STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365811	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwestern Center	570 North Rocky River Drive Berea, OH 44017

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35771 Based on observation, closed medical record review, review of an emergency medical services run report, review of facility witness statements, review of the diet guide sheet and recipes, review of the facility's diet manual, review of employee disciplinary action and interviews, the facility failed to ensure residents with physician orders for mechanically altered diets were provided the correct texture food items to prevent choking and to meet their individual needs. This resulted in Immediate Jeopardy and actual harm/death on [DATE] during the dinner meal when Resident #91, who was ordered a Dysphagia Advanced diet, was edentulous and care planned for oral problems, was served a broccoli salad; the resident was subsequently found unconscious, required cardiopulmonary resuscitation (CPR) and when Emergency Medical Services (EMS) arrived, intubation was initially unsuccessful due to a piece of broccoli being found in the resident's airway. Resident #91 was pronounced deceased as a result of the incident. This affected one resident (#91) and had the potential to affect 15 additional residents (#3, #16, #19, #20, #21, #22, #24, #27, #31, #37, #38, #56, #57, #59 and #61) who the facility identified as being on a Dysphagia Advanced diet ordered by their physician or other delegated provider. The facility census was 90. On [DATE] at 11:28 A.M., the Administrator, Director of Nursing (DON) and Regional Director of Clinical Operations (RDCO) #8 were notified Immediate Jeopardy began on [DATE] at approximately 5:10 P.M. when Resident #91 was served a meal tray with a broccoli salad cut into bite size pieces in his room while sitting on the edge of his bed. At approximately 5:50 P.M., Resident #91 was found unconscious and not breathing, slumped over with his face on his dinner tray and CPR was started by facility staff. EMS was notified and arrived at the facility at 6:00 P.M. Initially, intubation was unsuccessful and [NAME] forceps were used to remove a piece of broccoli from the airway. Resident #91 expired at the facility. According to the EMS run report, the presumed cardiac arrest etiology was possible obstructed airway (broccoli removed). The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 6:25 P.M., Physician #17 was notified of Resident #91's death by Registered Nurse (RN) #9. At 6:39 P.M., Resident #91's daughter was notified of Resident #91's death by Licensed Practical Nurse (LPN) #10. (continued on next page)

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

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] by 7:00 P.M., LPN/Unit Manager #2 interviewed all residents with Dysphagia Advanced diet orders about their meal consistency for the dinner meal on [DATE] with no additional concerns identified. On [DATE] at 7:00 P.M., the DON and LPN/Unit Manager #2 initiated a house audit to identify any residents on Dysphagia Advanced diet. In addition, Regional Director of Operations Registered Dietitian (RDORD) #13 and RN #1 audited validation diet orders in the electronic medical record to ensure the meal tickets matched. On [DATE], the DON began conducting interviews and obtained witness statements from nursing staff working the time of the event involving Resident #91. All the interviews/witness statements were completed on [DATE] at 4:30 P.M. On [DATE], the DON initiated education with facility staff on Dysphagia Advanced diet, the difference between diets/food textures/thickened liquids/obstructed airway care and meal service policy. Education included dietary staff to serve food consistencies as ordered and nursing staff to validate meal being served to resident matches meal ticket prior to serving to residents. The education was completed on [DATE] at 4:30 P.M. On [DATE] at 7:30 A.M., the DON audited the breakfast meal to ensure Dysphagia Advanced diets were prepared appropriately with no concerns identified. On [DATE] at 12:30 P.M., the Administrator and DON reviewed all notes from Speech Language Pathologist (SLP) #15 and interviewed SLP #15 with no concerns identified. On [DATE] at 1:00 P.M., RDORD #13 reviewed Resident #91's meal ticket and dietary profile. On [DATE] at 1:30 P.M., RDORD #13 audited all diets in the electronic medical record and from the dietary meal tracker master list. Three (Residents #31, #20 and #12) residents' diet orders were fixed due to duplicate orders in the electronic medical record. On [DATE] at 2:00 P.M., the Administrator gave a verbal warning and suspended Cook #5 pending investigation in an effort to investigate the event prior to Cook #5 returning to work. On [DATE] at 2:00 P.M., the DON requested the EMS run report from the City Fire Department. On [DATE] at 5:30 P.M., RN #18 educated all residents/responsible parties with Dysphagia Advanced diets that refused to eat in dining room for potential risks of unsupervised dining. Education record assessment completed, and care plans were updated. On [DATE] at 11:00 A.M., Dietary Manager (DM) #4 educated Cook #5 on preparing a Dysphagia Advanced diet with a return demonstration completed successfully. On [DATE] at 11:50 A.M., the DON conducted an audit of all residents in house to identify residents ordered Dysphagia Advanced diet. The DON assessed all residents ordered a Dysphagia Advanced diet with no concerns identified. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 2:48 P.M., RDORD #19 in collaboration with Regional Speech Therapy Director #20 updated the Dysphagia Advanced diet policy/manual to define the appropriate size of chopped vegetables to be approximately 0.5 inches. There were no food exclusions outside what was listed on the Dysphagia Advanced policy as long as the food items met the size requirement. On [DATE] at 3:08 P.M., the DON conducted education with facility staff related to the updated Dysphagia Advanced policy/manual with the adjusted size of chopped vegetables to be approximately 0.5 inches via electronic communication to be completed on [DATE] by 12:00 P.M. Any staff not able to be educated by that time would be educated prior to the start of their next scheduled shift. On [DATE], DM #4 initiated education with all Cooks related to preparing Dysphagia Advanced diet, including a return demonstration. All additional Cooks would be trained prior to the start of their next scheduled shift. Beginning on [DATE], the Administrator/DON/Designee with support of interdisciplinary team bean audits which will be scheduled to be conducted on meal trays at different mealtimes to ensure correct meal consistencies were being served as ordered. Auditing would occur five times a week for two weeks, then three times a week for two weeks. Results of the audits will be reviewed with the Quality Assurance Performance Improvement (QAPI) committee with additional recommendations as warranted. Beginning on [DATE], Director of Therapy #21 conducted an audit of residents ordered a Dysphagia Advanced diet to identify date of last therapy screen. For any resident not screened in the last 90 days or that have not received speech therapy in the last 90 days, a screen would be completed by [DATE]. Although the Immediate Jeopardy was removed on [DATE], the deficiency remained at Severity Level II (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action and monitoring for effectiveness and on-going compliance. Findings include: Review of the closed medical record for Resident #91 revealed an admitted [DATE] and discharge date of [DATE]. Resident #91 had diagnoses including memory deficit following cerebral infarction, diabetes, peripheral vascular disease, hypertensive heart disease, hepatitis C, and hyperlipidemia. Review of the oral/dental care plan dated [DATE] revealed Resident #91 had oral/dental problems related to (being) edentulous (lacking teeth) and did not wear dentures with an intervention that included provide a mechanically altered diet. Review of the Speech Therapy (ST) evaluation dated [DATE] revealed Resident #91 was referred to ST due to exacerbation of decreased safety awareness during oral intake, increased signs and symptoms of dysphagia (difficulty swallowing) and risk for aspiration (when food or liquid enters the airway and eventually the lungs by accident). Review of the ST discharge summary dated [DATE] revealed Resident #91 had met short- and long-term goals and reached maximum potential with skilled services. Resident #91 was safely consuming the least restrictive diet consistency without overt signs and symptoms of difficulty/aspiration. Resident #91's recommended discharge diet order was mechanical soft textures (Dysphagia Advanced). (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the MDS 3.0 quarterly assessment dated [DATE] revealed Resident #91 was severely cognitively impaired and was independent with eating. Review of the nutritional assessment dated [DATE] revealed Resident #91 was ordered a Dysphagia Advanced texture diet with good appetite and oral intake. Review of the [DATE] physician orders revealed Resident #91 was ordered a Dysphagia Advanced texture diet and could have regular ground beef (hamburger on bun, patty, meatballs, meatloaf and regular fish). The order had been in place since [DATE]. Review of the nurse's note dated [DATE] timed 6:39 P.M. revealed Resident #91 was noted to be without vital signs, CPR started and 911 (EMS) and Power of Attorney (POA) notified. Continued CPR until EMS arrived and took over care of resident. EMS notified hospital emergency department and physician called time of death 6:19 P.M. Review of the Prehospital Care Report Summary (EMS run report) dated [DATE] revealed dispatch requested a squad for [AGE] year-old male not breathing at [address and name of facility]. Staff performing CPR and respirations on pulseless and apneic (not breathing) patient. Staff stated patient was last known well at 5:45 P.M. while eating dinner. Patient found unresponsive at approximately 5:52 P.M. at which time a Code was called by nurse supervisor. EMS crew took over manual CPR. Attempted intubation - no success. During resuscitation attempt, a piece of broccoli was removed from patient's airway with [NAME] forceps. Patient remained in asystole (without heartbeat) during code. Resuscitation attempt terminated per [name of physician]. Time of death was 6:19 P.M. Presumed cardiac arrest etiology: possible obstructed airway (broccoli removed). Review of a facility witness statement dated [DATE] authored by RN #9 revealed, I was passing dinner trays on [Front North]. I went into [Resident #91's room] and announced that I was bringing in dinner. [Resident #100] (Resident #91's wife/roommate) was sitting on her bed. [Resident #91] was lying down .[Resident #91] sat up and was sitting on the side of his bed like he always does to eat. He was acting his norm. I served [Resident #91] his tray. His tray was consistent with his diet order. Review of a facility witness statement dated [DATE] authored by State tested Nurse Aide (STNA) #15 revealed, I started collecting trays and when I got to [Resident #91's] room, found [Resident #91] slumped over his tray. I yelled for the nurse and the nursing staff came when it was called Code Blue. Review of a facility witness statement dated [DATE] authored by STNA #14 revealed, At approximately 5:50 P.M., I other aides and I went down the hall to collect trays. Upon entering the room, we found resident faced down in his food tray. At that point, we all screamed for help down the nurses station. Review of a facility witness statement dated [DATE] authored by LPN #10 revealed, I was at the nurses' cart charting, when aide called, and I ran down to patients room. Patient was face down in dinner tray. This nurse pushed and assisted patient back on bed to obtain vitals and start CPR . Review of the Diet Guide Sheet for Dinner Day 3, Week 1 on Tuesday revealed ,d+[DATE] cup of broccoli salad, chop for resident's ordered a Dysphagia Advanced diet. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the recipe for Broccoli (floret) Salad revealed steam or boil broccoli, cook until tender, drain off excess liquid and chop or slice into pieces. For Dysphagia Advanced: chop to small, appropriate small. Review of the facility's 2019 Diet and Nutrition Care Manual for Dysphagia Advanced diets revealed this diet was used for individuals with mild oral and/or pharyngeal phase dysphagia. Foods that were difficult to chew were chopped, ground, shredded, cooked, or altered to make them easier to chew and swallow. Foods to avoid included cooked rubbery or non-tender cooked vegetables. There was no definition of what the measurement was for small, appropriate size. Review of the Employee Corrective Action Form dated [DATE] revealed Cook #5 was given a verbal warning and suspended pending investigation due to incident that occurred on [DATE]. Review of the Teachable Moment form dated [DATE] revealed RN #9 was educated related to diet consistency and texture types and validating that meal matched diet type prior to serving residents. Interview on [DATE] at 8:05 A.M. with Dietary Manager (DM) #4 revealed broccoli salad was on the menu for dinner on [DATE] and the salad was served cold. DM #4 had observed Cook #5 steam and chop the broccoli; however, DM #4 was not at the facility when dinner was served. DM #4 was told that Resident #91 had received a piece or a couple of pieces of broccoli that were not properly chopped, the resident choked and passed away. Interview on [DATE] at 10:50 A.M. with RN #9 revealed she served Resident #91 his dinner on [DATE] while the resident was sitting on the edge of his bed. RN #9 placed a fork into the broccoli salad and the broccoli was chopped and soft. RN #9 felt the dinner served was consistent with his diet order. RN #9 stated after CPR was completed and EMS called Resident #91's time of death, a paramedic told RN #9 that, we did pull a piece of broccoli out of his airway. Interview on [DATE] at 11:40 A.M. with Cook #5 revealed for dinner on [DATE], he cooked the broccoli in the steamer for approximately 25 minutes, ran the broccoli under cool water to cool it off, then cut up the broccoli in to bite size pieces using a chef's knife. Cook #5 stated if the broccoli salad was served to residents on a Dysphagia Advanced diet, he would have had to chop the broccoli into finer/smaller pieces rather than bite size pieces. During the interview, Cook #5 could not recall if he made a separate broccoli salad for residents on a Dysphagia Advanced diet. Cook #5 did not respond when asked if he referenced the broccoli recipe while preparing the broccoli salad. Observation of the lunch tray line on [DATE] at 12:00 P.M. revealed Cook #6 was serving lunch which included Capri Vegetable Blend which contained cooked, diced carrots. Cook #6 served the Carpi Vegetable Blend to the meal tray intended for Residents #31 and #21 who were ordered a Dysphagia Advanced diet. The diced carrots were approximately the size of a half dollar-sized coin. Interview, during the observation, with DM #4 revealed she trained the cooks to chop food items into ,d+[DATE] inch pieces for a Dysphagia Advanced diet. Review of the recipe for Capri Vegetable Blend revealed Capri Blend included 35% Julienne cut carrots strips, 27% bias cut green beans, 23% half round yellow squash, and 15% crinkle cut zucchini. Steam or boil vegetables until tender, toss lightly with margarine. For Dysphagia Advanced: chop to small, approximate size. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 1:45 P.M. with DM #4, (Dietary District Manager (DDM) #11 and the Administrator were present) verified the Capri Vegetable Blend recipe called for Julienne cut carrots rather than diced carrots and verified the diced carrots in the Capri Vegetable Blend were larger than ,d+[DATE] inch. Interview on [DATE] at 2:20 P.M. with RDORD #13 verified there was no definition for small, appropriate size in the diet manual for a Dysphagia Advanced diet. Interview on [DATE] at 3:05 P.M. with STNA #15 revealed Resident #91 was a good eater and normally cleaned his plate. On [DATE], STNA #15 was assisting STNA #14 with collecting meal trays and STNA #15 began collecting trays from the back of the hallway. STNA #15 arrived at Residents #100 and #91's room, and STNA #15 began to collect Resident #100's tray (Resident #100 was not in the room) when STNA #15 looked up and observed Resident #91 slumped over his overbed table with his face down on his plate. STNA #15 rubbed Resident #91's head stating Resident #91's name. STNA #15 began yelling for LPN #10. Interview on [DATE] at 4:00 P.M. with the Administrator revealed the facility conducted an investigation after Resident #91 expired and the investigation concluded that Resident #91 had choked. Interview on [DATE] at 4:25 P.M. with Speech Language Pathologist (SLP) #16 revealed she worked with Resident #91 in June/[DATE] to determine his diet order. Resident #91 was edentulous. SLP #15 would expect that broccoli be served in ,d+[DATE] inch chopped, soft pieces and soft enough to mash with a fork for resident's ordered a Dysphagia Advanced diet. SLP #15 revealed broccoli stems were not able to be mashed. Interview on [DATE] at 10:15 A.M. with LPN #10 revealed she was Resident #91's nurse on [DATE]. That evening, LPN #10 was passing medications while three STNAs and one nurse passed meal trays to the residents on the hall. At approximately 5:20 P.M. or 5:30 P.M., LPN #10 administered medications to Resident #100 (Resident #91's roommate) in the hallway. At that time, LPN #10 observed Resident #91 sitting on the edge of his bed feeding himself without any concerns. LPN #10 returned to the nursing station and was standing at the medication cart when STNAs alerted the nurses to come to Resident #91's room. LPN #10 ran down the hallway into Resident #91's room and the resident's face was in his tray. A follow-up interview on [DATE] at 2:25 P.M. with SLP #16 revealed she had not screened Resident #91 for swallowing since [DATE] and a therapy screening list including Resident #91 should have been provided to the therapy department in [DATE] but that did not occur. The facility identified 15 additional residents, Resident #3, #16, #19, #20, #21, #22, #24, #27, #31, #37, #38, #56, #57, #59 and #61 who required a Dysphagia Advanced diet ordered by their physician or other delegated provider. The facility's failure to ensure food items were properly prepared and/or served at an appropriate size during the dinner meal on 04//,d+[DATE] and lunch meal on [DATE] placed these additional residents at risk for choking and/or adverse outcomes. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's Meal Distribution policy revised [DATE] revealed all meals would be assembled in accordance with the individualized diet order, plan of care and preferences. The nursing staff would be responsible for verifying meal accuracy and timely delivery of meals to residents/patients. For point-of-service dining, the Dining Services department staff, under the supervision of the licensed nurse, would assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient. This deficiency represents non-compliance investigated under Complaint Number OH00153286 and OH00153283.