STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Healthcare Rehabilitation and Skilled Nurs	2501 Rice Lake Road Duluth, MN 55811

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790 Based on observation, interview and document review, the facility failed to provide proper supervision during meals to prevent choking for 2 of 3 residents (R1, R2) who required 1:1 supervision during meals. This deficient practice resulted in an immediate jeopardy (IJ) for R1 and R2 when they were not provided 1:1 supervision during meals, and R1 had a coughing episode and R2 fell asleep with food in his mouth. The IJ began on 8/13/24 when R2 was found alone at the dining table sleeping with food in his mouth. The director of nursing (DON) and administrator were notified of the immediate jeopardy at 5:07 p.m. on 9/3/24. The IJ was removed on 9/4/24, but noncompliance remained at the lower scope and severity level of D - isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Provider Orders dated 7/8/24, indicated R1 had a regular diet with chopped texture, and nectar mild thick liquids. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 held food in his mouth and cheeks, or held residual food in his mouth after meals. R1 was on a mechanically altered diet, and needed limited assistance with eating. R1's care plan dated 7/2/24, indicated R1 had dysphagia (difficulty swallowing) and needed 1:1 close supervision in dining room for meals. R1 also required cues to alternate small bites and small sips, and take multiple swallows to clear food from his mouth and avoid choking. On 8/1/24 a therapy progress note written by physical therapist (PT)-A indicated trained medical assistant (TMA)-A administered R1's medications in the therapy gym. R1 became red in the face and attempted to cough, but was he was unsuccessful with clearing the medications by coughing. R1's inhalation was noted to be very wet (occurs when lungs fill with fluid and not air) PT-A provided three back thrusts to R1 when coughing, and R1 coughed up one large pill. R1 continued to have wet inhalation and exhalation with a poor cough. PT-A provided five more back thrusts, and R1 was able to clear a small amount of applesauce and one small white pill. R1 coughed intermittently throughout the session, and coughed up one more large white pill. PT-A notified licensed practical nurse (LPN)-A of the incident. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/1/24, at 3:50 p.m. an email from PT-A was sent to the DON, administrator, and facility nurse managers, and indicated R1 had a severe choking episode with his medications that morning. R1 needed back thrusts from PT-A several times cough up medications he was choking on. PT-A was concerned R1 aspirated (breathed liquid or food into lungs) as he continued to cough for 30 minutes. PT-A had notified LPN-A. A Therapy Note dated 8/2/24 written by speech therapist (ST)-A, indicated R1 needed 1:1 assistance/close supervision at all mealtimes due to him being a choking risk. On 8/29/24 a therapy progress note written by PT-A indicated R1 was at the breakfast table, and PT-A heard R1 coughing heavily with a mouth full of food. R1 was able to scoop food out of his mouth with his hands. Nursing staff was notified R1 needed to be on 1:1 supervision with meals, and there were no staff in the dining area with R1 when he began coughing. On 8/29/24 at 9:35 a.m. an email from physical therapy sent to the DON, administrator, and RN-A indicated R1 was on a chopped diet, and continued to have coughing episodes with eating. The note indicated R1 was not being supervised during meals. R1's meal ticket and speech recommendations indicated R1 should be on 1:1 supervision with meals which was not happening. R1's medical record lacked indicaton of the coughing episodes on 8/1/24 and 8/29/24. On 8/30/24 at 8:48 a.m., R1 was observed being given his meal of scrambled eggs, chopped coffee cake with syrup, oatmeal, and nectar thick milk. R1 was sitting at a table alone with his back towards the nurse's station. Three nursing assistants were in the dining area were passing trays, but no staff were providing R1 with 1:1 supervision. R1 was putting spoonful's of the coffee cake in his mouth before swallowing the previous bite. R1 did not cough or choke during the observation. At 8:56 a.m., nursing assistant (NA)-A was called to the nurse's station by RN-A. NA-A came back into the dining area, and sat with R1 while he was feeding himself. On 8/30/24 at 9:05 a.m., NA-A got up for the table as R1 was still eating, went out of the dining room talked with a staff member. NA-A came back to the dining room less than a minute later and patted another resident at a different table on the back to say hello, went back to R1's table and stood next to the table. R1's meal ticket indicated supervision at all meals. R2's Provider Orders dated 8/12/24, indicated regular diet with chopped texture and thin liquids. R2's admission MDS dated [DATE], indicated R2 had aphasia (disorder that affects communication), had a mechanically altered diet, no swallowing disorder, and needed supervision when eating. R2's care plan revised 8/14/24, indicated R2 needed 1:1 supervision and assist with all meals. On 8/13/24 a therapy progress note written by PT-A indicated R2 was found in the dining room hunched over toward his left side. R2's mouth was closed with visible pocketing of food in his left cheek. R2 was unarousable to sternal rub (firm rub on sternum) and trap pinch (gripping and twisting of trapezius muscle in shoulder). PT-A questioned staff on how long R2 had been like that, and staff stated he was tired. After several minutes, R2 was aroused and able to swallow the food in his mouth. The nurse manager was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/13/24 at 1:09 p.m. an email from therapy sent to RN-D, the DON, and the therapy director asked if R2 could be placed within staff's line of sight for meals. PT-A found him at the table with food in his mouth slumped over. He required multiple sternal rubs, trap pinch, and shaking to arouse. On 8/30/24 at 8:09 a.m., R2 was observed being given his meal of chocolate milk, scrambled eggs, chopped coffee cake with syrup, oatmeal, orange juice and coffee. R2 was not being provided with 1:1 supervision. R2 was eating at a fast pace, and was not swallowing what was in his mouth prior to putting more food in his mouth. R2 was drinking fluids while eating. Four staff members (NA-B, NA-C, NA-D and one unidentified staff) were in the dining room passing meal trays, and no staff was sitting with R2, or cued him to slow down. On 8/30/24 at 12:10 p.m., R2 was observed being served his lunch. R1 had white bread with the crust cut off, parmesan zucchini casserole, broccoli, peach chunks, and milk. Staff did not provide him with 1:1 supervision. On 8/30/24 at 9:13 a.m., NA-A stated R1 needed 1:1 supervision with all of his meals, and that plan had been in place for a few weeks. R1 required staff to sit next to him because he would stuff his mouth with food, and staff would have to remind him to slow down. On 8/30/24 at 11:16 a.m., R1 was interviewed and was able to shake/nod his head with yes or no answers. When asked if staff sat with him for all of his meals, R1 shook his head no. When asked if he had ever choked on his food or medications at the facility, R1 nodded his head yes. When asked if he had choked recently, R1 nodded his head yes. On 8/30/24 at 11:24 a.m., health unit coordinator (HUC)-A stated she had never seen R2 with 1:1 supervision during meals when she worked. She sat at the 2nd floor desk and had direct vision of the dining room. On 8/13/24 she saw R1 asleep at the table with food in his mouth, and no staff were around. HUC-A did not alert any of the staff he was asleep with food in his mouth, nursing staff were aware of who needed assistance as it was listed at the desk. On 8/30/24 at 12:34 p.m., NA-B stated 1:1 supervision with meals meant staff needed to sit next to the resident to make sure they did not choke. She had never seen R2 with 1:1 supervision with meals. She had been told only 10 minutes ago R2 required 1:1 supervision, and that was why no one was sitting with him during his lunch meal. On 8/30/24 at 12:39 p.m., NA-A stated they were passing trays at breakfast time, and that was why no staff were providing 1:1 supervision with R1 at the beginning of breakfast. NA-A stated 1:1 supervision meant someone needed to be right next to R1. On 8/30/24 at 1:09 p.m., R2 stated since he was admitted to the facility, no staff had ever sat with him during meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/30/24 at 1:36 p.m., ST-A stated she recommended R1 have 1:1 close supervision at all meals, and this was not happening. When she recommended 1:1 supervision, it meant nursing staff were to sit with the resident when they received their meal until they were done eating. It also meant staff needed to provide cues while eating. R1 had swallowing impairments, had a modified diet, and would shovel food in his mouth. If R1 did not have 1:1 supervision with meals, he could choke, aspirate, or possibly die. R2 was recommended to have 1:1 supervision with all meals. She had seen R2 eating alone in the dining room without 1:1 supervision. On 8/30/24 at 1:49 p.m., NA-C stated staff does not sit with R2 during meals, he normally eats alone. On 8/30/24 at 1:55 p.m., occupational therapist (OT)-A stated R1 had not had 1:1 supervision during meals on more than one occasion, but was unable to identify dates or meal times when this had occurred. On 9/3/24 at 6:58 a.m., LPN-A stated on 8/1/24 after the choking incident with R1 in the therapy room, the facility had switched his medications to being crushed per therapy request after ST-A saw R1. She was unaware if R1's provider had given an order for crushed medications, or if pharmacy was aware. On 9/3/24 at 7:18 a.m., TMA-A stated on 8/1/24 after R1 choked on his medications, ST-A saw him right away and stated to crush R1's medications moving forward. On 9/3/24 at 8:09 a.m., RN-A stated on 8/29/24 she received an email from the therapy department in regards to R1 coughing on his food. She emailed the nurse practitioner (NP)-A, and got orders for OT/ST to evaluate and treat R1, and an order for a swallow study to be completed. She assessed R1 on 8/29/24, and he was stable with clear lung sounds. She forgot to document her assessment and the NP update in R1's medical record. On 9/3/24 at 9:07 a.m., PT-A stated on 8/13/24, R2 was in the dining room for lunch, sitting [NAME] at a table hunched over in his chair. She could see food in R2's mouth. She tried a sternal rub and trap pinch on R1, but he was not waking up. NA staff came over and they where able to arouse him. On 8/29/24 at breakfast, R1 was sitting at a table in the dining room without 1:1 staff supervision, and was shoveling food into his mouth. She tried to cue R1 to stop, and he started scooping the food out of his mouth with his hands as he was coughing. There was no staff to provide R1 with 1:1 supervision, so she stayed with him while he ate. She sent an email to management about the incident. PT-A stated the response she got from management was R2 was just tired. On 9/3/24 at 9:23 a.m., HUC-A stated on 8/13/24, at lunch time R2 was sitting at the table in and out of sleep as he was eating. No one was sitting with R2, there was a nursing assistant in the dining room at first, but then they left the area as R2 was still eating. PT-A then came to the unit and R2 was asleep with food in his mouth. PT-A tried to wake R2, she finally got R2 to open his eye after several minutes, and there were still no NAs around. On 9/3/24 at 9:30 a.m., ST-A stated R2 had a history of aspiration prior to being 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	On 9/3/24 at 9:31 a.m., the medical director (MD)-A stated he was aware of the concerns with 1:1 supervision during meals, and this was not being followed at the facility. Staff were expected to follow ST recommendations. If a resident was coughing on their food, a nurse should be notified to assess the resident, including putting the assessment in the resident's medical record. On 9/3/24 at 9:39 a.m., RN-E stated on 8/29/24 in the morning, therapy came to her and stated R1 had too many sausages in his mouth. When RN-E went into the dining room, PT and OT were the only ones with R1. NAs were passing trays. R1 was supposed to have supervision with him when he was eating, She was not sure how far from R1 they could be when providing supervision, so RN-E kept an eye: on him. On 9/3/24 at 9:44 a.m., DON stated staff were to follow the residents care plan and assist them per therapy recommendations. 1:1 supervision meant staff were to sit next to a resident when they were eating. On 9/3/24 at 9:56 a.m., the administrator stated staff were expected to follow therapy recommendations when it came to 1:1 supervision at meals. On 9/3/24 at 3:56 p.m., nurse practitioner (NP)-A stated R1's diagnoses and tendencies when eating put him at high risk for aspiration pneumonia. On 9/3/24 at 4:40 p.m. (NP)-B stated R2 was at a higher risk for aspiration pneumonia due to his stroke and speech therapy concerns. The facility policy Activities of Daily Living- Dining/ Meal Assistance dated 6/8/22, directed supervision means observation while eating and 1:1 direct supervision means cueing and physical assist. The immediate jeopardy that began on 8/13/24, was removed on 9/4/24 when the facility reviewed and revised their current policy on meal assistance. The facility reviewed all resident care plans/Kardex to reflect current ST recommendations. The facility implemented a new system for therapy recommendations. The facility completed staff education on the meal assistance policy with post quiz. The facility completed audits on all residents who needed assistance or supervision with meals to ensure they were being assisted or supervised. This was verified through observation, interview and document review.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 47790 Based on interview and document review, the facility failed to provide mandatory training on the facility specific QAPI (Quality Assurance and Performance Improvement) program to include goals and various elements of the program, how the facility intends to implement the program, staff's role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program to all staff reviewed for QAPI training. Findings include: On 9/5/24 at 10:59 a.m., nursing assistant (NA)-C stated she does not recall ever being offered or receiving QAPI training. She would not know where to bring concerns in regards to QAPI, and does not even know what QAPI means for the facility. On 9/5/24 at 11:04 a.m., licensed practical nurse (LPN)-A stated she was not aware of ever receiving QAPI training or it being offered. She was unaware of the facility's QAPI plan. On 9/5/24 at 11:11 a.m., registered nurse (RN)-E stated she does not recall ever having QAPI training. She does not know what the QAPI plan is for the facility. On 9/5/24 at 11:21 a.m., the director of nursing (DON) stated all staff should be educated on QAPI. On 9/5/24 at 11:28 a.m., the administrator stated they discuss QAPI often, but there has been no formal education for staff by the facility. Review of the facility's Relias training (computer based training program) lacked indication of QAPI training for employees.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47790 Based on interview and document review, the facility failed to ensure completion of 12 hours of annual in-service training for 2 of 5 nursing assistants (NA-A, NA-D) reviewed for annual training. Findings include: NA-A's Relias education (facility's computer based education system) indicated on 9/5/24, NA-A had 8.57 hours of the required 12 hours of training in the last 12 months. NA-D's Relias education indicated on 9/5/24, NA-D had 3.5 hours of the required 12 hours of training in the last 12 months. On 9/5/24 at 11:14 a.m., NA-A stated the facility reminded her to do her continuing education almost daily, but NA-A had forgotten to get it completed. She has several modules overdue, and that was why she had not reached her 12 hours of training this year. On 9/5/24 at 11:21 a.m., the director of nursing (DON) stated all NAs were expected to complete the training by the due date. She expected all NAs to complete their 12 hours of training each year. On 9/5/24 at 11:28 a.m., the administrator stated NAs were expected to complete their 12 hours of training on time.