STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165223	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Specialty Care	1977 Albia Road Ottumwa, IA 52501

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35434 Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure staff spoke to residents with respect and dignity for 1 of 2 residents reviewed for dignity (Resident #20). The facility reported a census of 56 residents. Findings: The Minimum Data Set(MDS) assessment tool, dated 8/27/24, listed diagnoses for Resident #20 included bipolar disorder (a disorder characterized by alternating periods of depression and mania), schizophrenia (a mental health illness that affected a person's thoughts, feelings, and behaviors), and obsessive-compulsive disorder. The MDS listed a Brief Interview for Mental Status(BIMS) score of 3 out of 15, indicating severely impaired cognition. The Care Plan, Revision On: 9/9/24, included a Focus area to address I have impaired cognitive function/dementia or impaired thought processes. An Intervention included, in part: COMMUNICATION: Face me when speaking and make eye contact, and Stop and return if I am agitated. Date Initiated: 4/15/24. During a phone interview on 10/28/24 at 12:46 PM, Staff O Registered Nurse (RN) stated Staff P Licensed Practical Nurse (LPN) told him he needed to go to Resident #20's room. He stated Staff Q Certified Nursing Assistant(CNA) was very angry and stated she could not tolerate this disrespect anymore while she pointed her finger at him. Staff O stated the resident could have had hallucinations and she should have been receptive to his behavior. Staff O stated the resident was not in all senses and she shouldn't be that angry. He stated after the interaction, Staff Q immediately went home. During a phone interview on 10/28/24 at 2:00 PM, Staff P stated Staff Q stood beside Resident #20's roommate and stated that he didn't get to talk to her that way, it was rude and disrespectful, and she wouldn't put up with that. Staff P stated Staff Q was disrespectful, demeaning, and spoke to him like he was a child. During an interview on 10/29/24 at 10:25 PM, Staff Q stated Resident #20 swore at her and called her a b----. She told him he didn't need to disrespect her that way and she would not be disrespected. She stated after this interaction, Staff O sent her [Staff Q] home. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Incident, Accident, Unusual Occurrence Note, dated 10/16/24 at 10:00 PM, revealed a CNA yelled at a resident in Room [number redacted] and stated he was not going to be rude and disrespectful to her and told the resident his behavior was unacceptable. The CNA explained that the resident was rude and threw his remote. The nurse asked the CNA to leave the room. On 10/30/24 at 10:02 PM, the Assistant Director of Nursing (ADON) stated staff should speak to residents in a kind and respectful manner and stated if the resident had behaviors, she expected staff to remain calm and continue to be kind and respectful. On 10/30/24 at 10:16 PM, the Administrator stated staff should speak to residents kindly and with an attitude of customer service. He stated Staff Q could have chosen her words better. The facility policy Dignity revised February 2021, directed staff to care for residents in a manner that promoted and enhanced his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 45775 Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure call lights were accessible for 2 of 24 residents reviewed for call lights (Residents #18 and #28). The facility reported a census of 56 residents. Findings: 1. The Minimum Data Set(MDS) assessment tool, dated 8/13/24, listed diagnoses for Resident #18 which included dementia, diabetes, and cognitive communication deficit. The MDS stated the resident was dependent of staff for toileting and toileting hygiene and listed her Brief Interview for Mental Status(BIMS) score as 13 out of 15, indicating intact cognition. A Care Plan entry, dated 2/16/24, stated the resident required the assistance of 1 staff for toileting. On 10/22/24 at 8:35 AM, the resident sat in her recliner. The call light hung down from the wall on the other side of the bed, not in reach of the resident. On 10/22/24 at 9:02 AM, the resident's call light remained out of reach and a staff member retrieved it for her. 2. The MDS assessment tool, dated 10/5/24, listed diagnoses for Resident #28 which included diabetes, fracture of the tibia(frontal leg bone), and weakness. The MDS stated the resident was dependent on staff for toileting hygiene and listed the resident's BIMS score as 14 out of 15, indicating intact cognition. A 10/3/24 Care Plan entry stated the resident required substantial to maximal assistance with the bed pan. On 10/21/24 at 1:49 PM, the resident sat in a chair in her room. The resident's call light hung down from the wall on the other side of the bed, not within reach of the resident. The facility policy Answering the Call Light, revised March 2021, directed staff to ensure the call light was within easy reach of the resident. On 10/30/24 at 10:02 AM, the Assistant Director of Nursing (ADON) stated call lights should be accessible to residents and stated if she noticed a call light not in reach, she would educate the responsible staff member.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, facility record review, and staff interview, the facility failed to ensure resident equipment is cleaned and in good repair for 1 of 1 residents (Resident #14) reviewed. The wheelchair belonging to Resident #14 was observed for 3 days to have food debris on the wheelchair frame, seat cushion and lap belt. The facility reported a census of 56 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], for Resident #14 revealed a diagnosis of Huntington's disease, muscle wasting and dependent on a wheelchair for mobility. The Care Plan for Resident #14 revealed an inability to ambulate, required the assistance of 1 staff member with the reclining wheelchair and required substantial assistance to eat. During an observation on 10/21/24 at 1:30 PM, Resident #14 while in his wheelchair, had what appeared to be dried food substances on the lap belt. During an observation on 10/22/24 at 9:06 AM, Resident #14 while resting in bed, had his wheelchair positioned next to the bed. The seat of the wheelchair contained food debris, that went down the sides of the wheelchair and onto the lap belt. During an observation on 10/23/24 at 9:25 AM, Resident #14's wheelchair noted to have the same dried food substance on the seat cushion and on the seatbelt. During an interview on 10/23/24 at 12:58 PM, Staff B, Certified Medication Aid, (CMA) stated staff would change their clothes after a meal, if it was dirty. Staff B stated the HS shift (overnight) cleaned wheelchairs according to a schedule. During an interview on 10/23/24 at 2:53 PM, Staff F, Certified Nursing Assistant (CNA) stated if the resident needed their wheelchair cleaned right away, it was everyone's responsibility to keep them clean. Staff F stated each hall has a scheduled time for night shift to scrub down the wheelchairs. A document titled night shift cleaning schedule by the nursing staff (10-6a shift) revealed wheelchair cleaning every night, all wheel chairs must be cleaned at least once a week. During an interview on 10/23/24 at 1:15 PM, The Director of Nursing (DON) stated the cleaning schedule document was a guide line during the down time on the night shift. She stated all wheel chairs should be cleaned and Resident #14's wheelchair got dirty so quick because of the way he ate.

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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** 44512 Based on observation, clinical record review, family and staff interviews, the facility failed to develop a culturally competent care plan for 1 of 3 residents reviewed (Resident #36). The facility reported a census of 56 residents. Findings include: The Minimum Data Set (MDS), dated [DATE], revealed diagnoses for Resident #36 included diabetes mellitus, chronic obstructive pulmonary disease and heart disease. The MDS identified Resident #36's preferred language as Spanish. The Brief Interview of Mental Status (BIMS) score of 4 out of 15 indicated a severe cognitive impairment. The Care Plan, Date Initiated: 2/19/24, included a Focus area to address The resident has an interpretation need. I am unable to read or write. Interventions included, in part: Interpreter needed Spanish Ph: [phone number redacted] ID# [ID # redacted] Date Initiated: 4/11/24. Resident's preferred language is: Spanish (Mexico). Date Initiated: 2/19/24. The Care Plan Special Instructions notation documented Spanish speaking .Interpreter needed Spanish Ph. [phone number redacted] ID# [ID number redacted]. During an observation on 10/21/24 at 10:25 AM, Resident #36 was sitting in the dining room by self, frowning, with her head drooped. The resident did not participate in the activity occurring in the attached living room. During an observation on 10/21/24 at 1:16 PM, Resident #36 exited the shared bathroom, used walker to forcefully strike the floor and shouted in Spanish to her roommate, then walked to her bed to lay down. The roommate, Resident #55 stated that behavior happened daily and she felt awful as she was unable to speak Spanish. During an interview on 10/21/24 at 2:04 PM, a family member stated a couple of staff members speak Spanish and her mother liked Spanish music. The daughter expressed concern for mother not having needs met due to language barrier. During an interview on 10/24/24 at 11:00 AM, Staff T, Certified Nursing Assistant (CNA) stated she believed Resident #36 verbal aggressiveness had to do with the language barrier and people not understanding her. Staff T stated Resident #36 would ask for something in Spanish that staff could not understand. Staff T stated she would have some conversation, Enough to find out what she needs. Staff T stated Resident #36 would benefit from something directed toward her culture as she displayed signs of isolation, always in room, did not participate in activities. During an interview on 10/24/24 at 1:30 PM, the Director of Nursing (DON) stated Staff G, MDS Coordinator completed the Care Plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 10/24/24 at 1:50 PM, Staff G stated she visited the facility 3 days a week to complete the Care Plans and the DON or Assistant Director of Nursing (ADON) would complete the changes to the Care Plans. Staff G stated the Social Services Director would create the culturally competent care plans in this facility. During an interview on 10/24/24 at 2:02 PM, Staff U, Social Worker stated she would complete the family history, advanced directives, guardian and the long term or short term to return home, That is all I do for the care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512 Based on observations, clinical record review, and staff interviews, the facility failed to assist a resident with changing their clothing after food spilled on their pants and shirt during a meal (Resident #8) for 1 out of 3 residents reviewed. The facility reported a census of 56 residents. Findings include: The Minimum Data Set, dated dated [DATE], for Resident #14 revealed diagnoses of Huntington's disease, muscle wasting and anxiety disorder. The MDS identified the resident dependent on a wheelchair for mobility. The Care Plan, Date Initiated: 10/6/23, included a Focus area to address Activities for Daily Living (ADL's). Interventions included, in part; Eating - I am substantial assist x 1 (one staff), Upper Body Dressing - I am dependent assist x1, and Lower Body Dressing - I am dependent assist x 1 with a Date Initiated: 10/6/23. During an observation on 10/22/24 at 9:06 AM, Resident #14 assisted to his room by Staff S, Certified Nursing Assistant (CNA) after breakfast. Spilled food noted on Resident #14 shirt and pants. After exiting the room, Staff S stated staff assists Resident #14 to eat, and she provided pericare after assisting the resident to bed. Resident #14 dressed in same clothing after cares. During an observation on 10/22/24 at 1:10 PM, after lunch Resident #14 in bed. Resident wearing same shirt and pants, with additional food spilled from the noon meal. During an interview on 10/23/24 at 12:58 PM, Staff B, Certified Medication Aid, (CMA) stated staff should change a resident's clothes after a meal if it is dirty. During an interview on 10/23/24 at 2:53 PM, Staff F, CNA stated staff should change resident's clothes anytime they have food on them. I wouldn't want to walk around with food on my clothes and they shouldn't either. During an interview on 10/23/24 at 1:15 PM, the Director of Nursing (DON) stated her expectation was for the staff to change resident's clothes if dirty.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51573 Based on observation, staff interview, and clinical record review, the facility failed to provide continued assessment for Resident #23 after an episode of excessive coughing caused by taking medications with a thin liquid, instead of the physician ordered nectar consistency liquid. The facility reported a census of 56 residents. Findings Include: The Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #23 scored a 4 out of 15 on a Brief Interview for Mental Status (BIMS) test, indicating severely impaired cognition. The MDS listed diagnoses included: aphasia (inability to swallow), cerebrovascular accident (CVA-interruption of blood flow to the brain leading to neurological issues), transient ischemic attack (TIA-a brief blockage of blood flow to brain), or stroke, and dysphagia (swallowing difficulties). The MDS identified Resident #23's with a Mechanically altered diet - required change in texture of food or liquids (e.g., pureed food, thickened liquids). The Oral/Dental Status of the resident indicated No natural teeth or tooth fragment(s). A review of the Care Plan Diagnosis section, revealed, in part, PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT. A review of Physician Orders revealed an order, dated 4/27/23, for Regular/NAS (no salt added) diet. Level 4 Pureed texture, Level 2 Mildly Thick (Nectar) consistency. The Care Plan, updated on 10/22/2024, included a Focus area to address I am at increased nutritional risk d/t (due to) med dx (diagnosis) of severe protein-calorie malnutrition, dysphagia, underweight, HTN (high blood pressure), HLD (high cholesterol), GERD (gastroesophageal reflux disease, cause of heartburn). An Intervention included, in part: Regular diet, Puree texture, level 2 mildly thick Nectar thick liquids. Date Initiated: 10/27/23. Revision on: 7/8/24. During an observation on 10/23/24 at 8:02 AM, Staff A, Certified Medication Assistant (CMA) administered Resident #23's medications with regular, unmodified consistency water. After the administration, the resident began coughing significantly. Staff A retrieved nectar thickened water to assist Resident #23 with the coughing. Staff D, Licensed Practical Nurse(LPN), commented that Resident #23 was thickened liquids to which staff A replied I know. Staff D then commented she normally administered Resident #23's medications in pudding to prevent him from choking to which Staff A replied that she was not aware of that. Staff D then came over to Resident #23 and asked him if he was ok and wiped his nose and mouth with a tissue. Resident #23 continued to cough and had large amounts of drainage from his mouth and nose. Staff D observed Resident #23 at the nurse's station for approximately 3 minutes until he stopped coughing. The resident then continued down the hall to his room. During an interview on 10/23/24 at 8:13 AM, Staff A, CMA stated that she provided Resident #23 with non-thickened liquids. Staff A was aware that Resident #23 had a thickened liquid diet order but she was not aware that he normally received his pills with pudding. Staff A stated she normally mixed his Miralax (stool softener) with water to dissolve the Miralax and then added a thickened supplement to it afterwards but was running low on the supplement so she forgot to thicken the liquid. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 8:30 AM, Staff D, LPN stated that the pudding was just a personal preference for the resident and that she believed that the resident has had Speech Therapy change his liquid consistency several times. Staff D noted that there was an area on the electronic MAR that documented resident preferences that was put into place for agency staff. During an observation on 10/23/24 at 8:32 AM, Resident #23 while in his room, sat in his recliner. His face appeared bright red, and he had large amounts of secretions coming from his mouth and nose. When the State Agency (SA) asked the resident if he was ok, he shook his head no and pointed to his chest and stated he felt like something was stuck. The SA informed Staff D, LPN of the findings. Staff J, Director of Nursing (DON) and Staff K, Regional Director of Clinical Services (RDCS) accompanied Staff D into Resident #23's room. On 10/23/24 at 8:37 AM, Staff D, LPN brought in a basin and equipment for vital signs (thermometer, blood pressure cuff, pulse oximeter, stethoscope). Staff D listened to the resident's lung sounds on his back, and obtained a blood pressure, and temperature. The resident stated that he did not feel better. When Staff J, DON asked the resident if he felt short of breath, he shook his head no. On 10/23/24 at 8:42 AM., Staff J, DON asked the resident if he felt like he had something stuck in his throat and he responded yes. On 10/23/24 at 8:45 AM, the resident continued to have a cough and runny nose and stated he did not feel well. On 10/23/24 at 8:48 AM, Staff J, DON and Staff K, RDCS cleaned up the resident and asked him to take a deep breath and cough several times. At this time Staff J left the room and called the physician to notify him of the resident's status. On 10/23/24 at 8:53 AM, the resident took one drink of thickened liquids and began coughing. Staff K, RDCS stated to call the physician and Staff J, DON said that she had already called. The resident coughed up a large amount of secretions after he took one drink. On 10/23/24 at 8:54 AM, Staff D, LPN left the room for one minute and came back in with new orders from the physician for a two-view chest x-ray and orders for temperature and lung sounds every shift for the next three days. On 10/23/24 at 9:26 AM, via phone, Staff R Registered Dietician (RD) stated Resident #23 had an order for nectar thick liquid which was in place since April of 2023. She stated she would absolutely not be ok with him receiving thin liquids since he had dysphagia (difficulty swallowing) and could aspirate (inhale food or liquids into the lungs). On 10/23/24 at 9:53 AM, the resident sat in his recliner watching TV with no obvious signs of distress observed at this time. On 10/23/24 at 9:56 AM, the Certified Dietary Manager (CDM) stated Resident #23 had always received thickened liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 10:39 AM, the DON stated residents should receive the ordered liquid consistency and Resident #23's order was nectar thick. She stated (after a coughing episode) she expected the nurse to complete a full respiratory assessment to include vitals, an oxygen level, and a check for cyanosis (blue color to the skin). She stated she expected the nurse to notify the provider and check on them every 15-30 minutes. She stated she expected staff to stay with him if they thought something was stuck (in the throat). On 10/30/24 at 12:35 PM, Staff N, Speech Therapist stated that she believed that Resident #23 was a high risk for aspiration as that was why he was ordered for a mechanically altered diet. He did not have any teeth and she recommended that he be provided with nectar thickened liquids at all times. 35434 The facility policy, revised February 2021, titled Change in a Resident's Condition or Status, Policy Interpretation and Implantation section, directed staff, in part, to: 1. The nurse will notify the resident's attending physician or physician on call when there has been: a. accident or incident involving the resident; d. significant change in the resident/s physical/emotional/mental condition; 2. A significant change of condition is a major decline or improvement in the residents status that: a. requires interdisciplinary review and/or revision of the care plan; 3. Prior to notifying the physician or healthcare provider, the nurse will make a detailed observation and gather relevant and pertinent information for the provider, including information prompted by the SBAR (Situation, Background, Assessment, Recommendation) communication form. 9. If a significant change in the resident's physician or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA (Omnibus Budget Reconciliation Act) - federal law aimed to improve quality of care in long term care facilities) regulations governing resident assessments and as outlined in the MDS RAI (Resident Assessment Instrument) Instruction Manual.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 45338 Based on observation, clinical record review and staff interviews, the facility failed to ensure safe wheelchair transport for 1 of 1 residents reviewed (Resident #12). The facility reported a census of 56 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #12 scored 00 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated severely impaired cognition. The MDS indicated the resident utilized a wheelchair for mobility, and had not attempted to self propel due to medical condition or safety concerns. Review of the Care Plan for Resident #12 dated 6/13/22, revised 6/6/23 revealed, I am at risk for falls. The Intervention dated 5/26/23 revealed, Keep my w/c (wheelchair) pedals off due to my like to self propel. An observation on 10/22/24 at 3:18 PM revealed Staff A, Certified Medication Aide (CMA) pushed Resident #12 while the resident's feet were off of the pedals of the wheelchair, and were below the level of the wheelchair pedals. On 10/22/24 at 3:21 PM, Resident #12 observed pedaling herself in her wheelchair in the common area. On 10/22/24 at 3:43 PM, Staff B, CMA observed assisting Resident #12 to move while the resident was in their wheelchair. One of the resident's feet observed to drag on the floor at the time of the observation. During an observation on 10/22/24 at 4:14 PM. Staff C, CNA (Certified Nursing Assistant)/CMA assisted Resident #12 from dining room while Resident #12 present in their wheelchair. The resident's feet were not on the wheelchair pedals, and both feet slid across the floor while the staff member assisted the resident. On 10/22/24 at 4:19 PM, Staff C observed assisting the resident back into the dining room, and the resident's feet slid across the floor not on the foot pedals. During an interview on 10/23/24 at 2:18 PM, Staff E, CNA queried about where feet were to be when assisting resident in wheelchair, and acknowledged on pedals. During an interview on 10/23/24 at 2:58 PM, Staff F, CNA acknowledged resident's feet should be no the foot pedals when resident assisted in wheelchair. During an interview on 10/24/24 at 3:32 PM, the Director of Nursing (DON) explained she had been given misinformation from the previous DON that staff could be present on the side to assist for residents who could self propel, and explained not allowed to do anything without foot pedals.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35434 Based on observation, menu review, policy review, and staff interview, the facility failed to provide the correct texture for 5 of 5 residents with a mechanical soft diet order. The facility reported a census of 56 residents. Findings: The Therapeutic Spread Report-Spring/Summer Menu '24 for Week 2 Tuesday Lunch directed staff to provide residents on a mechanical soft diet ground chicken and noodles. During an observation on 10/22/24 at 11:51 AM, Staff V [NAME] prepared the lunch meal and stated the residents who received a mechanical soft diet would receive the regular chicken and noodles. Staff R Registered Dietician(RD) was present and stated the residents with a mechanical soft diet order would be fine with the regular chicken and noodles but stated she needed to look at the spreadsheet [Therapeutic Spread Report]. She looked in the kitchen and could not locate a spreadsheet so she left the kitchen to retrieve one. When she returned she told Staff V to break it into pieces and the dice it. The State Agency requested Staff R look in the pan of chicken and noodles to verify that this did not need to be ground. Staff R looked in the pan and told Staff V to grind the portions used for the residents with mechanical soft. The pieces of shredded chicken were up to approximately 1.5 inches in length. During an interview on 10/23/24 at 9:26 AM, via phone, Staff R RD, stated the expectation was for dietary staff to follow the therapeutic diet spreadsheets. She stated residents on a mechanical soft diet should receive ground food. During an interview on 10/23/24 at 2:37 PM, the Certified Dietary Manager(CDM) stated she found out yesterday that the sheets they had in the kitchen did not have the right information (for therapeutic diets) but stated they now had the spread sheets in the kitchen. The facility policy Dysphagia-Clinical Protocol revised 9/2017, Assessment and Recognition section indicated the staff and physician would identify residents with a history of swallowing difficulties or related diagnoses such as dysphagia (difficulty swallowing). The policy stated if a modified consistency was indicated, nursing would obtain an order for such restrictions from the physician. During email correspondence on 10/30/24 at 11:48 PM, the Administrator stated the facility did not have a separate policy regarding mechanically altered diets.

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	165223	A. Building B. Wing	10/31/2024

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51573 Based on observation, interview, and clinical record review, the facility failed to provide Resident #23 the correct diet ordered liquid consistency during medication administration causing excessive coughing and production of copious amounts of phlegm. Resident #23 has diagnoses of dysphagia (difficulty swallowing) and a history of pneumonitis due to inhalation of food and vomiting. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of residents who resident in the facility. The facility reported a census of 56 residents. The State Agency (SA) informed the facility of IJ that began on October 23, 2024 at 8:02 AM, on October 23, 2024 at 1:00 PM. The Facility Staff removed the Immediate Jeopardy on October 24, 2024 through the following actions: a. The facility provided education with staff, including agency staff, to follow physician orders for fluid consistency. b. The facility provided education with nursing staff, including agency staff, on adequately assessing residents with changes in condition, to include vital signs and appropriate assessments. Physician is to be notified immediately and staff to remain with resident if change in condition. c. Resident #23 was assessed at bedside. The physician was notified. Physician orders were obtained for the following: Chest x-ray, referral to speech therapy, suction as needed (suction machine placed at bedside), crush medications as indicated, monitor lung sounds and pulse oximetry (blood oxygen) every shift for three days. d. Completed an audit of all residents on an altered liquid consistency to ensure that it is reflected on their Medication Administration Record (MAR), resident care plan, and Kardex. e. Director of Nursing (DON) or designee will monitor and audit 4 medication passes per week for 6 weeks to ensure appropriate fluid consistency given as physician ordered. DON or designee will monitor and audit 3 changes in condition per week for 6 weeks to ensure appropriate assessments are completed and physician notifications are completed. Concerns are to be addressed with Quality Assurance Performance Improvement (QAPI). The Scope and Severity was lowered from an J to a D at the time of the survey after ensuring the plan of removal was put in place and implemented. Findings Include: (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Quarterly Minimum Data Set (MDS), dated [DATE], indicated Resident #23 scored a 4 out of 15 on a Brief Interview for Mental Status (BIMS) test, indicating severely impaired cognition. The MDS listed diagnoses included: aphasia (inability to swallow), cerebrovascular accident (CVA-interruption of blood flow to the brain leading to neurological issues), transient ischemic attack (TIA-a brief blockage of blood flow to brain), or stroke, and dysphagia (swallowing difficulties). The MDS identified Resident #23's with a Mechanically altered diet - requires change in texture of food or liquids (e.g., pureed food, thickened liquids). The Oral/Dental Status of the resident indicated No natural teeth or tooth fragment(s). A review of Physician Orders revealed an order, dated 4/27/23, for Regular/NAS (no salt added) diet. Level 4 Pureed texture, Level 2 Mildly Thick (Nectar) consistency. The Speech Therapy SLP Evaluation and Plan of Treatment, dated 10/4/23, revealed that Resident #23 was at risk for aspiration and needed to remain nectar thickened liquids. The Care Plan, updated on 10/22/2024, included a Focus area to address I am at increased nutritional risk d/t (due to) med dx (diagnosis) of severe protein-calorie malnutrition, dysphagia, underweight, HTN (high blood pressure), HLD (high cholesterol), GERD (gastroesophageal reflux disease, cause of heartburn). An Intervention included, in part: Regular diet, Puree texture, level 2 mildly thick Nectar thick liquids. Date Initiated: 10/27/23. Revision on: 7/8/24. The resident's Medical Diagnosis report listed a primary medical diagnosis upon admission as pneumonitis(inflammation of the lungs) due to inhalation of food and vomit. A SPN Focused Evaluation on 7/12/24 noted the resident had a mild cough, with most of his coughing occurring during meals. During an observation on 10/23/24 at 8:02 AM, Staff A Certified Medication Assistant (CMA) administered the Resident #23's medications with regular (thin) consistency water. After the administration, the resident began coughing significantly. Staff A retrieved nectar thickened water to assist Resident #23 with his coughing spell while Staff D Licensed Practical Nurse (LPN) commented that Resident #23 was thickened liquids to which staff A replied I know. Staff D then commented she normally administered Resident #23's medications in pudding to prevent him from choking to which Staff A replied that she was not aware of that. During an interview on 10/23/24 at 8:13 AM, Staff A, CMA stated that during the morning medication administration, she provided Resident #23 with non-thickened liquids. Staff A was aware that Resident #23 was ordered a thicken liquid diet but she was not aware that he normally received his pills with pudding. Staff A normally mixed his Miralax (stool softener) with water to dissolve the Miralax and then added a thickened supplement to it afterwards but was running low on the supplement so she forgot to thicken the liquid. On 10/23/24 at 8:30 AM, Staff D, LPN stated that the pudding was just a personal preference for the resident and that she believed that the resident had Speech Therapy change his liquid consistency several times. Staff D noted that there was an area on the electronic MAR that documented the resident preferences. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 9:26 AM, via phone, Staff R Registered Dietician (RD) stated Resident #23 had an order for nectar thick liquid which was in place since April of 2023. She stated she would absolutely not be ok with him receiving thin liquids since he had dysphagia(difficulty swallowing) and could aspirate(inhale food or liquids into the lungs). On 10/23/24 at 9:56 AM, the Certified Dietary Manager (CDM) stated Resident #23 had always received thickened liquids. On 10/23/24 at 10:39 AM, the Director of Nursing (DON) stated residents should receive the ordered liquid consistency and Resident #23's order was nectar thick. She stated (after a coughing episode) she expected the nurse to complete a full respiratory assessment to include vitals, an oxygen level, and a check for cyanosis (blue color to the skin). She stated she expected the nurse to notify the provider and check on them every 15-30 minutes. She stated she expected staff to stay with him if they thought something was stuck (in the throat). On 10/30/24 at 12:35 PM, Staff N, Speech Therapist stated that she believed that Resident #23 was a high risk for aspiration as that was why he was ordered for a mechanically altered diet. He did not have any teeth and she recommended that he be provided with nectar thickened liquids at all times. 35434 The facility policy, revised September 2017, tiled Dysphagia-Clinical Protocol declared the staff and physician would identify residents with a history of swallowing difficulties or related diagnoses such as dysphagia (difficulty swallowing). The policy stated if a modified consistency was indicated, nursing would obtain an order for such restrictions from the physician. The facility policy, revised April 2019, titled Administering Medications directed staff to administer medications in accordance with prescriber orders

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35434 Based on observation, policy review, and staff interview, the facility failed to ensure safe food handling and kitchen sanitation for 1 of 2 kitchen observations. The facility reported a census of 56 residents. Findings: A kitchen observation on 10/21/24 starting at 9:26 AM, revealed: a. A metal bowl of fruit sat in the sink on the left hand side of the kitchen. b. [NAME] crumbs were present on the top of the dish washer. c. Staff M, Dietary Aide (DA), ran a dishwashing cycle. The Certified Dietary Manager (CDM) then dipped a test strip into the dish machine water and it remained white. According to the test strip container, a white color indicated 0 parts per million sanitizer concentration. Staff M stated he tested it this morning but forgot to write it down but it turned green to indicate 100 ppm. A follow-up observation on 10/21/24 at 9:43 a.m., revealed the test strip was 100 ppm. The CDM stated she adjusted the sanitizer tubing. d. The October 2024 Dish Machine Temperature Log for the period of 10/1/24-10/21/24 was blank and lacked documentation staff checked the dish machine strip: 1/1/24, 1/2/24, 1/6/24, 1/7/24, 1/8/24, 1/9/24, 1/10/24, 1/11/24, 1/12/24, 1/14/24, 1/15/24, 1/16/24, 1/17/24, 1/18/24, 1/19/24, 1/20/24, 1/21/24. e. Staff M had a mustache approximately 3/4 inches in lengths and did not wear a hair restraint to cover this area. Observations in the kitchen on 10/22/24 revealed: a. At 9:15 AM, the facility's ice machine had a red substance accumulating alongside the inner top part of the dispenser. b. At 10:45 AM, during lunch preparation, and again at 11:15 a.m., Staff L, DA observed with significant hair hanging out from the back of her hair net. c. At 11:15 AM, Staff M, DA while making coffee, picked up a wrapper off the floor. Without completing hand hygiene, Staff M continued to make and dispense the coffee, and began to assemble room trays. d. At 12:55 PM, a plate of half eaten food was found in the microwave, cold to touch and a sticky substance on the outside of the microwave. A trash can, next to the microwave, overflowing to the point the lid could not be closed. The trash receptacle near the handwashing sink overflowing on to the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 2:37 PM, the CDM stated hair nets should cover all hair and staff should wash their hands after picking up garbage. She stated the maintenance department was responsible for cleaning the ice machine. Staff should test the dishwasher three times per day but were not doing this. She stated she completed training related to this. She stated the kitchen should be clean and in good order. The facility policy Sanitization, revised October 2008, Policy Statement declared The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and Implementation, in part, directed staff to: #8. Dishwashing machines must be operated using the follow specifications: Low-Temperature Dishwasher (Chemical Sanitization) a. Wash Temperature (120 degrees F (Fahrenheit). b. Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds. #12. Ice machines and ice storage containers shell be drained, cleaned, and sanitized per manufacturer's instructions and facility policy. The facility policy Food Preparation and Service, revised April 2019, Policy Statement declared Food and nutrition services employees prepared and served food in a manner that complied with safe food handling practices. Policy Interpretation and Implementation, Food Preparation Area section, in part, directed staff to: #5. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness. Policy Interpretation and Implementation, Food Service/Distribution section, in part, directed staff to: #4. Food and nutrition services staff, including nurses services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handing food trays. #7. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc) so that hair does not contact food.