STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Rehabilitation and Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a history of dysphagia (difficulty swallowing) with several episodes of choking which required nursing staff to perform the Heimlich Maneuver (a first-aid procedure for dislodging an obstruction from a person's windpipe in which sudden strong pressure is applied on the abdomen, between the navel and the rib cage), the Facility failed to ensure his/her Dysphagia Care Plan was reviewed and/or revised related to effectiveness of interventions, when he/she remained on the same diet but continued to experience choking episodes and despite recommendations from Speech Therapy to implement a new intervention for direct supervision by staff during all meals, he/she was only supervised from a distance by staff. On 5/02/25, Resident #1 choked on his/her meal and died. Findings include: Review of the Facility's policy, titled Comprehensive Person-Centered Care Plans, with a revision date of March 2022, included the following: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident #1 was admitted to the facility in July 2013, diagnoses included dysphagia, dementia, and right-side hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral vascular accident (CVA/stroke). Review of Resident #1's Significant Change in Status Minimum Data Set (MDS) assessment, dated 05/06/24, indicated he/she scored a 12 out of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests a resident is cognitively intact), required staff supervision for eating, and was on a mechanically altered diet. Review of Resident #1's Incident Investigation, dated 07/09/24, indicated Resident #1 had a choking episode during supper and nursing staff performed the Heimlich Maneuver with success. The Investigation indicated Resident #1's diet was downgraded from diced to ground and a request for a Speech Language Pathologist (SLP) screen was submitted. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Dysphagia Care Plan, reviewed and renewed with the Significant Change in Status MDS assessment, indicated the following interventions were initiated on 07/09/24: *Problem: [The Resident] is at risk for aspiration secondary to dysphagia following CVA. *Interventions included: -Instruct [the Resident] to eat in an upright position, to eat slowly, and to chew and bite thoroughly, -Encourage him/her to eat meals in highly visible areas, -Encourage him/her to take small bites followed by small sips, -Alternate liquids and solids, -Monitor for difficulty swallowing, holding food in mouth, -Monitor for coughing, shortness of breath, choking, labored respiration and or lung congestion. -Refer to SLP as indicated Review of Resident #1's Incident Investigation, dated 08/09/24, indicated Resident #1, who was seated near the Nurses Station, choked during supper and nursing staff performed the Heimlich Maneuver which caused him/her to expel large pieces of unchewed meat and bread. Further review of the Investigation indicated Resident #1 was re-educated to take small bites with small sips and alternate between, Resident #1 continued to be non-compliant with nursing education. Review of Resident #1's Dysphagia Care Plan indicated the following intervention was added on 08/09/24: -Re-educate/Encourage [the Resident] to take small bites alternating with small sips. Offer assistance /cut items such as bread into bite size pieces. Review of Resident #1's SLP Evaluation, dated 08/15/24, indicated Resident #1 reported knowingly overstuffing his/her oral cavity, and swallowing food without fully masticating (chewing) the bolus which led to the choking events. The Evaluation indicated that the SLP recommended a Modified Barium Swallow Study (a special x-ray to evaluate how well a person swallows) but Resident #1's Health Care Agent declined. Further review of the Evaluation indicated the SLP recommended that Resident #1 continue with his/her current diet of ground solids and thin liquids, the need for direct supervision by staff with PO [anything by mouth] and required the following swallow strategies/supervision: -Direct supervision with PO -Upright positioning (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Slow rate of eating -Small bites -Aspiration Precautions -Safe swallow strategies Review of Resident #1's Dysphagia Care Plan indicated no additional interventions were added after the SLP Evaluation was conducted on 08/15/24, despite the recommendation from the SLP that Resident #1 needed direct supervision with po [intake]. Review of Resident #1's Nursing Progress Note, dated 11/25/24, indicated Resident #1 choked on food during his/her evening meal and nursing staff performed abdominal thrusts. The Note indicated Resident #1 had a large mouthful of cheese from pizza which was cleared from his/her mouth and throat. Review of Resident #1's Dysphagia Care Plan, indicated no revisions or additional interventions, including specifically the need for direct supervision by staff during meals per SLP, were entered following Resident #1's episode of choking on 11/25/24. Review of Resident #1's Incident Investigation, dated 12/18/24, indicated Resident #1 was seated at the Nurses' Station eating his/her meal when Nurse #2 heard Resident #1 cough. Nurse #2 assessed Resident #1 and noted that he/she was choking on a piece of broccoli, was unable to talk, and she initiated the Heimlich Maneuver with good effect. Review of Resident #1's Dysphagia Care Plan indicated no revisions, or additional interventions, including specifically the need for direct supervision by staff during meals per SLP, were entered following Resident #1's episode of choking on 12/18/24. During an interview on 06/03/25 at 3:05 P.M., Unit Manager #1 said when a resident choked, they would put in a request for a SLP evaluation. Unit Manager #1 said once a resident was evaluated by an SLP, the recommendations from the evaluation were written and given to her. Unit Manager #1 said Resident #1 and his/her family had been educated about the importance of adhering to his/her diet, but that she had not documented the education. Unit Manager #1 said the education she provided was mostly verbal or over the phone. Unit Manager #1 said she was unable to provide any additional documentation regarding Resident #1's SLP Evaluation conducted on 8/15/24, and was unable to offer an explanation as to why the recommendation for the addition of an intervention for nursing to provide direct supervision during meals was never added to the care plan or implemented. During a telephone interview on 06/04/25 at 8:24 A.M., Nurse #3 said Resident #1 always ate his/her meals at the Nurses Station. Nurse #3 said Resident #1 was at a very high risk for choking and that we all knew the sound Resident #1 made when he/she was choking. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #3 said staff was always within earshot of Resident #1 during mealtimes, but that no one staff member was assigned to stay with Resident #1 while he/she was eating to provide direct supervision. Further review of Resident #1's medical record indicated there was no documentation to support that nursing made any additional referrals to Speech for Resident #1 for additional SLP evaluations following his/her choking episodes on 11/25/24 and 12/18/24, or that SLP's recommendation for direct supervision during meals was added to his/her Dysphagia Care Plan as an intervention. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/02/25, which included the Facility Investigation indicated Resident #1 was observed by a staff member to be eating lunch at the Nurses Station when the staff member noticed that Resident #1's lips were blue. The staff member summoned help from nearby nursing staff, who initiated the Heimlich Maneuver with assistance from Emergency Medical Technician's (EMTs), who were in the facility for a different resident, but Resident #1 lost consciousness and died at the facility. During a telephone interview on 06/04/25 at 1:24 P.M., the Director of Nurses (DON) said after Resident #1's SLP Evaluation on 8/15/24, the recommendation for direct supervision by staff during meals was not added to his/her care plan as an intervention. The DON also said, despite Resident #1 continuing to experience choking episodes while eating meals, there were no new interventions added and no changes were made to Resident #1's Dysphagia Care Plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a history of dysphagia (difficulty swallowing), was identified to be at increased risk for aspiration, with multiple choking episodes which required the nursing staff to perform the Heimlich Maneuver (a first-aid procedure for dislodging an obstruction from a person's windpipe in which sudden strong pressure is applied on the abdomen, between the navel and the rib cage), and for whom Speech Therapy had recommended the need for direct supervision by nursing staff while eating, the Facility failed to ensure they provided an adequate level of staff supervision for Resident #1 in an effort to maintain a safe environment, when on 5/02/25, he/she choked again on his/her meal, and although nursing staff performed the Heimlich Maneuver, Resident #1 died. Findings include: Review of the Facility's policy, titled Accidents and Incidents, with a revision date of April 2024 included the following: -It is the policy of the Facility to provide a safe and healthful work environment. -Definition of an incident: Any event occurring by chance or arising from unknown cause which is not consistent with the desired operation of the facility or the care of the resident. -The following data, as it may apply, must be obtained: Corrective action taken. Resident #1 was admitted to the facility in July 2013, diagnoses included dysphagia, dementia, and right-side hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral vascular accident (CVA/stroke). Review of Resident #1's Documentation of Resident Incapacity Pursuant to the Massachusetts Health Care Proxy Law, indicated Resident #1 lacked the capacity to make, or to communicate, health care decisions and his/her HCP was invoked indefinitely, as of 05/09/24, due to moderate dementia. Review of Resident #1's Significant Change in Status Minimum Data Set (MDS) assessment, dated 05/06/24, indicated he/she scored a 12 out of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests a resident is cognitively intact), required staff supervision for eating, and was on a mechanically altered diet. Review of Resident #1's Incident Investigation, dated 07/09/24, indicated Resident #1 had a choking episode during supper and nursing staff performed the Heimlich Maneuver with success. The Investigation indicated Resident #1's diet was downgraded from diced to ground and a Speech Language Pathologist (SLP) screen was submitted. Review of Resident #1's SLP Progress Note, dated 07/10/24, indicated the SLP attempted to evaluate Resident #1 and he/she refused the evaluation. Review of Resident #1's Physician's Order Report, dated August 2024, included an order for ground diet with thin liquids at all meals, along with a lip plate and adaptive cup. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Incident Investigation, dated 08/09/24, indicated Resident #1, who was seated near the Nurses Station, choked during supper and nursing staff performed the Heimlich Maneuver which caused him/her to expel large pieces of unchewed meat and bread. Further review of the Investigation indicated Resident #1 was re-educated to take small bites with small sips to alternate between, and that Resident #1 continued to be non-compliant with nursing education. Review of Resident #1's SLP Evaluation, dated 08/15/24, indicated Resident #1 reported knowingly overstuffing his/her oral cavity, and swallowing food without fully masticating (chewing) the bolus which led to the choking events. The Evaluation indicated that the SLP recommended a Modified Barium Swallow Study (a special x-ray to evaluate how well a person swallows) but Resident #1's Health Care Agent declined. Further review of the Evaluation indicated the SLP recommended that Resident #1 continue with current diet of ground solids and thin liquids and that he/she needed direct supervision with PO [anything by mouth], and he/she required the following swallow strategies/supervision: -Direct supervision with PO -Upright positioning -Slow rate of eating -Small bites -Aspiration Precautions -Safe swallow strategies Review of Resident #1's Dysphagia Care Plan indicated no additional interventions were added after the SLP evaluation dated 08/15/24, despite the recommendation from the SLP for him/her to receive direct supervision from staff with po [intake]. Review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, dated 10/25/24, indicated he/she scored an 8 out of 15 on his/her BIMS, was on a mechanically altered diet, and required supervision at meals. Review of Resident #1's Nursing Progress Note, dated 11/25/24 and signed by Nurse #3, indicated Resident #1 choked on food during his/her evening meal and nursing staff performed abdominal thrusts. The Note indicated Resident #1 had a large mouthful of cheese from pizza which was cleared from his/her mouth and throat. The Note indicated that Resident #1 allowed staff to cut his/her food following the choking episode. Review of Resident #1's Incident Investigation, unsigned and dated 11/25/24, indicated Resident #1 choked during supper and nursing staff performed abdominal thrusts with good effect. The Investigation indicated Resident #1's invoked Health Care Agent was notified and refused for Resident #1's diet to be downgraded. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 06/04/25 at 8:24 A.M., Nurse #3 said she was on duty for the 3:00 P.M. through 11:00 P.M. (evening) shift on 11/25/24. Nurse #3 said Resident #1 always ate his/her meals at the Nurses Station. Nurse #3 said Resident #1 ate a piece of pizza for the evening meal and choked on a large piece of cheese. Nurse #3 said she had to perform abdominal thrusts to help clear Resident #1's mouth and airway. Nurse #3 said Resident #1 was at a very high risk for choking and that we all knew the sound Resident #1 made when he/she was choking. Nurse #3 said staff was always within earshot of Resident #1 during mealtimes, but that no one staff member was assigned to stay with Resident #1 while he/she was eating to provide direct supervision. Review of Resident #1's Incident Investigation, dated 12/18/24 and signed by Nurse #2, indicated Resident #1 was seated at the Nurses' Station and eating his/her meal when Nurse #2 heard Resident #1 cough. The Investigation indicated Nurse #2 assessed Resident #1 and noted that he/she was choking on a piece of broccoli, was unable to talk and Nurse #2 initiated the Heimlich Maneuver with good effect. During an interview on 06/03/25 at 3:20 P.M., which included a review of his written statement, Nurse #2 said he was on duty during the evening shift on 12/18/24, and was at the Nurses Station when he heard Resident #1's voice changing and he knew he/she was choking. Nurse #2 said he performed the Heimlich Maneuver and Resident #1 coughed out a full piece of broccoli. Nurse #2 said that a referral for Resident #1 to have an evaluation by SLP should have been done, but that he did not put one in, and said that he had already done his part. Nurse #2 said Unit Manager #1 should have followed up on the need for a SLP referral. Review of Resident #1's medical record indicated that although he/she experienced two additional incidents of choking on food after his/her 8/15/24 SLP Evaluation, which required nursing staff to perform the Heimlich Maneuver, there was no documentation to support that nursing staff provided direct supervision during meals as recommended by SLP Therapy. Review of Resident #1's Physician's Orders, for the month of May 2025, included an order for a ground diet with thin liquids at all meals, along with a divided plate and adaptive cup. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 05/02/25, indicated Resident #1 was observed by a staff member to be eating lunch at the Nurses Station when the staff member noticed that Resident #1's lips were blue. The staff member summoned help from nearby nursing staff. That nursing staff initiated the Heimlich Maneuver with assistance from Emergency Medical Technician's (EMTs) who were in the facility for a different resident, and that Resident #1 lost consciousness and died at the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/03/25 at 2:09 P.M., which included review of her written statement, Nurse #1 said she was on duty on 05/02/25 during the 7:00 A.M. through 3:00 P.M. (day shift). Nurse #1 said she was standing at her medication cart on one side of the Nurses Station around 12:00 P.M., Resident #1 was seated near the Nurses Station, and two staff members were on the other side of the Nurses Station talking to each other when one of them called out that Resident #1 appeared to be choking. Nurse #1 said that Nurse #4 initiated the Heimlich Maneuver on Resident #1 and green mush was coming out of his/her mouth. Nurse #1 said EMTs were on the unit for a different resident and assisted nursing staff with bringing Resident #1 to his/her room to continue with abdominal thrusts and back blows, but said the interventions were unsuccessful. Nurse #1 said that Resident #1 always sat at the Nurses Station during mealtimes and that Resident #1 often needed to be reminded by staff to slow down and chew his/her food. Nurse #1 said there was no specific staff person or formal assignment for a staff member to provide supervision for Resident #1. Nurse #1 said whoever was at the Nurses Station would supervise him/her. The Surveyor was unable to interview Nurse #4, as he did not respond to the Department of Public Health's telephone or letter requests for an interview. During an interview on 06/03/25 at 1:18 P.M., which included review of her written statement, Certified Nurse Aide (CNA) #1 said she was on duty during the day shift on 05/02/25. CNA #1 said that Resident #1 often ate too fast and choked all the time, that it was normal for him/her. During an interview on 06/03/25 at 1:37 P.M., which included review of her written statement, CNA #2 said she was on duty during the day shift on 05/02/25. CNA #2 said Resident #1 ate his/her meals at the Nurses Station and there was no one specifically assigned to supervise Resident #1 because we are just all around. During a telephone interview on 06/05/24 at 8:16 A.M., CNA #3 said she was on duty during the day shift on 05/02/25. CNA #3 said Resident #1 was able to feed him/herself and eat his/her meals at the Nurses Station. CNA #3 said she was passing meal trays to residents in their rooms when she heard staff calling for help. During a telephone interview on 06/06/25 at 8:01 A.M., CNA #4 said she was on duty during the day shift on 05/02/25. CNA #4 said Resident #1 ate his/her meals at the Nurses Station and she did not think anyone was specifically assigned to supervise him/her while he/she was eating. Although staff said Resident #1 was seated during meals in front of the nursing station so they could watch him/her, staff said they were also passing out meal trays, administering medications or performing other tasks, and that there was no staff member specifically assigned to sit with and directly supervise him/her while eating. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/03/25 at 3:05 P.M., which included a review of her written statement, Unit Manager #1 said she was on duty during the day shift on 05/02/25. Unit Manager #1 said she was in her office when she heard a nurse calling for help. Unit Manager #1 said she came out of her office and saw Resident #1 seated at the Nurses Station and Nurse #4 performing abdominal thrusts on him/her. Unit Manager #1 said she performed back blows on Resident #1, and he/she coughed up chewed up pieces of broccoli and phlegm. Unit Manager #1 said they brought Resident #1 to his/her room where she (Unit Manager #1) and Nurse #4 continued with the Heimlich Maneuver. Unit Manager #1 said Resident #1 became unresponsive, EMTs were already at the Facility and confirmed that Resident #1 was in asystole (complete absence of a heartbeat) and Resident #1 was pronounced dead. Unit Manager #1 said Resident #1 refused to slow down when he/she ate and would stuff his/her mouth with food. Unit Manager #1 said Resident #1 and his/her family were educated about the importance of adhering to his/her diet, but that she did not document the education. Unit Manager #1 said the education was mostly verbal or over the phone. Unit Manager #1 said that the Unit Secretary or the Nurses on duty were expected to provide supervision for residents who ate their meals at the nurses station, but that there was no specific staff person assigned to provide the supervision. Unit Manager #1 said when a resident choked, they would put in a request for a SLP evaluation. Unit Manager #1 said when nursing staff called her to report a choking incident, she would remind them to put in a request for a SLP evaluation. Unit Manager #1 said once a resident was evaluated by an SLP, the recommendations from the evaluation were written and given to her. Unit Manager #1 said she was unable to provide any additional documentation for the surveyor during the survey related to the SLP Therapy Evaluation from 8/15/24, that recommended Resident #1 needed direct supervision from staff during PO (intake). During an interview on 06/03/25 at 2:40 P.M., the Rehabilitation Director said that residents were often referred to SLP for an evaluation due to choking or coughing episodes. The Rehabilitation Director said when he received a request for a resident to be evaluated due to choking, he made those requests a priority. The Rehabilitation Director said he was unable to provide any documentation to support that any additional SLP screens and/or evaluations were requested by the nursing staff for Resident #1 after the SLP evaluation that was completed on 08/15/24. During a telephone interview on 06/04/25 at 3:51 P.M., Speech Language Pathologist (SLP) #2 said he had worked with Resident #1 off and on over the years. SLP #2 said that he had observed Resident #1 several times, that due to his/her cognitive deficits and right-hand tremor, he/she had difficulty eating and did not always understand what he/she should be doing. SLP #2 said that when SLP makes a recommendation for direct supervision, it means that the resident requires a staff member to always be present with the resident during the entire time while eating and even if a resident was able to physically feed him/herself, they may need constant cueing for safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 06/04/25 at 8:33 A.M., the Registered Dietician (RD) said Resident #1 ate his/her meals seated at the Nurses Station and said she considered that to be distant supervision. RD #1 said direct supervision meant a staff member who was certified in Cardiopulmonary Resuscitation (CPR) always had their eyes on a resident and did not walk away or have any other tasks to do during mealtimes. During a telephone interview on 06/04/25 at 1:24 P.M., the Director of Nurses (DON) said that it was her expectation that a referral to SLP would have been done after Resident #1's choking incidents on both 11/25/24 and 12/18/24. The DON said she was unable to find documentation to support that, but said it was facility protocol to refer a resident to SLP following any episodes of choking. The DON said that the SLP was the one to determine what level of supervision was required at mealtimes. The DON reviewed the SLP evaluation completed on 08/15/24 which included a recommendation from SLP for Resident #1 to have direct supervision when having anything by mouth. The DON said after Resident #1 had choking choking incidents on 11/25/24 and 12/18/24, he/she continued to receive distant supervision by staff at the Nurses Station when eating. The DON said that if Resident #1 required direct supervision, per the 8/15/24 SLP recommendation, that it meant that a staff member would be required to sit with him/her during mealtimes.