STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525264	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook at Appleton	1335 S Oneida St Appleton, WI 54915

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 - Immediate jeopardy to resident health or safety 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** 38793 Based on staff interview and record review, the facility did not ensure food was prepared and served in a form designed to meet individual needs for 1 resident (R) (R1) of 4 residents who had an order for a mechanically-altered diet. R1 was admitted to the facility on [DATE] following a hospitalization . R1's hospital discharge orders indicated R1 should receive a pureed diet, however, staff transcribed R1's diet order as mechanical soft with nectar-thickened liquids. On 3/13/24, R1 received the wrong meal tray and was served food that was not in accordance with R1's diet order. R1 aspirated, required hospitalization , and passed away on 3/23/24 from respiratory failure secondary to aspiration pneumonia. The facility's failure to prepare and serve food in a form to meet a resident's needs created a finding of Immediate Jeopardy that began on 3/13/24. The State Agency (SA) notified Nursing Home Administrator (NHA)-A of the Immediate Jeopardy on 4/2/24 at 3:34 PM. The Immediate Jeopardy was removed and corrected on 3/17/24. Findings include: As of October 2021, the Academy of Nutrition and Dietetics announced International Dysphagia Diet Standardization Initiative (IDDSI) is the only professionally recognized standard of care for texture modified diets in the Nutrition Care Manual of the Academy of Nutrition & Dietetics for the United States. The IDDSI framework identifies five levels for foods: 7. Regular, easy to chew; 6. Soft and bite-sized (most similar to mechanical soft); 5. Minced and moist; 4. Pureed; and 3. Liquidized. The facility's Consistency of Modified Foods policy, revised January 2021, indicates: Pureed foods are pudding-like or have a consistency similar to mashed potatoes with a homogenous consistency, without coarse textures . The facility's Physician Orders policy, revised March 2020, indicates: When receiving a written/faxed order . After noting an order, the receiving licensed nurse enters the order into the electronic medical record (EMR) and ensures it is active in the electronic administration record as appropriate. (continued on next page)

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

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/2/24, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] with diagnoses including dementia, Down syndrome, anxiety, and dysphagia (difficulty swallowing). R1's Minimum Data Set (MDS) assessment, dated 3/14/24, contained a Brief Interview for Mental Status (BIMS) score of 99 which indicated R1 was cognitively impaired. R1's guardianship was active upon admission. On 4/2/24, Surveyor reviewed an investigation, dated 3/17/24. The investigation indicated R1 was given a regular diet instead of a pureed diet on 3/13/24 and had an episode of coughing and emesis (vomiting). R1 was hospitalized the following morning and diagnosed with aspiration pneumonia. The investigation indicated an incorrect diet was entered in R1's medical record upon admission. Surveyor noted R1's hospital discharge paperwork, dated 3/10/24, stated Dysphagia I Pureed diet, however, R1's medical record contained a diet order, dated 3/10/24, that stated Regular diet, mechanical soft texture, nectar thickened liquid consistency. R1's baseline care plan indicated R1 had a regular, mechanical soft diet with nectar-thickened liquids and ate in the dining room. A nursing progress note, dated 3/13/24, indicated: (Licensed Practical Nurse (LPN)-E) was informed by (Certified Nursing Assistant (CNA)-G) that (R1) was given the wrong tray in the dining room. (R1) coughed and vomited. (LPN-E) called the Nurse Practitioner (NP) who gave an order for a stat (immediate) chest X-ray one time only for suspected aspiration. On 4/2/24 at 9:40 AM, Surveyor interviewed NP-F who verified an on-call NP ordered an X-ray on 3/14/24 and instructed staff to send R1 to the hospital. NP-F reviewed R1's hospital record and stated R1 received intravenous (IV) antibiotics for aspiration pneumonia. NP-F confirmed R1 passed away at the hospital on 3/23/24 due to respiratory failure secondary to aspiration pneumonia. On 4/2/24 at 10:14 AM, Surveyor interviewed LPN-E who verified LPN-E took verbal report via telephone for R1's admission. LPN-E stated LPN-E was made aware of R1's pureed diet order and completed a dietary communication form that indicated R1 should receive a pureed diet. LPN-E stated on LPN-E's next shift on 3/13/24, CNA-G told LPN-E that R1 was coughing and spitting out R1's dinner. LPN-E immediately assessed R1 and notified the on-call NP. On 4/2/24 at 10:19 AM, Surveyor interviewed Dietary Manager (DM)-H who verified R1's dietary slip stated mechanical soft. DM-H stated R1 was served a bean and meat burrito, not cut up because the tortilla was soft enough, along with refried beans and banana crumble with no topping. On 4/2/24 at 11:10 AM, Surveyor interviewed Registered Nurse (RN)-D who verified RN-D entered a mechanical soft diet order in R1's medical record. RN-D could not recall where RN-D got the order and was unsure if a second check was completed for R1's admission orders. RN-D could not recall if RN-D placed R1's admission orders on the nursing station desk or in the basket designated for orders needing a second check. On 4/2/24 at 12:42 PM, Surveyor interviewed Chief Nursing Officer (CNO)-C who verified the facility was unable to confirm if a second check was completed for R1's admission orders, but confirmed all orders should be verified by a second licensed nurse. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/2/24, Surveyor reviewed a written and signed statement from Cook (CK)-I that indicated CK-I provided R1 with a dinner tray on 3/13/24. CK-I stated R1's dietary card stated mechanical soft and R1 was served a mechanical soft tray. On 4/2/24, Surveyor reviewed a written and signed statement from CNA-G, dated 3/17/24, that stated R1 was seen spitting up R1's food and coughing. CNA-G immediately notified LPN-E. CNA-G indicated R1 had not received a pureed diet since R1 was admitted to the facility. The failure to prepare and serve a diet which met R1's needs led to serious harm for R1 which created a finding of Immediate Jeopardy. The facility removed and corrected the jeopardy on 3/17/24 when it completed the following: 1. Reviewed residents' diet orders for accuracy. 2. Educated all nursing, dietary, and CNA staff. 3. Initiated daily audits to ensure diet accuracy.