STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montevista Rehabilitation and Skilled Care	7604 Quanah Parker Trailway Lawton, OK 73505

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 0805 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 34333 Based on record review and interview, the facility failed to ensure a resident received food prepared to meet the resident's needs, which resulted in hospitalization , for one (#1) of four residents reviewed for therapeutic diets. The administrator reported a census of 84 residents. Findings: A Menu Planning policy, dated 11/01/17, documented in part, .Nutrition Services will be responsible to prepare and serve the diet as ordered .Nursing staff will notify the NSM of needed consistency changes . Resident response to special and modified diets will be evaluated. Ineffective or inappropriate diets, including texture modifications, will be referred .to the attending physician, dietitian, and/or therapy department for evaluation . Resident #1 had diagnoses which included traumatic brain injury, hemiplegia, hemiparesis, and muscle spasms. A physician order, dated 11/29/23, documented a diet order for puree level 4. An MDS assessment, dated 02/17/24, documented the resident required a mechanically altered diet. The assessment documented the resident was severely cognitively impaired. A care plan, dated 02/19/24, documented resident #1 required a pureed level 4 diet. The care plan documented the resident required extensive to total assistance with activities of daily living. A nurse note, dated 03/19/24, documented in part, .Dietician reviewed resident recently. Awaiting call back from physician with decisions related to referral for peg tube or dietary changes . There was no documentation related to a choking incident on this day. A nurse note, dated 03/23/24, documented a focus assessment related to report of respiratory distress and initial O2 reading of 64%. The note documented the resident was placed on O2, EMS was called for transport to the ER, and the resident left the facility at 1:38 p.m. (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

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F 0805 Level of Harm - Actual harm Residents Affected - Few	An emergency department note, dated 03/23/24 at 2:31 p.m., documented the resident was diagnosed with pneumonia and likely aspiration pneumonia. The note documented the resident was intubated related to respiratory distress. Hospital records documented the resident remained in the intensive care unit as of 04/01/24. On 04/01/24 at 1:12 p.m. the DM reported the facility currently had three residents with pureed diet orders. The DM reported these residents were normally fed in the assisted dining room. The DM reported dietary staff had meal cards they referred to for each resident, and stated she would be implementing color-coded cards the following week to assist in identifying special diets. On 04/01/24 at 1:30 p.m., LPN #2 reported she assessed Resident #1 the day the resident was sent to the hospital for respiratory distress. The LPN #2 stated one of the CNAs had gotten the resident up for lunch and reported the resident was short of breath and appeared to be struggling with his breathing. The LPN #2 reported the resident had not started eating lunch at that time and they informed the CNA #1 not to feed the resident since Resident #1 wasn't feeling good. The LPN #2 reported the resident had only had fluids for breakfast that morning, a thickened mighty shake and juice, but to their knowledge had not been fed any food on that day. On 04/01/24 at 1:40 p.m., LPN #2 reported after Resident #1 was admitted to the hospital, an unidentified staff member was told by a family member that the resident was diagnosed with aspiration pneumonia related to the resident being fed corn. The LPN #2 stated during a conversation between nursing staff, CNA #1 reported to LPN #2 that they had fed the resident corn, and informed the LPN #2 that the tray had the resident's name on it. The LPN #2 stated they normally didn't have problems getting the wrong diets for residents and they did not report the incident to anyone. On 04/01/24 at 2:20 p.m., the administrator reported they had not been informed of any resident choking or being fed the wrong diet. On 04/01/24 at 3:14 p.m., CNA #1 reported they were new to the facility and still getting to know the residents. The CNA #1 stated during the previous week, possibly their 2nd day to work, another CNA asked CNA# 1 to feed resident #1. CNA #1 stated the resident had mashed potatoes, pureed corn, and what looked like ground or chopped beef. The CNA #1 stated there were whole chunks of fruit on the tray and they knew not to feed the fruit to the resident since the other food was either pureed or chopped. The CNA #1 confirmed the corn was pureed but they could still tell it was corn. The CNA #1 stated the resident normally made grunting sounds and they noticed the resident was quieter. The CNA #1 called for the nurse and the nurse told her to sit the resident up straighter. The CNA #1 stated they pulled the resident up and the resident coughed up some liquid and seemed better. The CNA #1 reported the nurse assessed the resident and they seemed okay after that. The CNA #1 was uncertain of the exact date of the incident, but stated the resident did not go to the hospital that day. On 04/01/24 at 4:00 p.m., RN #1 provided diets and menus which showed cream-style corn and hamburger meat had been served on Tuesday, 03/19/24, prior to the resident being sent to the hospital on Saturday, 03/23/24. The RN confirmed the resident had a choking episode a few days before being sent out to the hospital which, by the nurse note, would have been on 03/19/24. (continued on next page)

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F 0805 Level of Harm - Actual harm Residents Affected - Few	On 04/02/24 at 11:50 a.m., the restorative aide reported they normally worked Monday through Friday and usually fed resident #1. The aide stated they had been out for surgery so they was not working on the days leading up to resident #1 being sent to the hospital. The aide reported they had observed the resident to have choking episodes in the past, which resulted in them requesting the resident be changed to the current pureed diet. The restorative aide stated because of the choking episodes, they always fed resident #1 in the unit dining room so they would be close to a nurse if the resident had any issues. The aide stated they had observed the resident get the wrong tray before, but they would return the tray to the kitchen and request a pureed tray. The restorative aide stated they thought it was just a mistake with kitchen staff being in a hurry to fill trays, but ultimately it was the responsibility of nursing staff to ensure the resident received the correct diet as ordered.