STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Health and Rehabilitation Center	5757 N Knoll San Antonio, TX 78240

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable interior for 4 of 5 Resident's (Resident #2, Resident #3, Resident #6, and Resident #7) reviewed for environment. 1. The facility failed to prevent Resident #2's bathroom from having a black substance caked over the interior of the toilet bowl and the air conditioning unit was covered in dust. 2. The facility failed to ensure the wall on the back of Resident #3's bed did not have peeling drywall. 3. The facility failed to ensure Resident #6's room floor was cleaned near/under furniture and in the closet. 4. The facility failed to ensure Resident #7's room floor was cleaned. These failures could affect any resident and place them at risk for a diminished quality of life and a diminished clean, homelike environment. The findings included: 1. Record review of Resident #2's face sheet, dated 4/11/24 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), hypertension (elevated blood pressure), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movement, behaviors, sensations or states of awareness), hemiplegia and hemiparesis (hemiplegia is defined as paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one?sided weakness, but without complete paralysis) affecting the right dominant side, muscle weakness and abnormalities of gait and mobility. Record review of Resident #2's most recent quarterly MDS assessment, dated 1/27/24 revealed the resident was moderately cognitively impaired for daily decision-making skills, required 1-person assist with mobility and transfers and had bowel and urinary incontinence. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's comprehensive care plan, with edited date 1/30/24 revealed the resident had bowel and urinary incontinence with approaches that included to check the resident for incontinence as needed after an incontinence episode. Observation and interview on 4/10/24 at 10:29 a.m. revealed Resident #2 lying in a low bed with a urinal at the bedside on the left side of the bed. Resident #2 stated, the facility staff dump the urine in the toilet, but did not actually use the toilet because he was unable to walk, so had not actually seen the bathroom. Resident #2 revealed, housekeeping staff cleaned the room daily, including sweeping and mopping the floor and emptying the trash. Resident #2 stated a family member who visited had mentioned something about the bathroom being dirty. Observation of Resident #2's bathroom revealed the toilet had a black substance caked over the interior of the toilet bowl. Observation on 4/11/24 at 8:19 a.m. revealed the toilet in Resident #2's room had a black substance caked over the interior of the toilet bowl. Observation on 4/11/24 at 9:58 a.m. revealed two unidentified housekeeping staff on the 200 hall where Resident #2 resided, were providing housekeeping services, including mopping the floor in the hall. Observation and interview on 4/11/24 at 10:48 a.m. revealed, Resident #2 sitting up in bed and two family members at the bedside. Resident #2 revealed, housekeeping staff had been in the room earlier that day and only saw staff go in the bathroom but did not see how the bathroom was cleaned. Observation of Resident #2's bathroom revealed the toilet continued to have a black substance caked over the interior of the toilet bowl. Resident #2's family member stated, I guess they still haven't cleaned the toilet. During an observation and interview on 4/11/24 at 11:32 a.m., Housekeeper B revealed he had cleaned Resident #2's room earlier in the morning, which included mopping the bedroom and bathroom and dusted around the perimeter of the air conditioning unit. Housekeeper B further revealed he cleaned Resident #2's bathroom, including the interior of the toilet bowl. Housekeeper B stated, he was aware of the black substance caked over the interior of the toilet bowl and stated, it was not the first time he had seen it. Housekeeper B revealed he had cleaned the toilet bowl but needed additional materials to scrub the black substance caked over the interior of the toilet bowl. Housekeeper B revealed he could not identify what the black substance was and stated, It looks dirty, I know it's not lime. I would not like that in my house and it would make the resident feel uncomfortable and a little concerned. Housekeeper B revealed he had made the Maintenance Director aware of the issue but had not received additional materials to scrub the toilet. Housekeeper B observed the perimeter of Resident #2's air conditioning unit and confirmed the air conditioning unit was covered in dust. Housekeeper B stated he would ask the Maintenance Director if he was allowed to remove the cover that was over the air conditioning unit so he could clean the dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/11/24 at 1:58 p.m., the Maintenance Director revealed he oversaw the Housekeeping Staff in addition to providing maintenance services. The Maintenance Director revealed he was in charge of replacing the air conditioning filters but the Housekeeping Staff were expected to clean around the perimeter of the air conditioning units because it kept the air conditioners working longer. The Maintenance Director revealed, Housekeeping Staff cleaned the rooms daily, including dusting, sweeping and mopping and cleaning the bathroom toilets. Observation of Resident #2's bathroom with the Maintenance Director revealed he believed the interior of the toilet bowl looked like it had mold and had been made aware of it two weeks ago and should have used the pumice stone to clean the toilet. The Maintenance Director observed the air conditioning unit in Resident #2's bedroom and confirmed the perimeter of the unit was covered in dust. 2. Record review of Resident #3's face sheet, dated 4/11/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included disorder of brain, pneumonia (lung inflammation caused by bacterial or viral infection in which the air sacs fill with pus and may become solid), lack of coordination, muscle wasting and atrophy (wasting or thinning of muscle mass), tremors, cognitive communication deficit, and respiratory disorders. Record review of Resident #3's most recent quarterly MDS assessment, dated 3/21/24 revealed the resident was severely cognitively impaired for daily decision-making skills and required substantial to maximal assistance with activities of daily living. Observation on 4/10/24 at 10:04 a.m. revealed Resident #3 sitting up in the wheelchair in the bedroom. Resident #3's wall behind the bed was observed with peeling drywall. During an observation and interview on 4/11/24 at 2:09 p.m. with the Maintenance Director revealed Resident #3 with peeling drywall on the wall behind the head of the bed. The Maintenance Director stated, I know it is there but I have not gotten to it. The Maintenance Director revealed if his family was living in a facility that looked like that it would be upsetting to him. 3. Record review of Resident #6's face sheet, dated 4/12/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included excoriation (skin picking) disorder, muscle weakness, type 2 diabetes, and abnormalities of gait and mobility. Record review of Resident #6's most recent quarterly MDS assessment, dated 3/20/24 revealed the resident cognition was intact for daily decision-making skills. Observation and interview on 4/10/24 at 11:30 a.m. Resident #6 stated they last cleaned her room [ROOM NUMBER] days ago. Resident #6 stated they often used dirty mop water to clean the floor. Resident #6 stated they had never cleaned the floor in her closet. Resident #6's closet floor was a darker color than the rest of the floor in her room. A plastic storage container was next to the resident's bed. Behind the container was dark stains on the floor with small debris stuck to it. Resident #6 stated she had never seen anyone clean behind the storage container. 4. Record review of Resident #7's face sheet, dated 4/12/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cellulitis (serious bacterial infection of the skin) of right lower limb, sepsis (infection of the blood stream), muscle weakness, unsteadiness on feet, parkinsonism (a clinical syndrome characterized by tremor, bradykinesia (slowed movements), rigidity, and postural instability), and type 2 diabetes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's most recent quarterly MDS assessment, dated 3/19/24 revealed the resident cognition was intact for daily decision-making skills. During an observation on 04/11/24 at 11:44 p.m. Resident #7 was in her room. Resident #7 stated she was using the restroom. Resident #7 was in the room alone and self-toileting. Observation and interview on 4/12/24 at 9:28 a.m. revealed Resident #7's room floor had popcorn, an unknown brown color food, an empty cup, clear shiny unknown substance, brown substance covering 3x3 foot area, a bed pad, and hospital gown on the floor. Resident #7 stated staff came to her room the day before to clean it and she asked them to wait because she was changing her gown. Resident #7 stated they never came back to clean her room. Resident #7 stated it bothered her that her room was dirty. Resident #7 stated she had pain and could not pick up the spilled drink. During a joint interview on 04/12/24 at 9:45 a.m. the Maintenance Supervisor and Housekeeper B stated they attempted to clean Resident #7's room the day before but had to wait for CNAs to change her from an incontinent episode. This surveyor told them the resident was observed self-toileting the day before and they stated they did not know anything about that. They were shown a picture of Resident #6's room floor and stated they were working on moving furniture and cleaning behind it. The Maintenance Supervisor stated he was new and was working on cleaning the facility better. Record review of the facility's policy and procedure titled, Infection Control - Environmental Rounds, effective date 10-2020 revealed in part, .It is the policy of this home that the Administrator or other appropriate designee completes environmental rounds on a regular basis .Environmental rounds will be an integral part of the daily routine and also will be performed regularly throughout the entire home, with detailed reporting to all units and departments as needed .(It is suggested that a selection of individual units as well as the dietary, laundry and housekeeping departments be specifically identified for closer scrutiny each month) . Environmental rounds reports will be retained to illustrate the improvement of quality of life within the facility and for review/comparison purposes within the home over a period of time . 45857

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 4 residents (Resident #1 and Resident #5) reviewed for care plans. 1. The facility failed to care plan Resident #1's refusal eating in the dining room for supervision with meals. 2. The facility failed to care plan Resident #5's use or refusal to use fall mats. This failure could place residents at risk of not having their needs met. Finding Included: 1. Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated [DATE], revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated [DATE] revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on [DATE] by the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 11:13 a.m. Resident #1 was in his room alone in bed. Resident #1 was sitting up in bed. Resident #1 had a regular plate (not a divided plate as indicated in the resident's order) with spaghetti, cooked squash, a hard brown piece of toast, a dessert dish with watery gelatin snack, a coffee cup with no top, and a clear cup with a purple liquid drink with no top. The tray of food had liquid spilled all over it. A napkin was soaked with brown liquid and the diet sheet was also stained with brown liquid. Resident #1 grabbed the hard toast, took a bite, and a crunch noise was heard. The resident put the bread down. This survey asked Resident #1 if the bread was too hard and Resident #1 nodded his head yes. Resident #1 lifted his fork with his left hand. Resident #1's hand was shaking, and food fell off the fork. The Resident #1 put the fork down on the tray. Resident #1 grabbed a handful of spaghetti and began to shove it in his mouth. Resident #1 ate quickly. No straws, condiments, or cheesecake were noted on the tray of food. There was a diet sheet from the kitchen which showed Resident #1's name, stated he was on a regular mechanical soft diet with thin liquids, no allergies were listed, adaptive equipment: divided plate, entree: meat sauce, starch: spaghetti noodles, vegetable: zucchini, bread garlic toast, dessert: cheesecake, condiment salt/pepper/margarine, and beverage: choice of beverage and water. During an observation on [DATE] at 11:30 Resident #1 was delivered a meal tray by an unidentified male staff. The staff exited the room right after delivering the tray. Resident #1 was eating in his room alone. At 11:38 a.m. an unidentified female staff went into his room. The resident's plate had no food left. The staff lifted a utensil with the last bite of food for the resident to eat. The staff stated Resident #1 can eat on his own, but she will go in to help him because he made a mess. Resident #1 again had a regular plate. The staff stated the resident chose to eat with his hands. During an interview on [DATE] at 9:12 a.m. the Speech Therapist stated Resident #1 was evaluated in March. The SP stated she was working with the Resident due to history of stroke and he had dysphagia. The SP stated if Resident #1 was presented food he would not take it and preferred to eat with his hands. The SP stated in March she recommended Resident #1 eat in the dining room per her notes because he could not communicate to staff and in case of an emergency he needed to be with in sight. The SP stated she they attempted to take Resident #1 to the dining room for meals in March after her recommendation but the Resident had a panic attack. The SP stated her recommendations were given to the rehab director and to the DON. The SP stated the Resident should have a divided plate with meals and his cups should have plastic lids and a straw. The SP stated she did go in the room to assist the resident with meals because she also helped with other residents and could not always be in the room with him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:35 a.m. the DON stated the Rehab director would usually let them know what findings they had from an evaluation. The DON stated Resident #1 was supervised only for meals, he was able to feed himself, he could use utensils, staff would set the tray up uncover everything for him, give him the spoon, he would pick it up and feed himself, and she did not see him shake or have tremors. The DON stated they were notified Resident #1 needed to eat in the dining room for queuing (prompting to eat) and or if he dropped his silverware. The DON stated the resident was very contracted and he refused to go to the dining room because it was painful for him to move. The DON stated staff would set the resident up at 90 degrees in bed, would set up his tray, and would go in and out of his room to supervise him during meals in his room. The DON stated they did not document or care plan the resident's refusals to go to the dining room. The DON stated staff would attempt 3 times to get the resident up and then would notify the nurse if he refused. The DON stated the SP would go in the room to sit with the resident and help him eat. The DON stated she had not read the SP evaluation and plan of care for Resident #1. The DON read the POC and stated she did not agree that staff would not be able to assist the resident in an emergency because the staff was CPR certified and could also perform the Heimlich maneuver. The DON stated she had never been notified that the resident would cough or choke while eating and the SP should have reported this to nursing. During a joint interview on [DATE] at 4:37 p.m. with Rehab director and SP stated it was the RD's responsibility to communicate any evaluations and recommendations at clinical meetings to the nursing staff. They stated they were unable to get the resident to the recommended barium swallow study because the resident refused to cooperate. The SP stated the resident did not want to get into the wheelchair and he had no signs or symptoms of choking such as a pneumonia. The RD stated the evaluation was done in March of 2024 and since then the resident had progressed. The RD stated the resident did not need supervision with meals. The RD stated he would not get supervision from staff they would just check in on him when he ate. The RD stated the doctor signed the SP evaluation on [DATE] with no further recommendations. The RD stated she was never notified or told the resident was coughing while eating or choking. 2. Record review of Resident #5's face sheet dated [DATE] revealed a [AGE] year-old female, admitted on [DATE] and readmitted on [DATE] with diagnoses of cerebral infarction (stroke, is a brain lesion in which a cluster of brain cells die when they don't get enough blood.), Alzheimer's disease late onset (disease that affects memory), insomnia (inability to sleep or stay asleep), unsteadiness on feet, and history of falling. Record review of Resident #5's quarterly MDS dated [DATE] revealed Resident #5 was severely impaired for daily decision making, had 1 fall with no injury, and 1 fall with injury (except major) since admission/entry or reentry or admission. Record review of Resident #5's comprehensive person-centered care plan, dated [DATE], revealed the Resident #5 had a history of falls related to Alzheimer's with intervention to ensure proper footwear, staff to increase activities, wedge cushion ordered for chair, staff to ensure resident is positioned at nurses station, staff to provide frequent rounds, keep bed in lowest position with brakes locked, and staff to provide hand activities for resident while up. During an observation on [DATE] at 10:33 a.m. Resident #5 was lying in bed. There was a single fall mat folded into a stack of three layers on the ground, aligned on one side of the bed. The mat did not cover the side of the bed because it was folded up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 11:36 a.m. the mat was observed in the same position and the resident was still laying in the bed. During an interview on [DATE] at 12:14 p.m. the DON stated Resident #5 had memory issues and would often get out of bed and kick everything out of the way. The DON stated she had fall matts in her room and they had brought up that the resident would kick them out of the way at a care plan meeting before. The DON stated they should care plan the fall matts. Record review of document titled Speech Therapy Plan of Care - [DATE], dated [DATE], revealed profound language impairments and mild pharyngeal swallow function impairments (,d+[DATE]% ability). Section titled Underlying Impairments listed Verbal Expression- Automatic speech severe impairment, Auditory Comprehension- 1 step commands severe impairment, Auditory Comprehension- wh questions- Severe Impairment, and Pharyngeal Swallow Deficits- after swallow. The reasons for referral were without therapeutic intervention patient at risk for: choking, aspiration, weight loss, inability to meet nutritional needs via PO intake of least restrictive diet .Bedside Swallowing Assessment .Pharyngeal phase: Patient demonstrated no signs or symptoms of aspiration during meal or when drinking . Patient demonstrated strong reflexive coughing episode > 10 minutes after last PO intake with face reddening/eye tearing, suspected aspiration/penetration of secretions vs reflux material. Patient seized coughing and resumed normal breathing pattern within 20 seconds. Conclusion patient demonstrated grossly within functional limits oropharyngeal swallow at his current/baseline diet level however it is strongly recommended that the patient take meals in the dining room with staff supervision going forward, if he were to experience choking/aspiration during a meal in his room, staff would not be able to recognize the signs or help him in a timely manner, increasing his risk of an emergency event. Additionally patient shows signs that he may be aspirating/choking on reflux material after eating, and should be kept in an upright position, such as in his wheelchair and within close proximity to staff for supervision and assistance if necessary. SLP to provide skilled dysphasia intervention to provide staff education on choking/ reflux precautions and order/ complete MBSS to objectively assess for risk of aspiration, reflux, esophageal dysmotility, etc. Record review of Speech Therapy daily notes [DATE] through [DATE] stated: [DATE] patient taken for on site MBSS (Modified Barium Swallow Study (MBSS) is a specialized x-ray procedure that helps both the Radiologist (who specializes in using x-rays) and the Speech Language Pathologist (SLP) identify why someone is having trouble with swallowing). Patient presented with very high anxiety when SLP and transport aide attempted to bring him out- shaking, yelling, waving people away. Patient was briefly calmed while being taken to the van and set up. patient resumed elevated behavior when evaluating SLP presented trials. Patient accepted one teaspoon of thin liquid by cup and began to shout and rock back and forth violently before swallowing. Agitation continued across other trials/ consistencies attempted, and with multiple feeders. results inconclusive due to lack of patient participation, however no penetration/ aspiration observed with 1 swallow. Anatomy noted with cervical osteocytes and decreased lordodic curvature nearing pharyngeal space and creating pharyngeal pressure system deficit. Recommendations are to continue current diet (mechanical soft and thin liquid, crushed meds) while taking all meals upright and supervised with assistance as needed. [DATE] SLP discussed with CNA recommendations for patient to be up in wheelchair in dining room for lunch period CNA reported patient becoming severely agitated (screaming, shaking, vehemently refusing) during attempts to get him out of bed. CNA attempted again today and reported similar behavior. SLP acknowledged and documented CNA's report. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] SLP assisted patient with lunch at bedside. Patient mostly self-fed with fingers, occasionally accepting prefilled spoons with help from SLP. Patient ate rapidly/ impulsively and was not responsive to verbal/ gestural cues to pace himself or alternate bites/sips. Patient refused liquid wash each time it was offered. No signs or symptoms aspiration T/ O meal, adequate oral clearance at the end of the meal. [DATE] patient had ,d+[DATE] PBJ sandwich, unmodified, self-fed. Patient was able to take bites out of the sandwich. Ataxia (neurological sign consisting of lack of voluntary coordination of muscle movements that can include trouble eating and swallowing) evident during mastication but patient still able to manipulate and propel bolus effectively. Patient used liquid wash on his own. SLP checked oral cavity to ensure no pocketing/stasis after he finished. Record review of the facility's care plan policy, dated ,d+[DATE], stated policy: it is the policy of this home that staff must develop a comprehensive care plan to meet the needs of the resident .Note remember the residents care plan is a tool used to coordinate all care provided to the resident to be sure care is necessary, appropriate and planned to meet individual needs of the resident consonant with the physician's plan of care for the resident .12. Resident care plan documentation and use of the plan: a. the residents care plan is used to plan and assign care for all disciplines .c. The resident care plan must be kept current at all times .

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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** 45857 Based on observation, interviews, and record reviews, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1) reviewed for adequate supervision in that: The facility failed to ensure Resident #1 received supervision during mealtimes to prevent choking or aspiration. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 6:19 PM. While the IJ was removed on [DATE] the facility remained out of compliance at a scope of isolated with a severity of potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of choking, weight loss, decline in health, and death. The findings included: Record review of Resident #1's face sheet dated [DATE] revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated [DATE], revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated [DATE] revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on [DATE] by the physician. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Northgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5757 N Knoll San Antonio, TX 78240	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a nursing progress note, dated [DATE], stated Patient eating breakfast and begins coughing episode directly after eating. Patient airway patent upon assessment. Patient sitting upright in bed, call light with reach. NP notified RP, MD and staff nurse. Record review of document titled Speech Therapy Plan of Care - [DATE], dated [DATE], revealed profound language impairments and mild pharyngeal swallow function impairments (,d+[DATE]% ability). Section titled Underlying Impairments listed Verbal Expression- Automatic speech severe impairment, Auditory Comprehension- 1 step commands severe impairment, Auditory Comprehension- wh questions- Severe Impairment, and Pharyngeal Swallow Deficits- after swallow. The reasons for referral were without therapeutic intervention patient at risk for: choking, aspiration, weight loss, inability to meet nutritional needs via PO intake of least restrictive diet .Bedside Swallowing Assessment .Pharyngeal phase: Patient demonstrated no signs or symptoms of aspiration during meal or when drinking . Patient demonstrated strong reflexive coughing episode > 10 minutes after last PO intake with face reddening/eye tearing, suspected aspiration/penetration of secretions vs reflux material. Patient seized coughing and resumed normal breathing pattern within 20 seconds. Conclusion patient demonstrated grossly within functional limits oropharyngeal swallow at his current/baseline diet level however it is strongly recommended that the patient take meals in the dining room with staff supervision going forward, if he were to experience choking/aspiration during a meal in his room, staff would not be able to recognize the signs or help him in a timely manner, increasing his risk of an emergency event. Additionally patient shows signs that he may be aspirating/choking on reflux material after eating, and should be kept in an upright position, such as in his wheelchair and within close proximity to staff for supervision and assistance if necessary. SLP to provide skilled dysphasia intervention to provide staff education on choking/ reflux precautions and order/ complete MBSS to objectively assess for risk of aspiration, reflux, esophageal dysmotility, etc. Record review of Speech Therapy daily notes [DATE] through [DATE] stated: [DATE] patient taken for on site MBSS (Modified Barium Swallow Study (MBSS) is a specialized x-ray procedure that helps both the Radiologist (who specializes in using x-rays) and the Speech Language Pathologist (SLP) identify why someone is having trouble with swallowing). Patient presented with very high anxiety when SLP and transport aide attempted to bring him out- shaking, yelling, waving people away. Patient was briefly calmed while being taken to the van and set up. patient resumed elevated behavior when evaluating SLP presented trials. Patient accepted one teaspoon of thin liquid by cup and began to shout and rock back and forth violently before swallowing. Agitation continued across other trials/ consistencies attempted, and with multiple feeders. results inconclusive due to lack of patient participation, however no penetration/ aspiration observed with 1 swallow. Anatomy noted with cervical osteocytes (Osteophytes are exostoses (bony projections) that form along joint margins) and decreased lordodic curvature nearing pharyngeal space and creating pharyngeal pressure system deficit (the decrease of the normal curvature, near the throat, can cause increased pressure in the airway causing partial or complete block). Recommendations are to continue current diet (mechanical soft and thin liquid, crushed meds) while taking all meals upright and supervised with assistance as needed. [DATE] SLP discussed with CNA recommendations for patient to be up in wheelchair in dining room for lunch period CNA reported patient becoming severely agitated (screaming, shaking, vehemently refusing) during attempts to get him out of bed. CNA attempted again today and reported similar behavior. SLP acknowledged and documented CNA's report. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

[DATE] SLP assisted patient with lunch at bedside. Patient mostly self-fed with fingers, occasionally accepting prefilled spoons with help from SLP. Patient ate rapidly/ impulsively and was not responsive to verbal/ gestural cues to pace himself or alternate bites/sips. Patient refused liquid wash each time it was offered. No signs or symptoms aspiration T/ O meal, adequate oral clearance at the end of the meal.

[DATE] patient had ,d+[DATE] PBJ sandwich, unmodified, self-fed. Patient was able to take bites out of the sandwich. Ataxia (neurological sign consisting of lack of voluntary coordination of muscle movements that can include trouble eating and swallowing) evident during mastication but patient still able to manipulate and propel bolus effectively. Patient used liquid wash on his own. SLP checked oral cavity to ensure no pocketing/stasis after he finished.

During an observation on [DATE] at 11:13 a.m. Resident #1 was in his room alone in bed. Resident #1 was sitting up in bed. Resident #1 had a regular plate (not a divided plate as indicated in the resident's order) with spaghetti, cooked squash, a hard brown piece of toast, a dessert dish with watery gelatin snack, a coffee cup with no top, and a clear cup with a purple liquid drink with no top. The tray of food had liquid spilled all over it. A napkin was soaked with brown liquid and the diet sheet was also stained with brown liquid. Resident #1 grabbed the hard toast, took a bite, and a crunch noise was heard. The resident put the bread down. This survey asked Resident #1 if the bread was too hard and Resident #1 nodded his head yes. Resident #1 lifted his fork with his left hand. Resident #1's hand was shaking, and food fell off the fork. The Resident #1 put the fork down on the tray. Resident #1 grabbed a handful of spaghetti and began to shove it in his mouth. Resident #1 ate quickly. No straws, condiments, or cheesecake were noted on the tray of food. There was a diet sheet from the kitchen which showed Resident #1's name, stated he was on a regular mechanical soft diet with thin liquids, no allergies were listed, adaptive equipment: divided plate, entree: meat sauce, starch: spaghetti noodles, vegetable: zucchini, bread garlic toast, dessert: cheesecake, condiment salt/pepper/margarine, and beverage: choice of beverage and water.

During an observation on [DATE] at 11:30 Resident #1 was delivered a meal tray by an unidentified male staff. The staff exited the room right after delivering the tray. Resident #1 was eating in his room alone. At 11:38 a.m. an unidentified female staff went into his room. The resident's plate had no food left. The staff lifted a utensil with the last bite of food for the resident to eat. The staff stated Resident #1 can eat on his own, but she will go in to help him because he made a mess. Resident #1 again had a regular plate. The staff stated the resident chose to eat with his hands.

During an interview on [DATE] at 2:40 p.m. the Dietary Manager (DM) stated she had a binder of forms with dietary preferences and allergies for some residents but not all. The DM stated if a resident had an allergy, nursing would notify them with a paper . The DM stated she did not have a form in her binder for Resident #1. The DM stated they were not aware of Resident #1's food allergy to mushrooms and the spaghetti did not have mushrooms in it. The DM stated the kitchen did not have any mushrooms in it and it had been a while since the kitchen had any mushrooms. The DM stated the facility had divided plates available. The DM stated Resident #1 was supposed to receive a divided plate and staff needed to pay attention to what the diet sheet showed the resident needed for adaptive equipment. The DM stated the divided plate was needed to help the resident get his food better. The DM stated the cooks had over cooked the bread and needed to pay attention because residents would not be able to eat hard bread especially if they are on a mechanical soft diet. The DM stated the gelatin snack was not made right and was too watery. The DM stated the cooks had substituted the cheesecake with the gelatin snack but the resident should not have been served the watery gelatin snack.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:12 a.m. the Speech Therapist stated Resident #1 was evaluated in March. The SP stated she was working with the Resident due to history of stroke and he had dysphagia. The SP stated if Resident #1 was presented food he would not take it and preferred to eat with his hands. The SP stated in March she recommended Resident #1 eat in the dining room per her notes because he could not communicate to staff and in case of an emergency he needed to be with in sight. The SP stated she they attempted to take Resident #1 to the dining room for meals in March after her recommendation but the Resident had a panic attack. The SP stated her recommendations were given to the rehab director and to the DON. The SP stated the Resident should have a divided plate with meals and his cups should have plastic lids and a straw. The SP stated she did go in the room to assist the resident with meals because she also helped with other residents and could not always be in the room with him. During an interview on [DATE] at 12:35 a.m. the DON stated the Rehab director would usually let them know what findings they had from an evaluation. The DON stated Resident #1 was supervised only for meals, he was able to feed himself, he could use utensils, staff would set the tray up uncover everything for him, give him the spoon, he would pick it up and feed himself, and she did not see him shake or have tremors. The DON stated they were notified Resident #1 needed to eat in the dining room for queuing (prompting to eat) and or if he dropped his silverware. The DON stated the resident was very contracted and he refused to go to the dining room because it was painful for him to move. The DON stated staff would set the resident up at 90 degrees in bed, would set up his tray, and would go in and out of his room to supervise him during meals in his room. The DON stated they did not document or care plan the resident's refusals to go to the dining room. The DON stated staff would attempt 3 times to get the resident up and then would notify the nurse if he refused. The DON stated the SP would go in the room to sit with the resident and help him eat. The DON stated she had not read the SP evaluation and plan of care for Resident #1. The DON read the POC and stated she did not agree that staff would not be able to assist the resident in an emergency because the staff was CPR certified and could also perform the Heimlich maneuver. The DON stated she had never been notified that the resident would cough or choke while eating and the SP should have reported this to nursing. During a joint interview on [DATE] at 4:37 p.m. with Rehab director and SP stated it was the RD's responsibility to communicate any evaluations and recommendations at clinical meetings to the nursing staff. They stated they were unable to get the resident to the recommended barium swallow study because the residents refused cooperate. The SP stated the resident did not want to get into the wheelchair and he had no signs or symptoms of choking such as a pneumonia. The RD stated the evaluation was done in March of 2024 and since then the resident had progressed. The RD stated the resident did not need supervision with meals. The RD stated he would not get supervision from staff they would just check in on him when he ate. The RD stated the doctor signed the SP evaluation on [DATE] with no further recommendations. The RD stated she was never notified or told the resident was coughing while eating or choking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled 'Nutritional Recommendations, dated ,d+[DATE], stated policy: it is the policy of this home that the deal in/ DON will address recommendations by the console dietitian within three working days, if possible, of the exit of the dietician consult. Procedure: 1. the consultation will complete the nutritional recommendation form and/ or enteral feeding recommendations, sign, and date. 2. The consult dietitian will discuss the recommendations and exit conference with the administrator, director of nursing, and dietary service manager for clarification. After completion of the discussion, each will sign the form. 3. The dietitian will keep one copy of the form and give the other copy to the director of nursing. 4. The director of nursing or designee will contact the physician for orders or denial of the recommendation. The director of nursing or designee will write the physician's response and date and the follow up section. A note should be made regarding the reason for refusal if the physician denies the recommendation. 5. when recommendations have been completed and follow up column filled in, the director of nursing gave a copy to the administrator and dietary service manager. 6. The director of nursing/ designee will write orders in the medical records to initiate the approval recommendations. 7. The [nursing/ dietary communication form] will be completed regarding any diet or supplement changes. The original copy will be placed in dietary section of the medical record and the copy will be given to the dietary. 8. On the console dietitian next visit, the completed recommendations will be reviewed, and if indicated, follow up will be made in the clinical software. 9. It is the administrator's responsibility to see that recommendations are addressed within three business days, if possible, of the consulting dietitians exit conference. The Administrator was given the IJ template and was notified of the IJ on [DATE] at 6:19 PM and a POR was requested. On [DATE] at 1:35 PM, the POR was accepted. It was documented as follows: [DATE] Plan of Removal - F 689 Immediate Action Taken Resident Specific Resident #1 will be supervised by staff during all 3 meals daily beginning on [DATE] at 7:00 pm. Resident #1 had the appropriate care plan updates completed on [DATE] at 11:20 am. System Changes On [DATE] at 7:00 pm a facility audit took place to ensure that all residents requiring supervision for meals will receive appropriate supervision. On [DATE] at 7:00 pm DON and therapy reviewed all residents who require supervision for meals have had their care plans audited to ensure that the care plans accurately reflect the residents need for supervision with meals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting on [DATE] and ongoing therapy will be present in morning meetings to ensure that all orders are communicated directly between nursing and therapy to ensure that residents requiring supervision with meals will have recommendations reviewed and carried out appropriately. Starting on [DATE] and ongoing the DON will monitor two meals daily x 5 days a week to ensure staff compliance with meal supervision for those residents requiring supervision. Starting on [DATE] and ongoing residents dietary and supervision statuses will be audited upon change of condition, appropriate MDS cycles or anytime necessary. Starting [DATE] at 11:00 am the facility's mechanism for ensuring correct diet texture for the residents is that all trays will be compared to the actual plated meal for the resident by a licensed staff member prior to being served to the resident. The meal ticket/diet order will be compared for accuracy. Education On [DATE] at 7:00 pm the Assistant Director of Nursing provided education to all staff regarding residents needing to have supervision at meals to ensure those residents will be supervised at mealtimes. Staff on future shifts will be educated prior to taking the floor. This will be accomplished by having a designated staff member in the building for that purpose and with that specific assignment. Licensed staff will be assigned by the DON to ensure that all trays/plates are correct prior to being served to the residents. Diet orders will match correctly to what is being served to the residents. This assigned licensed staff member will ensure specifically that texture, larger utensils, cup covers etc are being utilized for the residents. On [DATE] at 7:00 pm the Regional Clinical Consultant provided education to Administrator and Director of Nursing regarding residents needing supervision for meals. On [DATE] at 7:15 pm the Regional Clinical Consultant will educate DOR and clinical team as to communication and follow up during morning meetings. Starting on [DATE] at 7:00 pm the regional clinical consultant will be responsible for ensuring that staff receive the in-service/training regarding residents needing supervision during meals. Starting on [DATE] the residents dietary and supervision status will be communicated to facility staff directly by the DON and ADON. This process will be accomplished through photocopy and written communication. Starting on [DATE] the DON will be responsible for ensuring that the residents who require supervision during meals receive supervision. Starting on [DATE] at 7:00 pm during the daily stand up process all recommendations and orders will be audited by the clinical team in consultation with the therapy team to ensure compliance and follow up for all residents with orders and recommendations. The clinical consultant will review orders and recommendations daily x 4 weeks as a tool for oversight to ensure compliance. 100% Staff education compliance of the above mentioned by noon [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Verification of Plan of Removal: Confirmed via Observation of lunch and dinner meals on [DATE]. Confirmed via Record Review of Resident #1's care plan . Confirmed via Interview with Regional Clinical Consultant and DON. They each had a list of all staff with check marks. Interviewed about their process for identifying residents who needed supervision and how they ensured no one was falling through the cracks. Interviewed each independently and they both said they went through each clinical record looking at: therapy notes and recommendations, physician notes, POC notes from CNAs, progress notes from LVNs and RNs, MDS assessments, and care plans. On [DATE] at 7:00 pm DON and therapy reviewed all residents who require supervision for meals have had their care plans audited. Confirmed via Interview with Dir of Rehab and DON. Record review of the care plans for all eight of the residents (Resident #1 and additional seven who require assistance). Five care plans had been updated - edits were observed - and the updates clarified and added more specific language. For example, instead of saying supervision as needed the language was updated to read supervision at all times by nursing staff. The two that were not updated were already very precise and specific in their wording. Confirmed via Interview with Dir of Rehab DON, and Administrator Confirmed via Interview with DON. Record review of chart of items to check for each resident identified and had filled in the chart for each meal served since IJ was called. Confirmed via Interview with Regional Clinical Consultant, DON, MDS/Care Plan Coordinator, and Administrator. There were 52 total staff members 41 of the 52 staff have received in-service. Interview in person or by phone with 32 of the 52 staff members and confirmed they received the trainings and could verbalize understanding of the training. Of the 11 staff who did not receive the training: 1 FMLA, 1 vacation, and 9 PRN. Observation of a sign on the time clock stated for staff not to clock in for shift until they received in-service trainings dated [DATE]. Observation of both lunch and dinner service on [DATE] revealed each meal had an assigned licensed nurse to check meal tickets against trays. Observation of weekend RN meal tickets and trays revealed checking tickets for 15 residents versus what they had been served were completed and all were correct. The DON stated she would personally check two meals per day M-F, and weekend RN would check all three weekend meals (The DON and weekend RN work 6 am to 6 pm). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of the residents who required assistance in dining hall revealed staff were treating them with dignity, their tickets and meals were correct, and assistive devices(e.g. divided plate, built up utensils) were in place. Observation of Resident #1 dining in his room revealed his ticket and meal were correct, a divided plate was in place, covered cups in place, and a member of nursing staff was providing 1 on 1 supervision. Interviews conducted on [DATE] from 3:42 p.m. to 7:45 p.m. and on [DATE] from 9:03 a.m. to 1:30 p.m. revealed there were 14 nurses on staff, and interviewed 12 of them and all have received the in-service trainings (more detail on trainings below). Interviews conducted on [DATE] from 3:42 p.m. to 7:45 p.m. and on [DATE] from 9:03 a.m. to 1:30 p.m. revealed there are 17 CNAs on staff, 13 of them were interviewed and all received the in-service trainings. Confirmed via Interview with Regional Clinical Consultant and Record Review of in-service training. Confirmed via Interview with DON and with ADON. Record review of the in-services. One of the in-services which was given to all nursing staff identified all eight residents who require supervision and/or assistance for dining. Confirmed via Interview with DON. Observation of lunch and dinner comparison of their care plans and meal tickets against the meal, assistive devices, and level of supervision for the eight residents who required assistance received during both lunch and dinner, revealed each was correct. Confirmed via Interview with Regional Clinical Consultant and DON, MDS/Care Plan Coordinator, and Administrator. During interviews staff confirmed abuse and neglect training was done in general and every staff member confirmed ANE trainings are provided at least monthly. Regional Clinical Consultant confirmed via interview that she was personally ensuring that all staff received in-service trainings. She was onsite today and planned to stay to catch the oncoming night shift. She provided her documentation via a staff list with check offs. An IJ was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure the drugs and biologicals used in the facility must be labeled and stored in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable for 1 of 4 resident rooms (Resident #4's room) reviewed for medication storage. The facility failed to ensure Resident #4's medications were stored properly in the facility. This deficient practice could affect residents who received medications for treatments and could result in less potent or an adverse effects and drug diversion. The findings included: Record review of Resident #1's face sheet, dated 4/10/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included fracture of shaft of fibula (lower leg bone that extends from the knee to the outside of the ankle), closed fracture with routine healing, pain, type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), blindness to both eyes, and hypertension (elevated blood pressure). Record review of Resident #4's most recent quarterly MDS assessment, dated 1/10/24 revealed the resident was cognitively intact for daily decision-making skills and had severely impaired vision. Record review of Resident #4's comprehensive care plan, with edited date 4/10/24 revealed the resident had hypertension with approaches that included to give anti-hypertensive medications as ordered and monitor for side effects such as orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), increased heart rate and effectiveness. Record review of Resident #4's Physician Order Report, for date range 3/10/24 to 4/10/24 revealed the following: - furosemide tablet, 20 mg, 1 tablet once a day for hypertension, with order date 10/3/23 and no end date During an observation and interview on 4/11/24 at 8:29 a.m., Resident #4 stated, I took a thyroid pill at 6:30 a.m. this morning and a furosemide pill. Resident #4 was noted sitting up in bed with the bedside table over the resident's lap. Resident #4's bedside table had a medication cup with one small, white, round pill in it. Resident #4 identified the pill as the furosemide pill and proceeded to take the pill and put it in her mouth. Resident #4 revealed a male nurse had left the pill in the medication cup at the bedside because the resident was not ready to take the pill at the time the male nurse gave it to her. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/24 at 10:12 a.m., LVN A stated he had given Resident #4 a furosemide pill earlier in the morning but Resident #4 told LVN A she wanted to take the furosemide later. LVN A stated, I forgot to check on Resident #4, and left the pill at the bedside. LVN A revealed, he was not supposed to leave the medication at the bedside because another resident could take the furosemide or Resident #4 could lose the pill or throw it away and it could result in Resident #4's blood pressure to increase, which could cause an increase in the furosemide dosage even if she did not need it. During an interview on 4/12/24 at 8:09 a.m., the DON revealed it was her expectation medications were not to be left unattended or at the bedside because anybody can take it and if the medication, such as furosemide was tossed out by the resident it was intended for, the resident could develop fluid overload, congestive heart failure or a heart attack. Record review of the facility policy and procedure titled, Medication Storage - in the Home, effective date 12/2017 revealed in part, .It is the policy of this home that medications will be stored appropriately as to be secure from tampering, exposure or misuse .Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications .

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NAME OF PROVIDER OR SUPPLIER Northgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5757 N Knoll San Antonio, TX 78240	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	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** 45857 Based on observation, interviews, and record reviews, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 1 of 3 residents (Residents #1) reviewed for food and nutrition services. The facility failed to ensure Resident #1 received a mechanical soft diet in the proper consistency. This deficient practice could place residents who received pureed meals at risk of dissatisfaction, poor intake, choking, and/or weight loss. The findings included: Record review of Resident #1's face sheet dated 4/10/24 revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated 02/20/24, revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated 01/18/24 revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on 02/01/24 by the physician. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/10/24 at 11:13 a.m. Resident #1 was in his room alone in bed. Resident #1 was sitting up in bed. Resident #1 was served a hard brown piece of toast with his lunch meal. Resident #1 grabbed the hard toast, took a bite, and a crunch noise was heard. The Resident put the bread down. This survey asked Resident #1 if the bread was too hard and Resident #1 nodded his head yes. Resident #1 lifted his fork with his left hand. Resident #1's hand was shaking, and food fell off the fork. The Resident #1 put the fork down on the tray. Resident #1 grabbed a handful of spaghetti and began to shove it in his mouth. Resident #1 ate quickly. No straws, condiments, or cheesecake were noted on the tray of food. There was a diet sheet from the kitchen which showed Resident #1's name, stated he was on a regular mechanical soft diet. During an interview on 04/11/24 at 2:40 p.m. the Dietary Manager (DM) stated the cooks had over cooked the bread and needed to pay attention because residents would not be able to eat hard bread especially if they are on a mechanical soft diet. The DM stated the gelatin snack was not made right and was too watery.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews, the facility failed to accommodate residents' food preferences and allergies for 1 of 3 (Resident #1) residents reviewed for food preferences and allergies, in that: The facility failed to ensure that Resident #1's daily dietary form reflected the residents allergy to mushrooms. These failures could cause an allergic reaction, a decrease in resident choices, and diminished interest in meals. The findings were: The findings included: Record review of Resident #1's face sheet dated 4/10/24 revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated 02/20/24, revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated 01/18/24 revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on 02/01/24 by the physician. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/10/24 at 11:13 a.m. Resident #1 was in his room alone in bed. Resident #1 was sitting up in bed. The resident was eating from a food tray. There was a diet sheet from the kitchen with the food tray which showed Resident #1's name, stated he was on a regular mechanical soft diet with thin liquids, no allergies were listed. During an interview on 04/11/24 at 2:40 p.m. the Dietary Manager (DM) stated she had a binder of forms with dietary preferences and allergies for some residents but not all. The DM stated if a resident had an allergy nursing would notify them with a paper. The DM stated she did not have a form in her binder for Resident #1. The DM stated they were not aware of Resident #1's food allergy to mushrooms an the spaghetti did not have mushrooms in it. The DM stated the kitchen did not have any mushrooms in it and it had been a while since the kitchen had any mushroom. During an interview on 04/12/24 at 12:35 a.m. The DON stated she was pretty sure the mushroom allergy was more of a dislike but could not be sure so they would treat it as an allergy. The DON stated if the resident ate something he was allergic to his throat could close up. Record review of the facility's policy titled 'Nutritional Recommendations, dated 12/2017, stated policy: it is the policy of this home that the deal in/ DON will address recommendations by the console dietitian within three working days, if possible, of the exit of the dietician consult. Procedure: 1. the consultation will complete the nutritional recommendation form and/ or enteral feeding recommendations, sign, and date. 2. The consult dietitian will discuss the recommendations and exit conference with the administrator, director of nursing, and dietary service manager for clarification. After completion of the discussion, each will sign the form. 3. The dietitian will keep one copy of the form and give the other copy to the director of nursing. 4. The director of nursing or designee will contact the physician for orders or denial of the recommendation. The director of nursing or designee will write the physician's response and date and the follow up section. A note should be made regarding the reason for refusal if the physician denies the recommendation. 5. when recommendations have been completed and follow up column filled in, the director of nursing gave a copy to the administrator and dietary service manager. 6. The director of nursing/ designee will write orders in the medical records to initiate the approval recommendations. 7. The [nursing/ dietary communication form] will be completed regarding any diet or supplement changes. The original copy will be placed in dietary section of the medical record and the copy will be given to the dietary. 8. On the console dietitian next visit, the completed recommendations will be reviewed, and if indicated, follow up will be made in the clinical software. 9. It is the administrator's responsibility to see that recommendations are addressed within three business days, if possible, of the consulting dietitians exit conference.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review, the facility failed to provide drinks, including, water and other liquids, consistent with resident needs and preferences for 1 (Resident #1) of 4 Residents observed for meal service. The facility failed to provide water during lunch on 04/10/24 for Resident #1. This failure could place residents at risk for thirst, dehydration, and decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 4/10/24 revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated 02/20/24, revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated 01/18/24 revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on 02/01/24 by the physician. During an observation on 04/10/24 at 11:13 a.m. Resident #1 had a coffee cup with no top, and a clear cup with a purple liquid drink with no top. The tray of food had liquid spilled all over it. A napkin was soaked with brown liquid and the diet sheet was also stained with brown liquid Resident #1's hand was shaking. There was no straws noted on the tray of food. There was a diet sheet from the kitchen which showed Resident #1's name and beverage: choice of beverage and water. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/13/2024 during lunch and dinner service Resident #1 was dining in his room revealed his ticket and meal was correct, a divided plate was in place, covered cups in place, and a member of nursing staff was providing 1 on 1 supervision. During an interview on 04/12/24 at 9:12 a.m. the Speech Therapist stated Resident #1 was evaluated in March. The SP stated she was working with the Resident due to history of stroke and he had dysphagia. The SP stated if Resident #1 was presented food he would not take it and preferred to eat with his hands. The SP stated the Resident should have a divided plate with meals and his cups should have plastic lids and a straw. The SP stated she did go in the room to assist the resident with meals but she also had to assist other residents and could not always be in the room with him. Record review of the facility's policy titled 'Nutritional Recommendations, dated 12/2017, stated policy: it is the policy of this home that the deal in/ DON will address recommendations by the console dietitian within three working days, if possible, of the exit of the dietician consult. Procedure: 1. the consultation will complete the nutritional recommendation form and/ or enteral feeding recommendations, sign, and date. 2. The consult dietitian will discuss the recommendations and exit conference with the administrator, director of nursing, and dietary service manager for clarification. After completion of the discussion, each will sign the form. 3. The dietitian will keep one copy of the form and give the other copy to the director of nursing. 4. The director of nursing or designee will contact the physician for orders or denial of the recommendation. The director of nursing or designee will write the physician's response and date and the follow up section. A note should be made regarding the reason for refusal if the physician denies the recommendation. 5. when recommendations have been completed and follow up column filled in, the director of nursing gave a copy to the administrator and dietary service manager. 6. The director of nursing/ designee will write orders in the medical records to initiate the approval recommendations. 7. The [nursing/ dietary communication form] will be completed regarding any diet or supplement changes. The original copy will be placed in dietary section of the medical record and the copy will be given to the dietary. 8. On the console dietitian next visit, the completed recommendations will be reviewed, and if indicated, follow up will be made in the clinical software. 9. It is the administrator's responsibility to see that recommendations are addressed within three business days, if possible, of the consulting dietitians exit conference.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 (Resident #1) of 3 residents reviewed for special eating equipment and assistance when consuming meals, in that: The dietary staff failed to provide Resident #1 with a divided plate to meet Resident #1's need for assistance with eating. This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem. The findings included: . Record review of Resident #1's face sheet dated 4/10/24 revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnoses of seizures, cerebrovascular disease, aphasia following cerebral infarction (a person may be unable to comprehend or unable to formulate language because of damage to specific brain regions), contracture right elbow (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), contracture right wrist, hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of half of the body). The facesheet stated Resident #1 was allergic to morphine, mushrooms, and penicillins. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was severely impaired for daily decision making, dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with ADLs in the areas of eating and drinking, and was on a mechanically altered diet. Record review of Resident #1's comprehensive person-centered care plan, dated 02/20/24, revealed the resident's interventions for ADLs included REQUIRED***EATING: Resident requires set up assist. Resident #1 had unplanned/unexpected weight loss with interventions for ice cream as ordered, monitor and record food intake at each meal, notify the dietician of the weight loss upon their next visit, notify the physician, resident and family of the weight loss, provide verbal assistance and cues during meals, weigh the resident weekly for at least 4 weeks or until weight has stabilized. Record review of Resident#1's Physician Order, dated 01/18/24 revealed an order for diet-regular, mechanical soft, and thin fluids. Special instructions FMP to all meals. Divided plate for every meal. The order was signed on 02/01/24 by the physician. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/10/24 at 11:13 a.m. Resident #1 was in his room alone in bed. Resident #1's meal was served on a regular plate, not a divided plate, a coffee cup with no top, and a clear cup with a purple liquid drink with no top. The tray of food had liquid spilled all over it. A napkin was soaked with brown liquid and the diet sheet was also stained with brown liquid. Resident #1 lifted his fork with his left hand. Resident #1's hand was shaking, and food fell off the fork. The Resident #1 put the fork down on the tray. Resident #1 grabbed a handful of spaghetti and began to shove it in his mouth. Resident #1 ate quickly. No straws were noted on the tray of food. There was a diet sheet from the kitchen which showed Resident #1's name, adaptive equipment: divided plate. During an observation on 04/11/24 at 11:30 Resident #1 lunch meal was delivered on a regular plate. During an interview on 04/11/24 at 2:40 p.m. the Dietary Manager (DM) stated the facility had divided plates available. The DM stated Resident #1 was supposed to receive a divided plate and staff needed to pay attention to what the diet sheet showed the resident needed for adaptive equipment. The DM stated the divided plate was needed to help the resident get his food better. During an interview on 04/12/24 at 9:12 a.m. the Speech Therapist stated Resident #1 was evaluated in March. The SP stated she was working with the Resident due to history of stroke and he had dysphagia. The SP stated if Resident #1 was presented food he would not take it and preferred to eat with his hands. The SP stated the Resident should have a divided plate with meals and his cups should have plastic lids and a straw. The SP stated she did go in the room to assist the resident with meals but she also helped with other residents and could not always be in the room with him. Record review of the facility's policy titled 'Nutritional Recommendations, dated 12/2017, stated policy: it is the policy of this home that the deal in/ DON will address recommendations by the console dietitian within three working days, if possible, of the exit of the dietician consult. Procedure: 1. the consultation will complete the nutritional recommendation form and/ or enteral feeding recommendations, sign, and date. 2. The consult dietitian will discuss the recommendations and exit conference with the administrator, director of nursing, and dietary service manager for clarification. After completion of the discussion, each will sign the form. 3. The dietitian will keep one copy of the form and give the other copy to the director of nursing. 4. The director of nursing or designee will contact the physician for orders or denial of the recommendation. The director of nursing or designee will write the physician's response and date and the follow up section. A note should be made regarding the reason for refusal if the physician denies the recommendation. 5. when recommendations have been completed and follow up column filled in, the director of nursing gave a copy to the administrator and dietary service manager. 6. The director of nursing/ designee will write orders in the medical records to initiate the approval recommendations. 7. The [nursing/ dietary communication form] will be completed regarding any diet or supplement changes. The original copy will be placed in dietary section of the medical record and the copy will be given to the dietary. 8. On the console dietitian next visit, the completed recommendations will be reviewed, and if indicated, follow up will be made in the clinical software. 9. It is the administrator's responsibility to see that recommendations are addressed within three business days, if possible, of the consulting dietitians exit conference.