

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Warroad Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Lake Street Northwest Warroad, MN 56763	

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)
<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569</p> <p>Based on observation, interview and document review the facility failed to provide the physician ordered mechanically altered diet for 1 of 3 residents (R1) reviewed who was at risk for choking and served the wrong textured diet. This resulted in an immediate jeopardy (IJ) for R1.</p> <p>The IJ began on 5/28/24, when R1 was served a regular diet instead of the physician ordered pureed diet which resulted in R1 choking and requiring the Heimlich Maneuver to dislodge a corn dog. The administrator was notified of the IJ on 6/12/24, at 3:21 p.m. The IJ was removed on 6/13/24, at 1:15 p.m., but noncompliance remained at the lower scope and severity level D, with no actual harm with potential for more than minimal harm that was not immediate jeopardy.</p> <p>Findings include:</p> <p>R1's Transfer/Discharge Report (no date) identified diagnosis that included Dysphagia (difficulty swallowing), quadriplegia and dementia.</p> <p>R1's Care Area Assessment (CAA) dated 10/9/23, identified swallowing problems and cognitive loss. The CAA indicated a swallowing evaluation was completed and a pureed, pudding thick diet was recommended. The CAA indicated R1 usually required total assistance from staff for eating and drinking and continued to cough at times when swallowing.</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he had upper extremity impairments on both sides. The MDS indicated R1 received a mechanically altered diet and was dependent on staff to eat.</p> <p>R1's care plan updated 5/30/24, identified a self care deficit and directed staff to provide total assistance to eat. The care plan further identified a nutritional problem due to dysphagia and directed staff to provide/serve diet as ordered: pureed texture, nectar thick liquids. Ensure upright position and remain upright for 30 minutes after meals.</p> <p>A facility Risk Review dated 4/24/24, indicated the recommended diet for R1 was pureed texture with nectar thick liquids. The report indicated R1 was an aspiration/choking risk. The report identified risks that included: choking, shortness of breath, poor communication abilities, aspiration pneumonia that could lead to hospitalization and potentially death.</p> <p>(continued on next page)</p>

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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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Order Summary Report printed 6/17/24, identified an order dated 11/7/23, pureed texture diet with nectar thick liquids related to Dysphagia.</p> <p>A facility document titled Lake Dining, updated 5/29/24, indicated R1's diet was pureed with nectar thick liquids.</p> <p>R1's Progress Note dated 5/28/23, indicated at 6:00 p.m., author walked into dining room. Upon entering, nursing assistant (NA) was performing Heimlich maneuver on R1. Food noted to be dislodged. Noted that resident was nectar thick with pureed food. Resident denied any pain or discomfort. No bruising noted. Physician notified of incident with orders to monitor for pain in ribs and/or while breathing. Physician did not feel an x-ray was appropriate at this time. Education was provided to NA about following care plan.</p> <p>A facility investigation dated 6/5/24, indicated on 5/28/24, R1 received a regular textured diet instead of the physician ordered pureed diet.</p> <p>During interview on 6/12/24 at 8:51 a.m., the activity director (AD) said she assisted with feeding residents. The AD said she went to the serving window and told the staff who she wanted food for and they gave it to her. When asked if she knew where to look for a residents diet type, the AD said, I just know so I tell my staff. The AD said the diets were also posted in the kitchenette.</p> <p>During observation on 6/12/24 at 11:51 a.m., activity aide (AA)-A was passing out food to residents in the dining room. AA-A was observed going to a window in the dining room where kitchen staff served the meal. AA-A would request food for a resident, dietary aide (DA)-A plated the food and AA-A brought food to the residents.</p> <p>During interview on 6/12/24 at 12:05 p.m., DA-A was asked how she knew what texture to serve the residents. DA-A said the diets were posted on the wall in the kitchenette and she had received training so she knew what to serve. The diets were observed hanging on the wall in the kitchenette and identified a pureed diet for R1. DA-A was asked to identify which food was pureed and pointed to a container with ground meat and gravy (mechanical soft, not pureed). When asked about reference materials related to textures, DA-A said there were none.</p> <p>During observation on 6/12/24 at 12:07 p.m., R1 was seated at a table in the dining room with NA-A. Across the table licensed practical nurse (LPN)-A was seated, assisting another resident to eat. R1's meal consisted of mashed potatoes with gravy and ground hamburger with gravy (mechanical soft). When asked about the texture of R1's hamburger, NA-A described the hamburger as minced and moist. NA-A said pureed food should have been put in a blender. Surveyor intervened before R1 was served incorrect diet.</p> <p>During interview on 6/12/24 at 12:17 p.m., cook (C)-A described a pureed diet and said they placed the food into the blender and blended until it looked like pudding. C-A said the finely ground meat was mechanical soft. C-A accompanied surveyor to R1's unit and verified pureed hamburger had been available and verified what R1 had received was not the correct diet.</p> <p>During a subsequent interview on 6/12/24 at 12:23 p.m., DA-A was asked why she had served R1 a mechanical soft diet. DA-A stated the girl in the colorful shirt (NA-B) asked for his ground food.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During interview on 6/12/24 at 12:54 p.m., AA-A stated she assisted with meal service and served coffee and snacks. AA-A said if she was not sure what to serve, she would ask a nurse. AA-A stated she would not know the difference between the different textured diets and said she expected the dietary staff to serve the right diet.</p> <p>During interview on 6/12/24 at 12:58 p.m., NA-B stated R1 was prescribed a pureed diet and said she had delivered R1's food to the table and said he had mashed potatoes but the meat was not pureed. NA-B acknowledged she should not have served the food if she was aware it was not correct. NA-B stated she served the ground meat to R1 because she did not think they had the right food available.</p> <p>During interview on 6/12/24 at 12:28 p.m., registered nurse (RN)-A stated R1 had a recent choking event on 5/28/24. RN-A said she had walked into the dining room and witnessed a NA performing the Heimlich Maneuver on R1. RN-A said the NA had dislodged a mini corn dog. RN-A stated the nursing assistant care guides listed the residents diets and said R1 was ordered a pureed diet with nectar thick liquids. RN-A stated staff were supposed to view the care guides at the beginning of their shift.</p> <p>On 6/12/24 at 1:17 p.m., the director of nursing (DON) and the dietary manager (DM) were interviewed. The DON stated when R1 had choked on 5/28/24, it appeared the NA had gone to the serving window and got a regular diet. The DON stated the NA served R1 the regular diet which resulted in R1 choking on the corn dog and required the Heimlich maneuver to dislodge the food. The DON stated the NA had been re-educated immediately following the incident and said all residents orders had been reviewed and posted in the kitchenettes for the dietary staff. No other staff involved in meals received re-education. The DM stated the servers should look at the chart in the pantry for the residents specific diet order and use that when serving. The DM acknowledged the servers did not have a visual guide that showed what each texture should look like but said they completed annual training that contained visual aides.</p> <p>Facility policy Texture and Consistency- Modified Diets dated 4/18/21, indicated the food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered. Care will be take to serve the foods and fluids as ordered on the consistency altered diet or fluids.</p> <p>The IJ was removed on 6/13/24, when it was verified through observation, interview and document review the facility completed the following:</p> <ul style="list-style-type: none"> - Reviewed and revised policies and procedures related to serving resident meals and ensuring residents receive correct textured meals. - Educated to procedures and revisions as appropriate. - Educated dietary and all staff who serve resident food to recognize each specific diet type/textured meal. - Educated dietary staff related to the importance of serving the correct diets to residents. - Educated all staff who serve resident food items on the importance of checking the diet slip, ensure the resident is getting the correct textured food, and then delivering the correct diet order to the resident. <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Developed and implemented a plan to complete all training before each staff worked their next shift.</p>		