

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Aspire at Colonial Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 15204 W Colonial Dr Winter Garden, FL 34787	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm 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** 49840 Based on interview, and record review, the facility failed to develop a comprehensive, person-centered care plan with measurable goals and interventions for a vulnerable resident with behaviors that posed a risk to their safety, (#1). Findings: Resident #1 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included Parkinson's disease, unspecified psychosis, need for assistance with personal care, dysphagia oropharyngeal phase, history of stroke, and unspecified dementia. Dysphagia oropharyngeal phase is a term to describe swallowing problems that occur in the mouth or throat, usually from impaired muscle function or sensory changes, (retrieved on 1/27/25 from www.uclahealth.org). Resident #1's Quarterly Minimum Data Set (MDS) assessment with reference date 9/30/24 revealed she had a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognitive impairment. She had no upper or lower extremity limitations, was independent for eating, and required set up or clean-up assistance for other Activities of Daily Living (ADLs). The assessment noted resident #1 required a mechanically altered diet due to her dysphagia diagnosis. A modified Quarterly MDS was completed on 12/27/24, post readmission from an acute care hospital which indicated she now required setup assistance for eating, had new behavior of rejecting care, and had difficulty swallowing due to coughing or choking during meals. The assessment noted resident #1 continued to require a mechanically altered diet. Review of resident #1's medical record revealed her diet orders were changed from a regular texture to a dysphagia mechanical soft texture on 8/29/23 which was continued until 12/25/24 after the choking incident. After 12/25/24 when resident #1 returned from the hospital her diet was changed to dysphagia with pureed texture. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 1:56 PM, the facility's Reportable and Adverse incident log from December 2024 was reviewed with the Risk Manager. She said that on 12/20/24 at around 11:00 AM, Certified Nursing Assistant (CNA) A alerted staff that resident #1, who at the time was in the day room of the memory care unit, was choking on a snack that had been provided to her. The Risk Manager continued to explain, the Heimlich maneuver was performed, and the resident was suctioned and subsequently transferred via Emergency Medical Service (EMS) to the hospital and admitted to the Intensive Care Unit (ICU) for acute respiratory failure with hypoxia. She recounted the facility's investigation of the event revealed that on 12/20/24 at around 10:50 AM, CNA A entered the memory care unit with a tray of snacks that included peanut butter and jelly (PB&J) sandwiches and placed the tray on a table across from resident #1. Resident #1 was not prevented from grabbing a sandwich by CNA A because she said that although the resident required a mechanical soft diet she had previously seen her eating bread and assumed the PB&J sandwich was okay. On 1/14/25 at 9:24 AM, in a telephone interview CNA A corroborated the Risk Manager's statements of the incident that involved resident #1 on 12/20/24. She recalled she had worked with resident #1 regularly and knew her well. CNA A explained that resident #1 had behaviors where she grabbed food from other resident's plates and staff tried to keep her safe by doing things like sitting her at a table by herself and ensuring the snack tray was not left unattended. She stated the snack trays were delivered to the nourishment room outside the secure memory care unit to prevent residents from grabbing food not prescribed for their diet. CNA A said she had never observed resident #1 grabbing food from the tray or from other residents during her shift, but other CNAs had previously reported the behavior to her. On 1/14/25 at 9:35 AM, Licensed Practical Nurse (LPN) C confirmed that on 12/20/24 she responded to the choking incident with resident #1 and assisted with first aid including the Heimlich maneuver. She recounted that she worked with resident #1 before and had observed her grabbing food from other residents during mealtimes. She stated resident #1 loved to eat and often ate very fast. On 1/14/25 at 9:40 AM, the Certified Dietary Manager (CDM) confirmed resident #1 was on a mechanical soft diet and did not have prescribed snacks but was offered a snack daily. He said he was aware resident #1 had behaviors of grabbing food from trays and from other residents. He confirmed dietary aids delivered the snack trays to the nourishment rooms. Review of resident #1's medical record revealed she had a care plan with revision date of 11/20/24 for potential nutritional problem related to need for mechanically altered diet, texture and past medical history of stroke, dysphagia, and history of significant weight gain. The interventions included monitor/document/report as needed any signs or symptoms of dysphagia. Review of the care plan revealed goals and interventions did not address the resident's known behaviors to ensure the resident's safety during meals. On 1/02/25, two weeks after the choking incident and nine days after readmission from the hospital, the Registered Dietician (RD) added to the care plan that resident #1 attempted to eat foods not on her prescribed food consistency. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 from 12:43 PM to 3:21 PM, interviews were conducted with CNAs E, F, G, H, I, J and K who had worked with resident #1 previously or had knowledge of her behaviors. The CNAs confirmed that resident #1 was known to grab food from others. CNA E said that resident #1 needed feeding assistance and monitoring during meals because she ate so fast and could choke. She said she avoided giving resident #1 snacks and sat her at a table by herself to ensure she would not grab foods from others. The six other CNAs corroborated the behaviors saying that prior to the choking incident they had observed resident #1 grabbing food from other residents and on one occasion a CNA attempted to remove food from her mouth to prevent her from choking. On 1/16/25 at 12:42 PM, the MDS Coordinator stated she was one of two staff members responsible for resident care plans and attended care plan meetings with residents and representatives. She explained the whole clinical team was responsible for developing and revising care plans. The MDS Coordinator said that in general, the care plan was updated when there were changes in the resident's condition, behavior, or preferences. She said she attended clinical meetings every morning with the administrative team and clinical staff where they reviewed resident changes such as falls, behaviors, and orders. The MDS Coordinator reported that if the resident developed any behaviors that were constant or posed risk to their safety, staff were responsible for reporting the behavior to a supervisor so that a care plan could be developed and implemented. She explained that the Social Service Department was responsible for developing care plans for a resident's behavior. The MDS Coordinator confirmed resident #1 had behaviors but said that none were related to grabbing food and did not recall speaking about these behaviors during clinical meetings with the resident's son. On 1/16/25 at 1:10 PM, in a joint interview with the Unit Manager (UM) for the memory care unit and the Director of Nursing (DON), the UM stated she was not aware that resident #1 had behaviors of grabbing food from others. She said she frequently observed staff in the dayroom to ensure that residents were properly monitored during meals but had not noticed any behaviors during mealtime. The UM explained she attended clinical meetings, and the choking incident had been discussed. She stated she expected staff to report any changes in resident behavior to their immediate supervisor. The DON reported she first learned about resident #1's behavior of grabbing food after the choking incident. She said they had discussed the choking incident during clinical meetings, but her behaviors had not been mentioned at that time. The DON confirmed the Social Service Department was responsible for behavioral care plans and her expectation was for staff to report any changes in behaviors to their immediate supervisor to ensure care plans were updated accordingly. On 1/16/25 at 1:51 PM, the Social Services Assistant confirmed she was responsible for creating the behavioral care plans and reported she attended the daily clinical meetings. She did not recall discussing resident #1 having unsafe behaviors during meals. Review of the facility's Policies and Procedures revised 9/25/17 revealed an individualized person-centered plan of care would be established by the interdisciplinary team (IDT) with the resident and/or representative and updated in accordance with state and federal regulatory requirements. The policy detailed that the care plan must be reviewed, updated and/or revised based on changing goals, preferences, and needs of the resident and in response to current interventions as needed. The document indicated that the IDT should ensure the plan of care addressed any resident needs and that the plan was oriented towards attaining or maintaining the highest practicable physical, mental, and psychosocial wellbeing.		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to ensure prescribed therapeutic diet of dysphagia mechanical soft consistency was followed for 1 of 8 sampled residents, (#1). This failure resulted in resident #1 consuming the wrong consistency snack, causing her to choke, and turn blue until she was transferred and admitted to the hospital Intensive Care Unit (ICU) and treated for acute respiratory failure with hypoxia. On 12/20/24 at 11:00 AM, resident #1, who was on a mechanical soft consistency diet, was allowed to consume a peanut butter and jelly (PB&J) sandwich from a tray of snacks left on a table in the dayroom by Certified Nursing Assistant (CNA) A. The CNA was aware resident #1 was on a mechanical soft diet but allowed the resident to eat the sandwich because she had seen her eat bread in the past. The CNA recalled she was called back into the dayroom by CNA B who told her resident #1 did not look good. She said resident #1 was sitting up in a chair with her mouth open and tongue sticking out. Licensed Practical Nurse (LPN) C and LPN D immediately responded, and LPN C attempted to administer the Heimlich maneuver but the resident was unresponsive. The resident was lowered to the floor and suctioned with some food removed from her airway. The resident remained unconscious with a pulse when the paramedics arrived and removed food from the back of the resident's airway. The resident was transported to the hospital and admitted to the Intensive Care Unit with admitting diagnoses of acute respiratory failure with hypoxia. The facility's failure to follow the prescribed therapeutic diet resulted in substandard quality of care at the Immediate Jeopardy level, starting on 12/20/24. The facility implemented actions to remove the immediacy as of 1/14/25. Findings: Cross reference F726 Resident #1 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included Parkinson's disease, unspecified psychosis, dysphagia oropharyngeal phase, history of cerebral infarction (stroke), unspecified dementia, generalized anxiety disorder, and major depressive disorder. Review of resident #1's physician orders for December 2024 revealed an order for a dysphagia mechanical soft texture diet since 8/29/23. Resident #1's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she had a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognitive impairment. The assessment indicated resident #1 had no upper or lower extremity limitations, was independent for eating, and required set up or clean-up assistance for other Activities of Daily Living (ADLs). The assessment did not document any symptoms of a swallowing disorder but showed she was on a mechanically altered diet which required a change in food texture or liquids. (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dysphagia is defined as difficulty swallowing that could, in some cases, make it almost impossible to swallow. Oropharyngeal phase dysphagia can be caused by neurological conditions such as Parkinson's disease. Not being able to swallow correctly can lead to complications such as aspiration pneumonia due to food entering the lungs and choking due to food getting stuck in the throat. When food gets stuck in the throat it can block the airway and lead to death if not attended to promptly (retrieved on 01/21/25 from the mayoclinic.org). The National Foundation of Swallowing Disorders, following the recommendations of The American Dietetic Association, described dysphagia mechanical soft texture diet included foods such as pureed breads but advised all other bread textures should be avoided. The recommendations included other foods to be avoided included sandwiches and peanut butter, (retrieved on 1/23/25 from swallowingdisorderfoundation.com). A progress note written by the Director of Nursing (DON) on 12/20/24 at 11:28 AM, revealed that at 11:10 AM, a hospice CNA and floor CNA were in the dining room of the memory care unit passing snacks. The floor CNA was called to assist on the floor and within seconds the hospice CNA alerted the floor CNA that the resident didn't look like she felt well. The note described the floor CNA stated that the resident had her mouth open and tongue sticking out, so she called the nurse immediately. The DON documented the LPN started the Heimlich maneuver and soggy bread material came out, then she was laid on the floor on her side and suctioned. The APRN, Physician Assistant (PA), and another LPN also responded. She detailed the resident's oxygen saturation was 71% on room air so oxygen was applied, and the oxygen saturations came up to 92%. The DON detailed that Emergency Medical Service (EMS) arrived and used a laryngoscope (a small tool to look in your throat) to remove the remaining object from blocking the airway. Resident #1 was transferred to the hospital for possible aspiration and the family was notified. Normal oxygen saturation levels should be between 95% and 100% for most people. Oxygen is essential to all body functions so low oxygen levels are concerning and may lead to many serious conditions and damage to individual organ systems, especially your heart and brain. If your level is lower than 88% you should get emergency treatment, (retrieved on 1/27/25 from www.myclivelandclinic.org). Review of a nursing progress note revealed a change in condition note entered on 12/20/24 at 1:30 PM, that indicated resident #1 had respiratory arrest. The note revealed resident #1's vital signs at that time were, blood pressure 85/56, pulse 44, no respirations, oxygen saturation 71% on room air, and mental status was unresponsive. The LPN documented that she responded immediately and noticed the resident had something in her mouth and her face was discolored. She started the Heimlich maneuver and soggy bread material was expelled from her mouth, so they lowered her to the floor on her side and suctioned. EMS was called, oxygen was applied on the resident, and the APRN gave the order to transfer the resident to the hospital. At 2:34 PM, the LPN documented she spoke with the resident's son who said he was at the hospital with the resident. (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nursing progress note dated 12/24/24 at 11:02 PM, indicated resident #1 returned to the facility from the hospital with orders for a diet change. On 12/25/24 at 10:25 AM, the Respiratory Therapist (RT) assessed the resident and documented she was awaiting orders from the APRN. The Registered Dietician (RD) evaluated the resident on 12/26/24 and noted resident #1's diet order was changed to a regular diet with pureed texture and thin liquids. She also documented the resident required supervision with meals due to her history of attempting to take food from others. On 12/26/24 a change in condition note was documented by a nurse that the resident had abnormal lung sounds (rales, rhonchi, wheezing) and the doctor ordered a chest X-ray due to chest congestion. Review of a physician progress note dated 12/29/24, revealed resident #1 was evaluated for resumption of care after a hospitalization from [DATE] to 12/24/24 due to choking resulting in intubation (a tube in her throat to breath) as per hospital records with administration of multiple Intravenous antibiotics in the ICU setting. She returned to the facility on antibiotic therapy for five days. Review of resident #1's hospital records with admitted [DATE], revealed she was seen due to a choking incident where she was unresponsive. The admission summary indicated the resident choked on her meal and became unresponsive, so EMS were called. Upon arrival to the hospital emergency room (ER), she remained unresponsive, so they intubated her for hypoxic (low oxygen) respiratory failure and admitted her to the ICU. The discharge summary on 12/24/24 showed the discharge diagnosis of acute hypoxic respiratory failure and noted that speech and swallow tests had been done, and her diet was adjusted. On 1/13/25 at 1:56 PM, the DON stated she served as the facility's Risk Manager. She confirmed that on 12/20/24 around 11:00 AM, CNA A alerted staff that resident #1 was choking on a snack in the memory care unit day room. The DON stated the facility found the root cause of the event was staff were not familiar with the approved snacks per diet texture orders and snacks being placed unsecured in the dementia unit. In a joint interview on 1/13/25 at 4:15 PM, with the Director of Rehabilitation (DOR) and the Speech Therapist (ST), the DOR stated resident #1's most recent Speech evaluation was completed on 8/27/24 and showed a decline in cognitive and swallowing function which required a mechanical soft/chopped textured diet. The DOR explained resident #1 also required supervision during meals and cues for swallowing. The ST stated their goal was for resident #1 to implement compensatory strategies to increase safety during meals. She explained that a mechanical soft diet consisted of foods like pudding, applesauce, Jello, and pureed bread but would not include peanut butter and jelly sandwiches. (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/14/25 at 9:24 AM, in a telephone interview CNA A said she had worked at the facility since July 2024 and had no prior experience as a CNA. She recounted that on 12/20/24 she was assigned to work the secure memory care unit and had worked with resident #1 before. CNA A stated she was aware resident #1 required a dysphagia mechanical soft texture diet and said around 11:00 AM she went to the nourishment room, outside of the secured unit, to get snacks for the residents. She recalled she grabbed a tray that contained labeled snacks with resident's names and other unlabeled snacks such as peanut butter sandwiches and cookies. She returned to the memory care unit's dayroom and saw resident #1 sitting at a table by herself, next to the door. CNA A said she placed the tray of snacks on a table across from resident #1 and saw her grab the peanut butter and jelly sandwich from the tray. She confirmed she allowed resident #1 to have the sandwich because she had seen her eating bread before, thought the sandwich was soft, and ok for her to eat. CNA A explained she was then called away by another CNA that needed help and left the dayroom. She recalled there was a hospice CNA in the dayroom that was attending to another resident who called her back into the dayroom a few moments later to say that resident #1, didn't look good. CNA A explained she returned to the dayroom and saw resident #1, who was turning blue, had her mouth open and tongue sticking out. She said she immediately called for help and LPN C and LPN D arrived to provide emergency care for resident #1. CNA A remembered resident #1 was unresponsive and they gave her supplemental oxygen until EMS arrived and transferred her to the hospital. CNA A explained she had not been educated about which foods were appropriate for a dysphagia mechanical soft diet and had not asked anyone if a peanut butter and jelly sandwich was appropriate for resident #1. On 1/14/25 at 9:35 AM, LPN C stated that she was assigned to the memory care unit on 12/20/24 and around the time of the incident she was out of the secured unit making copies at the nurse's station. She recalled at approximately 11:00 AM, CNA A came out of the secured unit saying she needed help right away. When she entered the dayroom, she saw resident #1 sitting up in a chair with her mouth open, tongue sticking out, and a creamy substance in her mouth. LPN C said she immediately started the Heimlich maneuver, and some food came out, but the resident was unresponsive. She recounted that LPN D came to the room with portable suction and assisted her to lower resident #1 to the floor, place her on her side and suction her mouth. LPN C explained some food came out of resident #1's mouth, but she was still unresponsive, and her oxygen saturation was low at 71%. She said at that time that they gave her supplemental oxygen and waited for EMS to arrive. LPN C said when EMS arrived they used the laryngoscope to get more food out of her mouth and then transported her to the hospital. She confirmed that resident #1 had known behaviors of grabbing food from others and ate very fast. LPN C stated resident #1 required a mechanical soft texture diet and therefore a peanut butter and jelly sandwich would not be appropriate for her because it was very sticky and hard to swallow. On 1/14/25 at 9:40 AM, the Certified Dietary Manager (CDM) confirmed that resident #1 was prescribed a dysphagia mechanical soft texture diet on 12/20/24. He stated that prescribed snacks were served around 10:00 AM and 2:00 PM daily but resident #1 did not get a prescribed snack. The CDM explained resident #1 was offered a daily snack because she liked them so extra snacks were always added to the tray. He related that the dietary aides were directed to place the snack trays in the 400-hall nourishment room and not in the memory care unit's dayroom, to prevent memory care residents from grabbing foods not prescribed for their diet. He explained some of the snacks offered were peanut butter sandwiches, applesauce, pudding, and cookies. He confirmed that resident #1 had behaviors of grabbing foods from others, so trays should not be left unattended. The CDM said pureed bread was okay, but peanut butter and jelly sandwiches were not acceptable or safe for a resident who needed a dysphagia mechanical soft texture diet. (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 12/20/24 the RD completed a quality review on residents diet orders and validated with the CDM against the kitchen's meal ticket identifiers to ensure that diets were being served as prescribed. Orders were clarified as needed. * On 12/20/24 resident diet orders were posted in pantry rooms and dining rooms. Print outs listing approved snacks for regular texture, dysphagia advanced, dysphagia mechanical soft, and dysphagia pureed were posted to dining rooms, nursing stations, and med carts. The CDM validated that snacks were delivered to the secured pantry. * Education for staff started on 12/20/24 and continued through 1/3/25. They educated staff on appropriate snacks based on resident diet texture order and the procedure to validate the resident's diet order if needed. Training also included Abuse/Neglect training and supervision during snack pass. Newly hired staff would receive education during orientation regarding appropriate snacks to be offered based on diet texture orders. * On 12/23/24 the CDM completed 100% training with dietary staff regarding meal ticket accuracy and procedures for snacks. New diet orders would be reviewed during morning clinical meeting. *On 12/23/24 Unit Managers began weekly audits to ensure appropriate snacks were being passed, meal tickets matched what was being served, and staff was able to verbalize where to find correct diet information. Audits were done 12/23/24, 12/30/24, and 1/06/25 with no discrepancies noted. *On 12/24/24 a facility wide quality review was begun by Speech Language Pathologist to verify that residents with dysphagia diagnosis were on the correct texture diets. The audit was completed on 1/14/25 with no discrepancies noted. *Resident #1 returned to the facility on [DATE] from the hospital with diet texture downgraded to puree. Orders and care plans were updated accordingly to reflect the texture change. The RD followed up with resident #1 on 12/26/24 with no new recommendations. * On 12/24/24 NHA and Interdisciplinary Team (IDT), including Medical Director, met for monthly QAPI meeting and to review the progress made. They determined that all plans that had been put in place were effective. *On 12/30/24 the RD completed the second quality review to ensure diet orders in the electronic medical record matched the meal tracker. There were no issues noted. Interviews conducted from 01/15/25 through 01/16/25 with 21 total facility staff who represented the dietary and nursing departments revealed they were knowledgeable of the facility's policy and procedure for dysphagia diet orders, and appropriate snacks. Interviews conducted with nursing staff, including 9 CNAs, 2 Registered Nurses, and 3 Licensed Practical Nurses, revealed they received education between 12/20/24 and 12/25/24.		

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NAME OF PROVIDER OR SUPPLIER Aspire at Colonial Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 15204 W Colonial Dr Winter Garden, FL 34787	
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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview, and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) had the knowledge, skill sets, and competencies to provide foods/snacks to residents in accordance with their plan of care and physician orders for 1 of 8 sampled residents, (#1). This failure resulted in the resident being allowed to consume the wrong consistency snack which resulted in the resident choking and being transferred to a higher level of care where she was admitted to the Intensive Care Unit (ICU) and treated for acute respiratory failure with hypoxia. On 12/20/24 at 11:00 AM, resident #1, who was on a mechanical soft consistency diet, was allowed to consume a peanut butter and jelly (PB&J) sandwich from a tray of snacks left on a table in the dayroom by CNA A. The CNA was aware resident #1 was on a mechanical soft diet but allowed the resident to eat the sandwich because she had seen her eat bread in the past. The CNA recalled she was called back into the dayroom by CNA B who told her resident #1 did not look good. CNA A said resident #1 was sitting up in a chair with her mouth open and tongue sticking out. Licensed Practical Nurse (LPN) C and LPN D immediately responded, and LPN C attempted to administer the Heimlich maneuver but the resident was unresponsive. The resident was lowered to the floor and suctioned with some food removed from her airway. The resident remained unconscious with a pulse when the paramedics arrived and removed food from the back of the resident's airway. The resident was transported to the hospital and admitted to the Intensive Care Unit with admitting diagnoses of acute respiratory failure with hypoxia. The facility's failure to follow the prescribed therapeutic diet resulted Immediate Jeopardy starting on 12/20/24. The facility implemented actions to remove the Immediate Jeopardy as of 1/14/25. Findings: Cross reference F692 Resident #1 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included Parkinson's disease, dysphagia oropharyngeal phase (trouble swallowing in the mouth or throat), history of cerebral infarction (stroke), and unspecified dementia. Review of resident #1's physician orders for December 2024 revealed orders for a dysphagia mechanical soft texture diet since 8/29/23. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 10 out of 15, which indicated moderate cognitive impairment. She had no upper or lower extremity limitations, was independent for eating, and required set up or clean-up assistance for other Activities of Daily Living (ADLs). She was not identified as having any symptoms of a swallowing disorder but was on a mechanically altered diet which required a change in food texture or liquids. (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's care plan, with revision date 11/20/24, identified she had a potential nutritional problem related to the need for mechanically altered diet texture and past medical history of Parkinson's disease, dysphagia, dementia, and Gastro Esophageal Reflux Disease. The interventions included staff to monitor/document/report as needed any signs or symptoms of dysphagia but failed to include interventions for staff to serve diet as ordered. According to the National Foundation of Swallowing Disorders, which followed the recommendations from the American Dietetic Association, a dysphagia mechanical soft texture included foods such as soft pancakes, and pureed breads but all other bread textures should be avoided. Other foods that should be avoided included sandwiches and peanut butter, (retrieved on 1/23/25 from Swallowingdisorderfoundation.com). On 1/13/25 at 1:56 PM, the facility's Reportable and Adverse incident log from December 2024 was reviewed with the Director of Nursing (DON) who was also the Risk Manager. She said that on 12/20/24 at around 11:00 AM, CNA A alerted staff that resident #1, who at the time was in the day room of the memory care unit, was choking on a snack. The Heimlich maneuver was performed, and the resident was suctioned but ultimately, was transferred via Emergency Medical Services (EMS) to the hospital. The DON recalled she responded to the scene along with two nurses, the Advance Practice Registered Nurse (APRN), and the Physician Assistant (PA). According to the DON, the root cause was staff not being familiar with the approved snack list based on diet texture orders and snacks being placed unsecured on a dementia unit. On 1/14/25 at 9:24 AM, during a telephone interview, CNA A stated she had worked at the facility since July 2024 and had no prior CNA experience. She reported on 12/20/24 she was assigned to work on the secure memory care unit. She noted she had worked with resident #1 before and was aware she was on a dysphagia mechanical soft texture diet. She recalled at about 11:00 AM, she went to the nourishment room, located outside of the secured unit, to get snacks for the residents. She said she picked up a tray with labeled snacks with resident names and other snacks such as peanut butter sandwich and cookies, that had no resident names. She stated she went back to the memory care unit's dayroom where resident #1 was seated at a table by herself next to the door. She said she placed the tray of snacks on a table across from resident #1 and then saw the resident grab a peanut butter and jelly sandwich. She said she allowed the resident to have the sandwich because she had seen her eating bread before, and the sandwich was soft. She remembered she was called away by another CNA that needed help and left the dayroom. She noted she was called back to the dayroom by a hospice CNA a few seconds later as resident #1 didn't look good. She said the resident was turning blue, had her mouth open and tongue sticking out. She recalled she immediately called for help and LPN C administered the Heimlich maneuver and LPN D assisted with suctioning the resident's airway. She reported resident #1 was unresponsive and was given supplemental oxygen until paramedics arrived and transferred the resident to the hospital. She said she was not trained on what foods were appropriate for a dysphagia mechanical soft diet and did not ask anyone if a peanut butter and jelly sandwich was appropriate for the resident. (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress notes revealed a change in condition note entered on 12/20/24 at 1:30 PM, by an LPN that noted the resident went into respiratory arrest. The note revealed resident #1's vital signs at the time of the incident were, blood pressure 85/56, pulse 44, respirations 0, oxygen saturation 71% on room air, and mental status was unresponsive. The LPN documented that she responded immediately and noticed the resident had something in her mouth and her face was discolored. She started the Heimlich maneuver and soggy bread material was expelled from her mouth. The note showed they lowered the resident on to the floor on her side and suctioned. The note read that EMS arrived, applied oxygen and the APRN gave the order to transfer the resident to the hospital. At 2:34 PM the LPN noted she spoke with the resident's son who said he was at the hospital with the resident. According to resident #1's hospital records with admitted [DATE], noted she was seen due to the choking incident and resident being unresponsive. The admission summary showed the resident was having her meal, started to choke and became unresponsive. On arrival to the emergency room (ER), she remained unresponsive, was intubated for hypoxic respiratory failure and admitted to the ICU. The discharge summary dated 12/24/24 showed the discharge diagnosis of acute hypoxic respiratory failure and noted that speech and swallow tests were done, and diet was adjusted. Review of resident #1's modified Quarterly MDS completed on 12/27/24, post readmission from an acute care hospital, revealed she required setup assistance for eating, had a new behavior of rejecting care, had difficulty swallowing due to coughing or choking during meals, and continued on mechanically altered diet. Review of a physician progress note dated 12/29/24, noted resident #1 was evaluated for resumption of care after hospitalization from [DATE] to 12/24/24 due to choking resulting in intubation as per hospital record with administration of multiple intravenous antibiotics in the ICU setting. She returned to the facility on antibiotic therapy for five days. Review of CNA A's personnel file revealed she was hired on 7/09/24 and had received her CNA certification in 2024. The facility's Job Description for CNAs noted CNAs were entrusted to provide responsible healthcare and were responsible to provide each of their assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan. Other duties and responsibilities included providing direct care in accordance with treatment plans and attending scheduled facility in-services, orientations, and educational classes. According to the job requirements, CNAs must demonstrate the knowledge and skills necessary to provide care appropriate to the age-related needs of the residents served. On 1/14/25 at 4:34 PM, the Assistant Director of Nursing (ADON) was interviewed with the Regional Nurse Consultant (RNC) and DON present. The ADON confirmed she was the Staff Educator and stated staff received orientation with general nursing topics that included nutrition but not specific to diet types and appropriate food textures. Review of CNA A's education file revealed she completed the new hire orientation packet and skills competency assessment for eating support on 7/10/24. There were no documented competencies or in-services related to caring for dysphagia residents, food textures, or appropriate foods/snacks for each diet type. (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/15/25 at 12:43, CNA E said that prior to the choking incident she had not been educated on diet types or food textures. She worked with resident #1 regularly and said she preferred not giving resident #1 a snack because she was at risk for choking. On 1/15/25 at 1:10 PM, CNA A stated she had not received training related to diet types or food textures when she was hired, and she did not remember attending any in-services prior to the choking incident. On 1/15/25 at 1:46 PM, LPN D reported he had worked at the facility for a total of two years. He said he had never received education during orientation related to diet types and food textures but had received education at a prior facility. On 1/15/25 at 3:21 PM, interviews were conducted with five CNAs from the first and second shift, who said they did not receive education regarding diet types or food textures prior to the choking incident. They confirmed they were responsible for passing out meal trays, handing out snacks, assisting with feeding residents, and monitoring residents during meals. A review of the Facility Assessment revised 8/01/24, noted the facility provided resident services such as eating assistance and nutritional services including individualized dietary plans and specialized diets. The assessment lacked an explanation of how the facility would educate their staff to ensure these services were provided safely and appropriately. According to section 3.4, Staff training/education and competencies, in-service trainings for nursing aides must address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff. According to the Consistency Census Report printed on 1/14/25 at 2:51 PM, 31 out of 175 residents in the facility required a mechanically altered texture diet (mechanical soft, pureed, thickened liquids) related to a dysphagia diagnosis. In the memory care unit six residents required a mechanically altered texture diet. The resident sample was expanded to include seven additional residents who required dysphagia diets. Review of immediate actions to remove the Immediate Jeopardy implemented by the facility revealed the following, which were verified by the survey team: *CNA A received a teachable moment regarding appropriate snacks according to diet texture with DON on 12/20/24. * On 12/20/24 an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was convened to review the action plan. The Medical Director reviewed and approved the plan. * On 12/20/24 the RD completed a quality review on resident diet orders and validated with the Certified Dietary Manager (CDM) against the kitchen's meal ticket identifiers to ensure that diets were being served as prescribed. Orders were clarified as needed. (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* On 12/20/24 resident diet orders were posted in pantry rooms and dining rooms. Print outs listing approved snacks for regular texture, dysphagia advanced, dysphagia mechanical soft, and dysphagia pureed were posted to dining rooms, nursing stations, and med carts. CDM validated that snacks were delivered to the secured pantry. * Education for staff started on 12/20/24 and continued through 1/3/25 with 98% trained. Education included recognizing the different diet types and food textures, appropriate snacks for each diet type, and procedure to validate the resident's diet order as needed. Training also included Abuse/Neglect training and supervision during snack pass. Newly hired staff would receive education during orientation regarding appropriate snacks to be offered based on diet texture orders. * On 12/23/24 CDM completed 100% training with dietary staff regarding meal ticket accuracy and procedure for snacks. New diet orders would be reviewed during morning clinical meeting. *On 12/23/24 Unit Managers began weekly audits to ensure appropriate snacks were being passed, meal tickets matched what was being served, and staff was able to verbalize where to find correct diet information. Audits were done 12/23/24, 12/30/24, and 1/6/25 with no discrepancies noted. *On 12/24/24 a facility wide quality review began by Speech Language Pathologist verifying that residents with dysphagia diagnosis were on the correct texture diets. The audit was completed on 1/14/25 with no discrepancies noted. *Resident #1 returned to the facility on [DATE] from the hospital with diet texture downgraded to puree. Orders and care plan were updated accordingly to reflect the texture change. Registered Diet (RD) followed up with resident on 12/26/24 with no new recommendations. * On 12/24/24 the Administrator and Interdisciplinary Team (IDT), including Medical Director, met for monthly QAPI meeting and to review the progress made. They determined that all plans that had been put in place were effective. *On 12/30/24 the RD completed the second quality review to ensure diet orders in the electronic medical record matched the meal tracker. There were no issues noted. Interviews conducted from 01/15/25 through 01/16/25 with 21 total facility staff who represented the dietary and nursing departments revealed they were knowledgeable of the facility's policy and procedure for dysphagia diet orders, and appropriate snacks. Interviews conducted with nursing staff, including 9 CNAs, 2 Registered Nurses, and 3 Licensed Practical Nurses, revealed they received education between 12/20/24 and 12/25/24.		