

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Latta Road Nursing Home East		STREET ADDRESS, CITY, STATE, ZIP CODE 2102 Latta Road Rochester, NY 14612	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49686</p> <p>Based on interviews and record review conducted during an Abbreviated Survey (NY00348559) for one (Resident #4) of three residents reviewed, the facility did not ensure that an incident was thoroughly investigated to rule out potential abuse, neglect, mistreatment, or a care plan violation. Specifically, Resident #4 had a choking episode that resulted in hospitalization . The facility was unable to provide documented evidence (including, but not limited to, statements from involved staff members or potential witnesses) that the incident was thoroughly investigated to rule out potential abuse, neglect, mistreatment, or a care plan violation. This is evidenced by the following:</p> <p>The facility policy Resident Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property-Prohibition, Investigation, and Reporting, dated 06/24/2024, documented the facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>The facility policy Nurse Guidelines, Resident Incident Reports dated February 2023 documented that an incident report should include specific information and only known facts about the incident, and staff should be interviewed during the shift when the incident is first noted.</p> <p>The facility policy Aspiration Precautions Protocol, dated December 2023, documented that a resident's meal tray should be checked with the meal tray ticket or card for accuracy.</p> <p>Resident #4 had diagnoses that included hemiplegia (paralysis on one side of the body), following cerebral infarction (stroke), dysphagia (difficulty swallowing), and dementia.</p> <p>The Minimum Data Set Resident assessment dated [DATE] (prior to the incident) documented the resident had moderately impaired cognition and was on a mechanically altered diet (food is chopped, ground, or pureed to make swallowing easier) and required set-up assistance for meals.</p> <p>Review of the resident's Comprehensive Care Plans, revised 03/13/2024, revealed that Resident #4 was on a ground/soft diet.</p> <p>Review of the Speech Language Pathology evaluation dated, 03/13/2024, revealed Resident #4 was on a ground/soft diet with thin liquids.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a nursing progress note, dated 07/16/2024 at 8:33 PM and 9:12 PM, Registered Nurse #1 documented Resident #4 had their call light on and when they entered the room Resident #4 whispered to them that they were choking and could not breathe. Registered Nurse #1 raised the resident's head of the bed to a 90-degree angle, administered back blows and the Heimlich maneuver (a first aide procedure for choking) and the resident's mouth was suctioned for mucous only. Registered Nurse #1 called 911 and the on-call medical provider and the resident was transferred to the hospital. In a follow up note, Registered Nurse #1 documented that Resident #4's tray table had contained three cups of beverages, but their dinner tray had been removed prior to them entering Resident #4's room.</p> <p>In a nursing progress note, dated 07/16/2024 at 11:30 PM, Licensed Practical Nurse #2 documented Resident #4's daughter had called the hospital and had been informed by the physician that Resident #4 had a large piece of chicken removed from their throat in two pieces.</p> <p>In a medical progress note, dated 07/17/2024 at 12:26 PM, the Nurse Practitioner #1 documented Resident #4 was found on 07/16/2024 choking on dinner and was transferred to the hospital in acute respiratory distress for presumed airway obstruction, was hypoxic (lack of oxygen), and an airway obstruction extraction (removal) was performed using forceps with sedation. Chest x-ray performed after was significant for bilateral atelectasis (collapsed lung on both sides). The resident had stated that they choked immediately upon eating chicken for dinner that night.</p> <p>Review of the facility's Investigation Summary, dated 07/17/2024, completed by the Director of Nursing #1 revealed Dietary Staff #1 was interviewed and stated Resident #4 may have had larger pieces of pulled pork on their sandwich, but Dietary Staff #1 did not work on 07/16/2024. Staff statements included in the Investigation Summary included the following:</p> <ul style="list-style-type: none"> - In a handwritten statement, dated 07/16/24, Registered Nurse #1 documented they provided back blows, the Heimlich maneuver, and oxygen for Resident #4. Registered Nurse #1's statement did not include what Resident #4 had eaten for dinner or what had been served on their tray. - In a hand-written statement, dated 07/17/2024, Licensed Practical Nurse #2 documented they had observed Resident #4's tray before the incident but did not document what was on it. <p>The Investigation Summary did not include verification or confirmation that Resident #4 had received food in consistency of ground/soft foods as ordered.</p> <p>During interviews on 01/02/2025 at 10:04 AM and 4:55 PM, Director of Nursing #2 stated they were not the Director of Nursing when the incident occurred but details about what food consistency was provided to a resident should be investigated if there was a choking incident to ensure that dietary orders were followed for the safety of a resident and a determination should be included in an investigation.</p> <p>10 NYCRR 415.4</p>		

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<p>F 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>49686</p> <p>Based on interviews and record review conducted during an Abbreviated Survey (NY00348559) for one (1) (Resident #4) of three (3) residents reviewed, the facility did not ensure food was prepared in a form designed to meet the residents needs as recommended by the speech-language pathologist and physician's orders. Specifically, Resident #4 had a diagnosis of dysphagia (difficulty swallowing) with a history of choking, was on a ground/soft diet (food that is ground or minced into pieces no larger than a quarter inch and are moist) and had a choking episode related to incorrect food consistency, which resulted in hospitalization . This resulted in actual harm to Resident #4 that was not Immediate Jeopardy as evidenced by the following:</p> <p>The facility policy Aspiration Precautions Protocol, dated December 2023, documented that a resident's meal tray should be checked with the meal tray ticket or card for accuracy.</p> <p>Resident #4 had diagnoses that included hemiplegia (paralysis on one side of the body) following a cerebral infarction (stroke), dysphagia (difficulty swallowing) and dementia.</p> <p>The Minimum Data Set Resident Assessment, dated 05/29/2024, documented the resident had moderately impaired cognition and was on a mechanically altered diet (food is chopped, ground, or pureed to make it easier to swallow) and required set-up assistance for meals.</p> <p>Review of the Speech Language Pathology evaluation, dated 03/13/2024, revealed Resident #4 required a ground/soft diet with thin liquids.</p> <p>Review of physician's orders, dated 03/13/2024, and the Comprehensive Care Plan dated 03/13/2024 revealed Resident #4 was on a ground/soft diet.</p> <p>In a nursing progress note, dated 07/16/2024 at 8:33 PM, Registered Nurse #1 documented Resident #4 had their call light on at approximately 6:50 PM to 7:00 PM and when they entered the room Resident #4 whispered to them that they were choking and could not breathe. Registered Nurse #1 raised the resident's head of the bed to a 90-degree angle, administered back blows and the Heimlich maneuver (a first aide procedure for choking) and the resident's mouth was suctioned for mucous only. Registered Nurse #1 called 911 and the on-call medical provider, and the resident was transferred to the hospital.</p> <p>In a nursing progress note, dated 07/16/2024 at 9:12 PM, Registered Nurse #1 documented that Resident #4's tray table had contained three cups of beverages, but their dinner tray had been removed prior to them entering Resident #4's room.</p> <p>In an emergency room medical progress note, dated 07/16/2024 at 7:59 PM, the physician documented that Resident #4 was admitted to the emergency room in acute respiratory distress, unable to speak and had diagnoses of foreign body aspiration (inhaling a foreign object), pneumonitis (inflammation of the lungs), hypoxia (low level of oxygen), and airway obstruction (blockage of the respiratory tract).</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an emergency room medical progress note, dated 07/16/2024 at 9:14 PM, the respiratory therapist documented Resident #4 was given medication for conscious sedation (a form of sedation that helps a patient to relax during a medical procedure) and two large pieces of chicken approximately four centimeters in size were removed from Resident #4's airway with forceps (medical device resembling a pair of tongs).</p> <p>In an interdisciplinary team progress note, dated 07/17/2024 at 12:26 PM, Nurse Practitioner #1 documented Resident #4 was found on 07/16/2024 choking on dinner and was transferred to the hospital in acute respiratory distress for presumed airway obstruction, was hypoxic (lack of oxygen) on six liters of oxygen and an airway obstruction extraction (removal) under sedation was performed using forceps. A post procedure chest x-ray was significant for bilateral atelectasis (collapsed lung on both sides). The resident had stated they choked immediately upon eating chicken for dinner that night.</p> <p>In an interview on 12/31/2024 at 4:12 PM, the Administrator stated if a resident choked (while eating), an investigation should be done and should include a determination that the correct food consistency had been served. After reviewing the incident report for Resident #4's choking incident, it appeared there was no food found in the room, the resident was alone, and they were unsure of how to determine if the correct consistency had been provided to the resident. The staff member who served the tray was no longer at the facility. The Administrator stated staff should confirm food consistency with the meal ticket before serving the meal.</p> <p>During interviews on 01/02/2025 at 10:04 AM and again at 4:55 PM, Director of Nursing #2 stated they were not the Director of Nursing at the facility when the incident occurred. Director of Nursing #2 stated that in the event of a choking incident, details about what food consistency was provided to the resident should be investigated to ensure that dietary orders had been followed for the safety of the resident.</p> <p>During an interview on 01/16/2025 at 9:37 AM, Nurse Practitioner #1 stated giving the incorrect consistency diet could potentially result in problems with chewing and swallowing, and lead to aspiration (inhalation of food into the lungs). Nurse Practitioner #1 stated it would be important to determine if the correct food consistency was given to Resident #4, but the information they had received was that the resident's tray was taken away prior to their choking incident.</p> <p>During an interview on 01/16/2025 at 10:18 AM, the Speech Language Pathologist stated a four-centimeter piece of meat would not be considered safe on a ground/soft diet.</p> <p>10 NYCRR 415.14(d)(3)</p>