (CRC). Staff L, LPN CRS stated resident care plans are developed using physician orders, hospital documentation, and interviews with the resident and/or the resident's family members, and would include anything needed to provide care to the resident. Staff L, LPN CRS stated everybody has access to the resident's care plan and can see the interventions in the care plans. Staff M, CRC stated staff should be following resident care plans if the care plan shows a resident was dependent on dining with an assist of one staff member. An assist of one staff member means the staff member would be physically assisting the resident with eating. Staff M, CRC stated interventions from the care plan are pulled over into the CNA charting system, which can be viewed by the CNA staff providing care to the resident. An interview was conducted on [DATE] at 12:17 p.m. with the facility's Medical Director (MD), who was Resident #2's primary care provider. The MD stated Resident #2 was initially admitted to the facility for a fractured hip and was receiving physical and occupational therapy. The resident had dementia, diabetes, mild congestive heart failure, and pulmonary hypertension, among other comorbidities. The MD stated the resident was not able to get out of the bed safely due to the hip fracture, so the resident had all of her meals in the bed and the MD, would guess she would need assistance with all of them. The MD stated he was aware the resident had a previous cerebral vascular accident (CVA), but did not think she had a problem with her swallowing because the CVA was not a recent issue. The MD stated he was not aware the resident required supervision with her meals and would think the resident was a self-feeder. The MD stated his knowledge of the event on [DATE] came from the NHA, who told him the resident was found unresponsive in bed and required CPR and use of the Heimlich maneuver before being transported to the hospital. He said he did not review any of the resident's hospital documentation but there was concern the resident could have aspirated. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:35 p.m. with Resident #2's daughter and emergency contact (EC). The EC stated in 2021, Resident #2 suffered a massive stroke and required nursing home care due to the resident's inability to care for herself. After suffering a fall with hip fracture at a previous facility, she decided to place the resident at this facility. The EC stated when at the previous facility, Resident #2 was provided a mechanical soft diet and needed supervision during meals because the resident could not feel food on the left side of her mouth and would pocket food. The EC observed Resident #2's meal tray left in the resident's room on several occasions and never observed staff assisting the resident or providing supervision to the resident during meals, even after informing the facility of the resident's needs several times. The EC stated when Resident #2 would attempt to feed herself, she would get food all over her and was not aware of how much food she was putting in her mouth. The EC was at work when she received a call from the facility informing her Resident #2 was unresponsive. When the EC asked the facility staff if the resident choked, they told her she was unresponsive and they were assessing the situation. The facility called the EC back appropriately five minutes later and was informed EMS personnel were taking Resident #2 to the hospital. During the phone call, the EC asked facility staff if Resident #2 choked on her food and the facility staff responded, I believe so. The EC stated Resident #2 passed away later that night on [DATE]. The facility's immediate actions to remove the Immediate Jeopardy included: - On [DATE], Resident #2 discharged to the hospital and has not returned to the facility. - An audit was completed on [DATE] of care plans for current residents, totaling 115, related to necessary dietary interventions to ensure that residents requiring assistance receive appropriate care during mealtimes as per the resident care plan and [CNA documentation system]. The audits for meal tray accuracy and appropriate level of assistance were initiated [DATE] and is currently ongoing. There are currently 50 audits at this time. The tray line audit reviewing adequate consistency and items matching meal tickets was initiated on [DATE] and is ongoing, there are currently 118 audits at this time. - The DON and NHA received directed education by the Regional Nurse Consultant on [DATE] on ensuring that resident care plans are implemented during meal times and ensuring that staff have knowledge of the resident care plan/[CNA documentation system] interventions. - A total of 90 out of 90 Licensed nursing staff and Certified Nursing Assistants were provided education by the DON or designee on ensuring that resident care plans are implemented during meal times and ensuring that staff have knowledge of the resident care plan/[CNA documentation system] interventions. This education was 100% completed on [DATE]. - An ad hoc Quality Assurance Meeting was held with the MD regarding removal plan activities. This meeting was held on [DATE]. Verification of the facility's removal actions was conducted by the survey team on [DATE]. Review of facility education was conducted. Staff roster provided by NHA and DON. All facility Licensed nursing staff and Certified Nursing Assistants were educated on ensuring that resident care plans are implemented during meal times and ensuring that staff have knowledge of the resident care plan/CNA documentation system interventions, completed on [DATE]. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Four additional resident records reviewed to verify care plan interventions related to assisted dining. All resident records reviewed revealed care plan interventions related to assisted dining and need for assistance. Observations were conducted [DATE] at 11:30 a.m. and on [DATE] at 5:00 p.m. of the facility's meal service process. Nursing staff were observed verifying meal tickets with the resident tray before handing the tray to CNA staff to provide to residents, who verified the meal tickets match the resident tray. Nursing staff observed holding resident meal trays with NURSING on the meal ticket, indicating the resident requires assistance with the meal. Nursing staff observed assisting residents with meals as required. Staff were observed providing direct supervision during meals held in facility dining rooms. Interviews were conducted with 37 facility nursing staff members, including 4 Registered Nurses, 8 LPNs, and 25 CNAs. The staff members were able to state that they had been trained and were knowledgeable about the subject matter regarding implementation of resident care plans and care plan/CNA documentation system interventions. Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 40775 Based on observations, interviews with the nursing staff, Nursing Home Administrator, the Director of Nursing, the resident's primary care physician, and review of the resident's medical record and facility policies, the facility failed to ensure one resident (#2) of three residents dependent upon staff to feed at meal times, was provided supervision and services related to the resident's difficulty swallowing and history of cerebral infarction and dementia. The facility staff failed to ensure the safety of Resident #2; on [DATE] at approximately 5:15 p.m., Resident #2 was provided a covered food tray in the resident's room by facility staff. Resident #2 consumed a portion of her dinner meal unsupervised and without assistance. The facility failed to take action to prevent the resident from choking by not providing supervision during the resident's meal and not checking the resident's plan of care prior to providing the meal to the resident. At approximately 5:38 p.m., Staff A, Licensed Practical Nurse discovered Resident #2 unresponsive after being alerted by Resident #2's roommate. Resident #2 required use of the Heimlich maneuver and cardiopulmonary resuscitation (CPR) by facility staff and Emergency Medical Services (EMS) staff due to suspected choking and being found without a pulse or respirations. Resident #2 was transported to the hospital where she expired. The failure created a situation that resulted in Resident #2's death and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D. Findings included: A review of Resident #2's Change in Condition Situation, Background, Assessment, and Recommendation (SBAR) Communication Form dated [DATE] and authored by Staff A, Licensed Practical Nurse (LPN), revealed under the section titled Mental Status Evaluation (compared to baseline; check all changes that you observe), Unresponsiveness, was checked. Under the section titled Functional Status Evaluation (compared to baseline; check all changes that you observe), Other (describe) was checked with a description symptom or sign of aspirated documented. The form revealed the following under Appearance: Writer was across the hall at [room number] providing medication. Writer turned to go to [Resident #2's room], [Resident #2's roommate] said to writer that, you need to look at [Resident #2]. Writer assessed resident, resident was unresponsive, writer called a code blue and grabbed the crash cart. Other nurses arrived and we began CPR, because the resident was eating dinner before going unconscious, we then began the Heimlich maneuver. The [Emergency Medical Services personnel] arrived and took over. According to the Mayo Clinic, choking occurs when a foreign object lodges in the throat or windpipe, blocking the flow of air. In adults, a piece of food often is the culprit. Because choking cuts off oxygen to the brain, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	give first aid as quickly as possible. The universal sign for choking is hands clutched to the throat. If the person does not give the signal, look for these indications: - Inability to talk - Difficulty breathing or noisy breathing - Squeaky sounds when trying to breathe - Cough, which may either be weak or forceful - Skin, lips, and nails turning blue or dusky - Skin that is flushed, then turns pale or bluish in color - Loss of consciousness https://www.mayoclinic.org/first-aid/first-aid-choking/basics/art- 637#:~:text=To%20perform%20abdominal%20thrusts%20([MEDICATION(S)]%20maneuver)%20on%20yourself%2C%20place, do%20in%20a%20choking%20emergency. A review of Resident #2's medical record Resident #2 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; muscle weakness; and dysphagia, oropharyngeal phase. A review of Resident #2's preadmission Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form, with a Physician Certification date of [DATE] revealed under Section C: Decision Making Capacity (Patient) Resident #2 required a surrogate for medical decision making. The transfer form revealed under Section U: Nutrition/Hydration, Resident #2 required assistance with eating. Section U: Mental/Cognitive Status at Transfer revealed Resident #2 was alert and disoriented but could follow simple instructions. A review of Resident #2's Admission/Readmission Data Collection assessment dated [DATE] revealed under section C: Body System Review, Resident #2 had no natural teeth or dentures and was on a mechanically altered diet. The assessment revealed under section D: Mobility/ADL/ROM (Activities of Daily Living/Range of Motion), Resident #2 was dependent on staff with eating. Resident #2's care plan was updated with a Focus: (Resident #2) has an ADL Self Care Performance Deficit. Interventions included assist of one staff with eating and dependent upon staff to feed. A review of the facility policy titled Admission/Readmission Data Collection, effective [DATE] revealed the Resident's Admission/Readmission Data Collection will provide a comprehensive description of the Resident's status on admission. The assessment is designed to identify past history, current findings, and factors that may put the Resident at risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's [DATE] Order Summary Report revealed the following orders: - Renal diet mechanical soft/soft and bite-sized texture, regular (thin) consistency. Dated [DATE]. - Full resuscitation. Dated [DATE]. - Speech Therapy Clarification resident to be seen 5 times per week for 6 weeks for focus on dysphagia management, resident/caregiver education, discharge planning with group treatment when appropriate/and do planning. Dated [DATE]. - Renal diet, regular texture, regular (thin) consistency. Dated [DATE] and discontinued on [DATE]. A review of Resident #2's care plan revealed a Focus area of the resident has an ADL self-care performance deficit. Interventions included an assist of 1 for eating and dependent upon staff to feed. Resident #2's care plan revealed a Focus are of the resident has impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included to provide orientation and validation, and cue, reorient, and supervise as needed. A review of Resident #2's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed under Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The assessment revealed under Section GG - Functional Abilities, Resident #2 required substantial/maximal assistance (helper does more than half the effort) with eating. The assessment revealed under Section K - Swallowing/Nutritional Status, Resident #2 had coughing or choking during meals or when swallowing medications and had a mechanically altered diet on admission and while a resident in the facility. An interview was conducted on [DATE] at 1:14 p.m. with Resident #6, former roommate of Resident #2. Resident #6 stated she was Resident #2's roommate during the duration of her stay at the facility and would regularly see the resident's daughter coming in to feed the resident, but never witnessed facility staff assisting the resident with her meals. Resident #6 stated on [DATE] during the dinner meal, she witnessed Resident #2 feeding herself and the resident, was eating as fast as she could get it in there. Resident #6 noticed Resident #2 had food coming out of her mouth and was no longer swallowing food, which is when she notified the nurse who was across the hallway Resident #2 needed help. Resident #6 stated the nurse entered the room to check on Resident #2 and ran down the hallway. Resident #6 stated she heard code blue followed by their room number on the overhead speaker and the entire room filled up with people. Resident #6 stated the following day she was informed by Resident #2's daughter the resident passed away. A review of Resident #6's MDS assessment with an ARD of [DATE] revealed under Section C - Cognitive Patterns, a BIMS score of 15, which indicated the resident was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility policy titled CPR Code Status Orders & Response, last revised in February 2023 revealed under the section titled Procedure for Initiating CPR, upon identification that a resident is unresponsive, the person making the identification will check for pulse and respirations, and immediately call for help; loudly calling Code Blue Room (#). Staff will respond to room with medical record and emergency cart. Code Status and resident will be verified by 2 identifiers such as [electronic health record] photo, armband, with another nursing care center personnel if resident is a full code CPR will be initiated. An interview was conducted on [DATE] at 3:11 p.m. with the facility's Nursing Home Administrator (NHA), Director of Nursing (DON), and Regional [NAME] President of Operations (VPO). The NHA stated on [DATE], an allegation of neglect was reported to her by Resident #2's daughter when she came to the facility to gather Resident #2's belongings. The NHA stated she was told by Resident #2's daughter, I know she choked on her food and that's why she was sent to the emergency room , prompting them to initiate an investigation. The DON stated they conducted interviews with the staff involved during the incident and discovered staff performed CPR on Resident #2 as well as the Heimlich maneuver because there was concern the resident may have had something in their airway and there was vomit in the resident's mouth during the CPR. The NHA stated Resident #2 aspirated during the incident and was suctioned by staff. The DON stated facility developed the following timeline of events through interviews with staff: - On [DATE] around 3:00 p.m., Resident #2 was observed by facility staff in her room, with no signs of distress and at her baseline level. Resident #2's care was assigned to Staff A, LPN and Staff B, Certified Nursing Assistant (CNA). - On [DATE] around 5:15 p.m., Staff B, CNA and her hall partner Staff C, CNA passed meal trays in Resident #2's hall while Staff A, LPN performed blood glucose checks and medication administration for other residents in the hall. Resident #2 was provided a dinner tray in her room by Staff C, CNA, which was left on the bedside table in front of her after the resident stated she did not want it. After passing meal trays, Staff B, CNA, looked into Resident #2's room and saw her upright in bed and eating without difficulty. Staff B, CNA went to another resident's room to assist the resident with dining. - On [DATE] at 5:38 p.m., Staff A, LPN entered Resident #2's room to administer medications to Resident #6. Resident #6 told Staff A, LPN she needed to first check on Resident #2. Resident #2 was observed upright in the bed with her head to the side and unresponsive. At that time, Staff A, LPN ran from the room to call a Code Blue overhead and grabbed the emergency cart. Staff A, LPN verified Resident #2's code status as a Full Code and responded back to the room. Staff D, CNA responded to the resident's room and began life saving measures, including CPR, on Resident #2. Staff E, LPN, Staff F, LPN, and Staff G, LPN all responded to Resident #2's room and assisted in providing CPR. During the CPR, Resident #2 had an episode of vomiting and regained a pulse and respirations, verified by Staff E, LPN by palpation and by attaching a pulse oximeter to the resident's finger. Staff sat Resident #2 up in the bed and performed the Heimlich maneuver on the resident. No food or vomit came out of Resident #2's mouth during the performance of the Heimlich maneuver. During the event, at 5:43 p.m., a staff member called 911. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] at approximately 5:58 p.m., Emergency Medical Services (EMS) arrived. Resident #2 became unresponsive without a pulse or respirations shortly after arrival of EMS and CPR was initiated by EMS. Per interview with Staff H, LPN, who was near the facility entrance when EMS left with Resident #2, Resident #2 had a pulse on the monitor and was intubated by EMS when she was being taken out of the facility and to the hospital. The DON stated the next day on [DATE], all information relating to the incident was collected to ensure the Code Blue process was properly executed and all CPR certifications of the involved staff were verified. The DON stated Resident #2's dinner meal was verified and the resident received the appropriate diet, but not the food she was supposed to receive per her diet slip. Resident #2 received potato salad on her dinner tray instead of rice with thick gravy. The DON addressed Resident #2's care plan revealed she required assistance of one staff member with dining, but the care plan did not indicate the resident could not feed herself. The DON stated Resident #2 was evaluated by the Speech Language Pathologist (SLP), who determined the resident was able to feed herself, but would consume food too quickly at times. The DON addressed Resident #2's care plan did not include anything related to the resident consuming food too quickly and stated none of the staff interviewed spoke about the resident consuming food too fast. The DON stated upon investigation and interview with staff, they determined Staff C, CNA was the staff member who passed the meal tray to Resident #2 and did not check the resident's plan of care prior to passing the meal tray and was not told the resident required assistance. The DON stated they could not verify if Resident #2 choked on her food during the meal due to documentation stating the resident had aspirate, which could have been from the CPR performed on the resident. The NHA stated after the facility investigation the concern, they substantiated the allegation of neglect due to Resident #2 receiving the wrong food on her meal tray and not being provided assistance with the meal per the plan of care. The DON stated the facility separated employment from Staff A, LPN, Staff B, CNA, Staff C, CNA, and Staff I, [NAME] following the incident. A review of an ambulance run report dated [DATE] revealed two EMS personnel (E2 and R1) were dispatched and responded to the facility after notification of Resident #2 being unresponsive. The run report included the following: E2 and R1 responded to a medical call. E2 was first on scene and found a 76 [year old] female in a nursing home in cardiac arrest. E2 began ACLS [Advanced Cardiac Life Support] procedures and CPR was initiated. E2 began CPR and ventilations per AHA [American Heart Association] guidelines. [Patient] was positioned in bed with [cervical] spine board to support CPR. Staff on scene state the [patient] appeared to be choking and they began the Heimlich maneuver. [Patient] became unresponsive and was laid supine as E2 walked into the room. E2 performed CPR and ventilations per AHA until R1 arrived . No pulse asystole. R1 arrived and assisted E2 in establishing ALS [Advanced Life Support] interventions. A suction was provided and utilized to removed emesis and food from the patients airway. A pulse check rhythm check was performed again after 2 minutes with no pulse, [patient] in asystole. CPR and ventilations were resumed per AHA throughout the duration of the call with a pulse check rhythm check every 2 minutes . Around 10 cycles of CPR were performed throughout the duration of the arrest. After the current cycle finished, a pulse check was performed, pulse present with sinus rhythm. ROSC [Return of Spontaneous Circulation] procedures were initiated. [Patient] was prepped for transport and transferred to the stretcher and secured. [Patient] placed into the rescue and emergency transport to [local hospital] started. [Patient] interventions were reassessed and intact. Pulse still present. A blood pressure was obtained and recorded. Pulse check performed on arrival of ER [emergency room], pulse present . (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The section of the run report titled Specialty Patient - CPR revealed the following: Cardiac Arrest Etiology: Respiratory/Asphyxia Estimated time of arrest: ,d+[DATE] Minutes The run report revealed the following Incident Times: Call received: 17:41 (5:41 p.m.) En Route: 17:44 (5:44 p.m.) On scene: 17:50 (5:50 p.m.) Depart scene: 18:18 (6:16 p.m.) At destination: 18:26 (6:26 p.m.) A review of Resident #2's Emergency Department Documents dated [DATE] revealed EMS reported Resident #2 was found unresponsive in her room with vomiting and fluid all over. Upon EMS arrival, Resident #2 was pulseless and in PEA (Pulseless Electrical Activity) cardiac arrest. On arrival to the ER, initial evaluation and pulse check demonstrated recurrent cardiopulmonary arrest. Resident #2 had a significant amount of oropharyngeal and aspiration output after ET (endotracheal) tube placement. The section of the documents titled Medical Decision Making revealed Resident #2 had no signs of significant neurofunction and had prolonged oxygen deprivation due to either prolonged downtime or severe aspiration. The section of the documents titled Assessment/Plan revealed Resident #2 had diagnoses of cardiopulmonary arrest and aspiration into airway (unspecified foreign body in respiratory tract, part unspecified causing other injury, initial encounter). A telephone interview was attempted on [DATE] at 9:48 a.m. with Staff D, CNA, who performed CPR on Resident #2 when she was found unresponsive on [DATE]. Staff D, CNA did not answer the phone call and a message was left for call back. The phone call was not returned by Staff D, CNA. A telephone interview was attempted on [DATE] at 10:10 a.m. with Staff C, CNA, who provided Resident #2's dinner meal tray on [DATE]. Staff C, CNA did not answer the phone call and a message was left for call back. The phone call was not returned by Staff C, CNA. A telephone interview was attempted on [DATE] at 10:21 a.m. with Staff I, Cook, who prepared Resident #2's dinner meal tray on [DATE]. Staff I, [NAME] did not answer the phone call and a message was left for call back. The phone call was not returned by Staff I, Cook. A telephone interview was attempted on [DATE] at 10:28 a.m. with Staff J, Dietary Aide, who verified the contents of Resident #2's dinner meal tray on [DATE]. Staff J, Dietary Aide did not answer the phone call and a message was left for call back. The phone call was not returned by Staff J, Dietary Aide. (continued on next page)

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	105029	A. Building B. Wing	04/16/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A telephone interview was conducted on [DATE] at 10:45 a.m. with Staff B, CNA, who was Resident #2's assigned CNA on [DATE]. Staff B, CNA stated the dinner meal arrived on her floor around 5:15 p.m. while she was assisting another resident with a shower. Two other CNA's came to the floor to pass dinner meals to the residents, including Resident #2. Staff B, CNA stated after seeing Resident #2 was set up with her dinner meal, she went to another resident's room to assist the resident with eating. While feeding the other resident, the staff member heard a Code Blue over the facility's intercom system and ran to Resident #2's room. Staff B, CNA observed Resident #2 laid flat in the bed with food on her gown and around her mouth and other staff members began CPR on the resident. Staff B, CNA stated when she asked what happened with the resident, Staff A, LPN told her Resident #2 was choking on her food. Staff A, LPN called 911 from her cell phone and passed the phone to Staff B, CNA while she continued CPR on Resident #2. Staff B, CNA stated once EMS arrived at the facility, they continued CPR on the resident. Staff B, CNA stated Resident #2 usually fed herself at meal times and was not fed by the facility staff. Review of the facility policy titled Dining Program, effective [DATE], revealed under Policy, the nursing staff assists residents in need of assistance during mealtimes. An interview was conducted on [DATE] at 11:28 a.m. with Staff K, Speech Language Pathologist (SLP). Staff K, SLP stated when Resident #2 was admitted to the facility she was on a regular diet but did not have any teeth and did not wear dentures. Staff K, SLP verified from Resident #2's previous facility the resident received a mechanical soft diet. Staff K, SLP stated a trial was conducted, which determined a mechanical soft diet with bite size food was an appropriate diet for the resident. Staff K, SLP stated she educated Resident #2's direct care staff regarding providing set-up assistance for the resident, sitting the resident up 90 degrees in bed for meals prior to the resident eating, and monitoring the resident to ensure she was eating safely. Staff K, SLP stated she did not witness the resident choking or having difficulty swallowing during trials, but the resident would occasionally take consecutive sips of liquids before swallowing what was already in her mouth. Staff K, SLP recommended the resident have supervision during her meals due to the resident's dementia and safe swallowing reminders might not be retained be the resident. Staff K, SLP stated she wanted nursing staff present in the room during meals to ensure the resident was safe during her meals, which was the level of supervision the resident had at her previous facility. Staff K, SLP stated she would expect nursing staff to put interventions in the care plan and communicate any recommendations she provides so all other nursing staff were aware. Staff K, SLP informed Resident #2's physician of the recommendations, who signs and approves the resident's orders. A review of Resident #2's SLP Evaluation & Plan of Treatment, initiated [DATE], revealed under Plan of Treatment, treatment approaches may include treatment of swallowing dysfunction and/or oral function for feeding and evaluation of oral and pharyngeal swallow function. The Evaluation & Plan of Treatment revealed the following under Initial Assessment/Current Level of Functioning & Underlying Impairments: Patient was admitted to the facility on regular/thin liquids diet from the hospital, however, nursing downgraded and referred to Speech Therapy due to patient complaints of difficulty masticating. Per daughter, patient was previously receiving mechanical soft/thin diet at her previous facility. Patient presents for a BSE (Bedside Swallowing Evaluation) to assess current swallow function. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Evaluation & Plan of Treatment revealed under Objective Tests/Measures & Additional Analysis, Resident #2 displayed behaviors impacting safety of decreased safety awareness and poor self-monitoring skills. The section titled Recommendations revealed recommendations for close supervision of oral intake. The Evaluation & Plan of Treatment was signed by the resident's physician on [DATE]. An interview was conducted on ,d+[DATE] at 11:53 a.m. with Staff G, LPN. Staff G, LPN stated on [DATE], she was working on the first floor of the facility when she heard a Code Blue on the overhead speaker. Staff G, LPN responded to Resident #2's room, which was on a different floor, and witnessed about four people already in the resident's room assessing the resident. Staff G, LPN stated Resident #2 appeared sitting upright in bed, was unresponsive, and appeared to be losing color. She was asked by Staff E, LPN for assistance in providing the Heimlich maneuver to Resident #2, so Staff G, LPN got onto the bed and behind the resident to perform the Heimlich maneuver. Staff G, LPN stated she put her hands in front of Resident #2's upper abdominal region and performed thrusts in an upward position. After a few thrusts, Resident #2 had an episode of vomiting, which the staff member described as watery and without solids. Staff G, LPN stated they performed the Heimlich maneuver on the resident because they suspected the resident may have had something in their airway and the resident's oxygen level was dropping. Staff G, LPN stated once she became fatigued, another staff member, who she was unable to state the name of, performed the Heimlich maneuver on the resident with no results. Staff G, LPN stated EMS arrived shortly after and stated, we kind of got out of the way. Staff G, LPN stated she returned to her floor after EMS arrived. According to the Cleveland Clinic, the Heimlich maneuver is a first-aid method for choking that you can use on adults and children. Another name for the Heimlich maneuver is abdominal thrusts, because it involves thrusting into the abdominal area. It is a quick and life-saving method, but you should only use it on conscious people who can not breathe on their own. https://my.clevelandclinic.org/health/treatments/21675-heimlich-maneuver (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:21 p.m. with Staff A, LPN, who was Resident #2's assigned nurse on [DATE]. Staff A, LPN stated when Resident #2 was first admitted to the facility, she was on a regular diet. After speaking with Resident #2's daughter, she found out the resident was previously receiving a mechanical soft diet and changed the resident's diet order. Staff A, LPN stated on [DATE], she was passing medications and went into Resident #2's room to administer medications to Resident #6. Resident #6 informed her to check on Resident #2 because she saw the resident eating and point to her mouth as if she could not breathe. Staff A, LPN stated Resident #2 appeared unresponsive with food all over her chest. Staff A, LPN put a pulse oximeter on Resident #2's finger and did not get a pulse reading, so she ran to call a Code Blue and retrieve the emergency cart. Staff A, LPN stated when she returned to the resident's room, a CNA was already doing CPR on the resident. Staff A, LPN retrieved a bag valve mask and applied it to Resident #2 while attempting to maintain the resident's airway. Staff A, LPN stated other nursing staff responded to the room and they eventually discovered a pulse using the pulse oximeter. Once they determined the resident had a pulse, they stopped CPR and began to perform the Heimlich maneuver on Resident #2 until EMS personnel arrived at the room. Staff A, LPN stated Resident #2 had an episode of emesis during the Heimlich maneuver, which was of a watery consistency. EMS personnel checked for the resident's pulse and the resident was still unresponsive, so they laid the resident back onto the bed and began CPR. Staff A, LPN stated EMS took Resident #2 to the hospital. The staff member stated Resident #2 fed herself and no staff assisted the resident since her admission. Staff A, LPN stated she did not look at Resident #2's care plan to determine if the resident required assistance and was told in the shift report the resident did not require assistance with dining. Staff A, LPN stated you just know, because this resident was an independent eater and had never needed help before. An interview was conducted on [DATE] at 10:08 a.m. with Staff L, LPN and Clinical Reimbursement Specialist (CRS) and Staff M, Clinical Reimbursement Consultant (CRC). Staff L, LPN CRS stated resident care plans are developed using physician orders, hospital documentation, and interviews with the resident and/or the resident's family members, and would include anything needed to provide care to the resident. Staff L, LPN CRS stated everybody has access to the resident's care plan and can see the interventions in the care plans. Staff M, CRC stated staff should be following resident care plans if the care plan shows a resident was dependent on dining with an assist of one staff member. An assist of one staff member means the staff member would be physically assisting the resident with eating. Staff M, CRC stated interventions from the care plan are pulled over into the CNA charting system, which can be viewed by the CNA staff providing care to the resident. An interview was conducted on [DATE] at 12:17 p.m. with the facility's Medical Director (MD), who was Resident #2's primary care provider. The MD stated Resident #2 was initially admitted to the facility for a fractured hip and was receiving physical and occupational therapy. The resident had dementia, diabetes, mild congestive heart failure, and pulmonary hypertension, among other comorbidities. The MD stated the resident was not able to get out of the bed safely due to the hip fracture, so the resident had all of her meals in the bed and the MD, would guess she would need assistance with all of them. The MD stated he was aware the resident had a previous cerebral vascular accident (CVA), but did not think she had a problem with her swallowing because the CVA was not a recent issue. The MD stated he was not aware the resident required supervision with her meals and would think the resident was a self-feeder. The MD stated his knowledge of the event on [DATE] came from the NHA, who told him the resident was found unresponsive in bed and required CPR and use of the Heimlich maneuver before being transported to the hospital. He said he did not review any of the resident's hospital documentation but there was concern the resident could have aspirated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 12:35 p.m. with Resident #2's daughter and emergency contact (EC). The EC stated in 2021, Resident #2 suffered a massive stroke and required nursing home care due to the resident's inability to care for herself. After suffering a fall with hip fracture at a previous facility, she decided to place the resident at this facility. The EC stated when at the previous facility, Resident #2 was provided a mechanical soft diet and needed supervision during meals because the resident could not feel food on the left side of her mouth and would pocket food. The EC observed Resident #2's meal tray left in the resident's room on several occasions and never observed staff assisting the resident or providing supervision to the resident during meals, even after informing the facility of the resident's needs several times. The EC stated when Resident #2 would attempt to feed herself, she would get food all over her and was not aware of how much food she was putting in her mouth. The EC was at work when she received a call from the facility informing her Resident #2 was unresponsive. When the EC asked the facility staff if the resident choked, they told her she was unresponsive and they were assessing the situation. The facility called the EC back appropriately five minutes later and was informed EMS personnel were taking Resident #2 to the hospital. During the phone call, the EC asked facility staff if Resident #2 choked on her food and the facility staff responded, I believe so. The EC stated Resident #2 passed away later that night on [DATE]. The facility's immediate actions to remove the Immediate Jeopardy included: - On [DATE], Resident #2 discharged to the hospital and has not returned to the facility. - The facility incorporated an additional notification on resident meal tickets through the meal tracker system to ensure facility staff are aware of the care and services needed by residents to include supervision and/or assistance during mealtimes in order to prevent further instances of neglect. The addition of this tray ticket notification indicator was complete on [DATE]. - The DON and NHA received directed education by the Regional Nurse Consultant on [DATE] regarding ensuring proper resident supervision and/or assistance during meals is occurring. - A total of 104 out of 104 nursing and therapy staff were provided education by the DON or designee on ensuring proper resident supervision and/or assistance during meals. Education regarding the added notification on resident meal tickets was provided including the meaning of the indicator and what to do when they see it. This education was 100% completed on [DATE]. - An ad hoc Quality Assurance Meeting was held with the MD regarding removal plan activities. This meeting was held on [DATE][TRUNCATED]