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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195571	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Jefferson Community Care Center	8340 Baringer Foreman Road. Baton Rouge, LA 70817

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47546 Based on interviews and record review, the facility failed to ensure a resident's assessment accurately reflected the resident's status for 2 (#2 and #3) of 3 (#1, #2, and #3) residents reviewed for MDS. Findings: Resident #2: Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed Resident #1 had a diagnosis of Dysphagia. Review of Resident #2's Physician Orders revealed the following: Regular diet, mechanical soft texture, regular- thin liquids consistency. Start date: 08/22/2024 Regular diet, mechanical soft texture, regular-thin liquids consistency. Start date: 11/21/2023. Discontinued: 08/16/2024. Review of Resident #2's MDS with an ARD of 07/26/2024 revealed mechanically altered diet- require change in texture of food or liquids was coded as no in Section K0520 titled Nutritional Approach. Resident #3: Review of Resident #3's Clinical Record revealed she was admitted to the facility on [DATE]. Review of Resident #3's Physician Orders revealed the following: Regular diet, mechanical soft texture, regular- thin liquids consistency. Start date: 08/22/2024 Regular diet, mechanical soft with chopped meats texture, regular- thin liquids consistency. Start date: 03/15/2024. Discontinued: 08/16/2024. Review of Resident #3's MDS with an ARD of 06/26/2024 revealed mechanically altered diet- require change in texture of food or liquids was coded as no in Section K0520 titled Nutritional Approaches. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/2024 at 9:20 a.m., an interview was conducted with S3CCC. She stated she was responsible for completing the resident MDS assessments. She reviewed Resident #2's MDS dated [DATE] and confirmed section K0520C titled Nutritional Approaches - Mechanically altered diet was not accurately coded for Resident #2's ordered mechanical altered diet. S3CCC confirmed if a resident was ordered a mechanical soft diet, section K0520C of the MDS should have been coded as yes and was not for Resident #2. On 08/27/2024 at 2:50 p.m., an interview was conducted with S3CCC. She reviewed Resident #3's MDS dated [DATE] and confirmed section K0520C titled Nutritional Approaches -Mechanically altered diet was not accurately coded for Resident #3's ordered mechanical altered diet. S3CCC confirmed if a resident was ordered a mechanical soft diet, section K0520C of the MDS should have been coded as yes and was not for Resident #3. On 08/27/2024 at 1:50 p.m., an interview was conducted with S1DON. She stated if a resident had a mechanical soft diet ordered, section K0520C - Nutritional Approach - Mechanically altered diet of the MDS should be coded as yes to accurately reflect the resident's diet order. 49343

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 47546 Based on observation, interviews, and record review the facility failed to ensure resident's received adequate supervision with meals for 1 (#1) of 3 (#1, #2, and #3) residents reviewed for supervision. This deficient practice resulted in an Immediate Jeopardy situation on [DATE] at 4:19 p.m. when S2CNA left Resident #1, a resident who required supervision with meals, unsupervised in his room eating supper. At 4:21 p.m., S4LPN entered the resident's room, found him still eating, and left the resident unsupervised at 4:24 p.m. At 4:27 p.m., S4LPN found Resident #1 in his room on the floor with food particles in his mouth, gasping for air. S4LPN performed an oral sweep of Resident #1's mouth which revealed food particles. Staff then performed the Heimlich maneuver and suctioned the resident. Resident #1 became pulseless after the Heimlich maneuver was stopped and expired at approximately 4:30 p.m. S5ADM was notified of the Immediate Jeopardy on [DATE] at 4:16 p.m. The Immediate Jeopardy was removed on [DATE] at 2:29 p.m., as confirmed by onsite verification through observations, interviews, and record reviews the facility implemented an acceptable Plan of Removal (POR) prior to the survey exit. Findings: Review of Resident #1's record revealed he was admitted to the facility on [DATE] with diagnoses which included Dysphagia. Review of the MDS with an ARD of [DATE] revealed Resident #1 had a BIMS of 4, which indicated the resident was severely cognitively impaired. Review of Section K revealed Resident #1 was coded for coughing or choking during meals or when swallowing medications and was on a Mechanically altered diet. Section GG part A. Eating revealed Resident #1 was coded for Supervision or touching assistance. Review of Resident #1's Physician's Progress Note dated [DATE] revealed Resident #1 returned from the hospital on [DATE] with an order for a regular, puree, thin liquids diet. Review of Resident #1's Nurse's note dated [DATE] at 2:26 p.m. revealed S3CCC spoke with the resident's daughter regarding the resident refusing to eat pureed foods. Resident #1's daughter agreed to advance the resident's diet to regular, mechanical soft, with thin liquids. Resident will be observed at meal times to evaluate tolerance of diet change. Noted by S3CCC Review of Resident #1's Physicians Orders revealed the following: Start date: [DATE] - Regular diet, Mechanical Soft with ground meats texture, regular - thin liquids consistency. Review of Resident #1's Care Plan revealed, in part, the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Onset: [DATE] Problem: ADL self-care performance deficit r/t my impaired cognition with fluctuating confusion. Interventions: supervision and set up assistance to eat. Review of Resident #1's Nurses Note dated [DATE] at 4:30 p.m. revealed S4LPN was in Resident #1's room passing medications to his roommate. Resident was sitting in his wheelchair feeding himself with the bedside table in front of him. He was not in distress. I heard a loud noise and observed Resident #1 on the floor, lying on his left side. I called out to him, and he did not respond. His body was flaccid as his pulse was palpated. The pulse was palpable as he gasped for air. Skin was cyanotic at that time. He was placed in a supine position. Food particles were noted in his oral cavity. The resident did not display signs of choking. Noted by S4LPN Review of Resident #1's Nurses Notes dated [DATE] at 9:11 p.m. revealed, at approximately 4:30 p.m., S4LPN noted Resident #1 in his room laying on the floor on his left side. S4LPN asked Resident #1 if he was okay with no response. S4LPN attempted to turn the resident over and noted Resident #1 gasping for air. S4LPN performed an oral sweep, and some food came out. S4LPN stayed with the resident while the CNA got help. Two additional nurses arrived with O2 and suction. Resident #1 was sat up to start the Heimlich maneuver. Small amounts of food were obtained during suction. No change in the resident. Resident #1's color changed, Heimlich maneuver stopped, attempted to obtain vitals with none noted and no pulse. Noted by S4LPN On [DATE] at 12:45 p.m., a telephone interview was conducted with S4LPN. She stated on [DATE] around supper time she entered Resident #1's room to administer medication to Resident #1's roommate. She stated Resident #1 was sitting up in his wheelchair with a meal tray in front of him, eating his supper. She stated after giving Resident #1's roommate his medication, she left the room. She stated she heard a noise and went back into Resident #1's room and found him on the floor. She stated she rolled the resident over onto his back and he was blue with a small amount of food coming out of his mouth. She stated at that time the resident had a pulse and was gasping for air. She stated immediately after calling for help, 2 other nurses ran into the room with oxygen and a suction, the Heimlich maneuver was performed and the suction was used which produced bits of food. She stated after performing abdominal thrusts, Resident #1's color changed, he became pulseless, and the resident was gone. On [DATE] at 1:08 p.m., a telephone interview was conducted with S2CNA. The CNA said she would check the signage above the resident's bed to know what type of assistance a resident required for meals. She stated if a resident's diet changed or supervision requirements changed, the nurse would inform the CNAs or the CNA could check the resident's chart. S2CNA explained if a resident required supervision and was eating in their room, the staff would walk in and out of the room to supervise the resident or place the resident in the hallway while eating so staff could monitor them. S2CNA stated Resident #1 did not require supervision with meals. She stated on [DATE] she and another CNA were passing supper trays on Resident #1's hall. She stated she delivered Resident #1's supper tray then she exited his room, leaving Resident #1 and his roommate eating in their room while she continued passing trays. She stated she heard a noise from Resident #1's room and went in after S4LPN. She stated she observed Resident #1 on the floor and his face was turning blue. She stated she called resident's name and got no response. She stated she was in Resident #1's room when the nurses performed the Heimlich maneuver and witnessed small bits of food coming out of Resident #1's mouth. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 3:05 p.m. an interview was conducted with S6LPN. She stated she was familiar with Resident #1. She stated Resident #1 was placed on a pureed diet after being released from the hospital on [DATE], but was not eating well and the resident's daughter requested a diet change to mechanical soft. She stated a few months ago the staff had to perform the Heimlich maneuver on the resident in dining room. She stated all residents had to eat in their rooms on [DATE] when the incident occurred so the residents were not in the dining room. She stated residents that needed supervision while eating should be placed in the hallway to eat so staff could supervise them. She stated Resident #1 did not require direct supervision for meals and was able to feed himself. On [DATE] at 8:18 a.m. an interview was conducted with S1DON. She stated on [DATE] she was notified immediately of Resident #1's death. She stated she was informed S4LPN was in the resident's room, walked out, and then heard a noise which prompted her to go back into room to find the resident on floor. S1DON stated she was told Resident #1 was on his side with mouth open and body flaccid when S4LPN went back into room. She stated she was informed by S4LPN Resident #1 was not grabbing at his throat as if choking. She stated CPR was not performed on the resident because he was a Do Not Resuscitate. She explained the staff instinctively performed the Heimlich maneuver and then suctioned the resident because there was evidence of food particles in his mouth. She confirmed Resident #1 died after this incident. She stated Resident #1 did not require supervision with meals. On [DATE] at 9:14 a.m. an interview was conducted with S3CCC. She stated she was responsible for coding the MDS assessments. She stated in order to make the determination that a resident would need supervision or touch assistance while eating, she would observe the resident to see what they could do without assistance and how much help was required to eat. She stated she would look for swallowing problems and a resident's ability to feed themselves. She stated if a resident was coded as requiring supervision while eating, a CNA should observe the resident while they are eating. She stated she would communicate to the nurses and CNAs when the MDS coding was completed to let them know what the resident needed. She reviewed Resident #1's MDS and confirmed he was coded for supervision or touching assistance with eating and someone should have been observing him while eating. On [DATE] at 11:12 a.m., an interview was conducted with S7CNA. She stated she was familiar with Resident #1 and often cared for him. She stated Resident #1 required assistance and supervision with meals. She said if Resident #1 ate in his room, she would stay with him to assist and would remain in the room the duration of his meal. On [DATE] at 11:15 an interview was conducted with S8LPN. She stated residents care planned and coded on the MDS for supervision with meals should be observed by staff while eating. She stated if a resident ate in their room, staff would check on them frequently while the resident was eating. She stated she was familiar with Resident #1. She stated the resident required more assistance with meals for about week after returning from the hospital in July, but after that he did not need assistance. On [DATE] at 11:28 a.m., an interview was conducted with S14CNA. She stated when residents ate in the dining area there was always staff supervising and assisting the residents. She stated if a resident preferred to eat in their room and required supervision or assistance with meals, the CNA who delivered the tray must remain with that resident until the resident is done eating. She said the nurse would notify her if a resident's care planned changed for the meal supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:15 p.m., an interview was conducted with S15LPN. She stated when residents ate in the dining area there was always staff supervising and assisting the residents. She stated if a resident preferred to eat in their room and required supervision or assistance with meals, the CNA who delivered the tray must remain with that resident until the resident is done eating. She said the nurse should notify the CNA if a resident's care planned changed for the meal supervision. On [DATE] at 4:52 p.m., review of the facility's surveillance video footage with S5ADM revealed the following: On [DATE] at 4:18 p.m., S2CNA entered Resident #1's room to deliver meal tray. On [DATE] at 4:19:49 p.m., S2CNA exited Resident #1's room. On [DATE] at 4:21:51 p.m., S4LPN entered Resident #1's room. On [DATE] at 4:24:55 p.m., S4LPN exited Resident #1's room. On [DATE] at 4:27:02 p.m., S4LPN entered Resident #1's room again and then stepped into the hall way to ask for help. On [DATE] at 4:52 p.m. an observation of the facility's video footage was completed with S5ADM. S5ADM confirmed on [DATE] at 4:18 p.m. S2CNA brought Resident #1 a supper tray and left the room without the tray. He further confirmed from 4:19:49 p.m. to 4:21:51 p.m. and from 4:24:55 p.m. to 4:27:02 p.m., Resident #1 was without supervision with his supper tray in the room. He stated Resident #1 was found by S4LPN at approximately 4:27 p.m. S5ADM stated the resident was described as unresponsive, with no pulse when S4LPN entered the room at 4:27 p.m. He confirmed Resident #1 was left unsupervised in his room with his supper meal. He confirmed Resident #1 died after the incident.