| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555118 | A. Building<br>B. Wing | 12/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Almond Vista Healthcare | 2030 Evergreen Avenue<br>Modesto, CA 95350 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44708<br><br>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received adequate supervision to prevent accidents when Resident 1 was admitted on [DATE] from an acute care hospital with known history of difficulty swallowing, assessed need for strict aspiration precautions (safety measures to prevent patients from breathing in foreign objects, like food or liquids, into their lungs), Minimum Data Set (MDS - a federally mandated process for clinical assessment of all residents of long term care nursing facilities) indicating moderate cognitive deficits (a stage of dementia where a person has significant difficulty with complex tasks and navigating new places) and need for assistance with meals and a care plan was not developed to address nursing staff to provide supervision during meals. Resident 1 was permitted to feed himself, unsupervised.<br><br>These failures resulted in Resident 1 choking during dinner on [DATE] and Resident 1 was transported to an acute care hospital for higher level of care. Resident 1 was diagnosed with Respiratory Failure (a serious condition that occurs when the lungs can't get enough oxygen into the blood or remove enough carbon dioxide from the body), Aspiration Pneumonia (a lung infection that occurs when food, liquid, saliva, vomit, or other foreign objects are inhaled into the lungs instead of being swallowed), Severe Protein Calorie Malnutrition (a significant inadequate intake of nutrition) and Chronic Kidney Disease Stage III (3; a moderate level of kidney damage) . and subsequently died on [DATE].<br><br>Findings:<br><br>During a review of Resident 1's Progress Notes (PN), dated [DATE], the PN indicated, Nurse (Licensed Vocational Nurse 1) was called by Certified Nursing Assistant (CNA) at 5:46 p.m. for patient not responding to verbal command, observed patient sitting in his wheelchair with his head down, tap patient shoulders, patient not responding, per CNA patient was just finished with his dinner and was yelling to the Sitter (one individual assigned to supervise one resident; Resident 1's roommate at the time) then suddenly stop and start gasping for air . mouth swept with no foreign object noted, weak pulse and noticing patient gasping for air. Heimlich (a first-aid technique that uses quick, upward thrusts to dislodge a foreign object from a choking person's airway) was performed immediately .911 (three-digit telephone number [DATE] has been designated as the Universal Emergency Number ) was notified at 5:50 p.m.CPR (cardiopulmonary resuscitation - life saving measure of chest compressions and rescue breathing) started at 5:53 p.m. EMT (Emergency Medical Technicians; a person trained to care for patients at the scene of an emergency and taking patients by ambulance to a hospital) arrived and took over at 6:05 p.m. Resident was transferred out to [acute hospital] at 6:15 p.m.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555118 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/03/2024 |
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| NAME OF PROVIDER OR SUPPLIER Almond Vista Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 2030 Evergreen Avenue Modesto, CA 95350 | |

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During a review of Resident 1's Certificate of Death (COD), dated [DATE], the COD indicated, .Cause of Death: Respiratory Failure, Aspiration Pneumonia, Severe Protein Calorie Malnutrition and Chronic Kidney Disease Stage III .

During a review of Resident 1's hospital Discharge Summary (DS), dated [DATE], the DS indicated, .Death Summary for 06.07 ([DATE]): He (Resident 1) passed away on ,d+[DATE] ([DATE]). Cause of death: respiratory failure secondary to aspiration pneumonia, CKD (Chronic Kidney Disease) stage 3, Severe protein calorie malnutrition .

During an interview on [DATE] at 4:12 p.m. with Certified Nursing Assistance (CNA) 3, CNA 3 stated, she was assigned to Resident 1 on [DATE]. CNA 3 stated, Resident 1 had behaviors of yelling, making grunting noise, was combative, hard to redirect, and not cooperative. CNA 3 stated, Resident 1 was able to feed himself and required assistance with setting up his meals. CNA 3 stated, on [DATE] after dinner time, she was picking up trays when the Sitter called for assistance to Resident 1's room. CNA 3 stated, she went to Resident 1's room and saw Resident 1 slumped over in his wheelchair and was unresponsive. CNA 3 stated, LVN 1 came to Resident 1's room and initiated Heimlich maneuver and CPR.

During an interview on [DATE] at 9:15 a.m. with Director of Nursing (DON), DON stated, Sitter was unavailable for interview. DON stated, Sitter was on a leave of absence (an extended period of unpaid time away from work). DON stated, LVN 1 was unavailable for interview. DON stated, LVN 1 resigned (someone who has voluntarily decided to leave their employment) on [DATE].

During a review of Resident 1's Admission Record (AR), dated [DATE], the AR indicated, Resident 1 was admitted to the facility on [DATE] with a history of Metabolic Encephalopathy (a group of neurological disorders that occur when a chemical imbalance in the blood affects the brain), Type 2 Diabetes Mellitus (a chronic disease that occurs when the body does not produce enough insulin; a hormone that lowers the level of glucose; a type of sugar in the blood or does not use it properly, resulting in high blood sugar levels), Cerebral Infarction without Residual Deficits (brain tissue damage due to a blockage of blood flow with no lasting neurological impairments or symptoms), Dysphagia (difficulty swallowing), Psychoactive Substance Abuse (the compulsive use of psychoactive drugs; substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions despite negative consequences), Schizophrenia (a chronic mental illness that affects a person's ability to think, feel, and behave normally), and Chronic Kidney Disease (an ongoing condition where the kidneys are damaged and cannot filter blood properly).

During a review of Resident 1's MDS, dated [DATE], the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS - an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 9 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment).

During a review of Resident 1's MDS for Functional Abilities and Goals (FAAG), dated [DATE], the FAAG indicated, Resident 1 required .Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently . when eating.

(continued on next page)

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| NAME OF PROVIDER OR SUPPLIER Almond Vista Healthcare | | STREET ADDRESS, CITY, STATE, ZIP CODE 2030 Evergreen Avenue Modesto, CA 95350 | |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Order Summary Report (OSR), dated [DATE], the OSR indicated, .CCHO (Consistent Carbohydrate Diet - is a diet that involves eating the same amount of carbohydrates each day to help manage blood sugar levels) diet Mechanical soft (a texture-modified diet that consists of foods that are soft and easy to chew and swallow) texture, Thin liquids consistency for diabetic diet .<br><br>During a review of Resident 1's hospital Speech Language Pathology (SLP - a specialty that involves diagnosing and treating communication and swallowing disorders) Progress Note (SLP PN), dated [DATE], the SLP PN indicated, .ST REC (Speech Therapy recommendation): Mechanical soft diet w/ (with) ground meats and thin liquids w/ strict aspiration precautions including 1:1 (one individual assigned to supervise one resident) supervision for small bites/slow pace and assist as needed, ensure clear oral cavity at completion of meal .<br><br>During a review of Resident 1's hospital Speech Language Pathology Progress Note (SLP PN), dated [DATE], the SLP PN indicated, .ST recommendation a Mechanical Soft Diet with Ground Meats and Thin Liquids with supervision due to impulsivity .<br><br>During a review of Resident 1's Speech Therapy SLP Evaluation and Plan Treatment (SLP E&P), dated [DATE], the SLP E&P indicated, .Clinical Impressions: Pt (patient) tolerating current Mech (Mechanical) Soft, thin liquid diet c (with) no overt s/s (signs and symptoms) aspiration. Pt. reports similar diet previously. Pt is believed to be at baseline level .<br><br>During a review of Resident 1's hospital Transfer: Interfacility From/& To Skilled Nursing Facility (SNF), Sub-Acute & Rehabilitation TRANSFER FORM (IFT; a form used to communicate patient information from one facility to another), dated [DATE], the IFT indicated, .NURSING INFORMATION. Eating: Assistance . was checked.<br><br>During a review of Resident 1's Resident Diet System (RDS - a tool developed for dietary departments in assisted living and skilled nursing communities designed to help improve communication and increase efficiency), undated, the RDS indicated, .Diagnosis: dysphagia, assistance with meals .<br><br>During a review of Resident 1's Tray Ticket (TK; a printed list of a patient's meal order and preferences for each meal), dated [DATE], the TK indicated, .Assistance: Assisted: . was left blank.<br><br>During a review of Resident 1's Care Plans (CP), dated [DATE], the CP indicated, there was no care plan for assisting Resident 1 with meals.<br><br>During an interview on [DATE] at 3:30 p.m. with the facility's Speech Language Pathologist (SLP- a specialist who diagnose and treats a wide range of speech, language, cognitive, and swallowing disorders), SLP stated, during her assessment (gathering of information) of Resident 1 on [DATE], Resident 1 did not demonstrate impulsive behaviors that would indicate Resident 1 required supervision at the time of the observation. SLP stated, during the observation, Resident 1 was able to feed himself independently and was able to swallow adequately. SLP stated,[EJ35] [ST36] she should have obtained Resident 1's [DATE] and [DATE] hospital SLP evaluations and recommendations to accurately assess Resident 1 to provide the appropriate recommendation. SLP stated, SLP would have recommended Resident 1 was supervised during mealtime. SLP stated, there was a missed opportunity to assess Resident 1 accurately to make the appropriate recommendation.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on [DATE] at 11:47 a.m. with Medical Doctor (MD), MD stated, Resident 1 was impaired (problems with a person's ability to think, learn, remember, and make decisions) with a history of substance (drug) abuse and was admitted to the psychiatric unit (a hospital setting where people receive short-term or in-patient treatment for severe mental health issues) on several occasions. MD stated, Resident 1 had a high risk for aspiration. MD stated, it was possible to aspirate on the recommended diet due to brain damage from drug use, impaired gag reflex (a natural bodily response that prevents choking and swallowing something unpleasant) and eating too fast.<br><br>During an interview on [DATE] at 6:00 p.m. with DON, DON stated, Resident 1's [DATE] and [DATE] hospital SLP evaluations and recommendations were not available at the facility. DON stated, Resident 1 was admitted on [DATE] from the acute care hospital and the hospital's SLP PN records was not sent with Resident 1. DON stated, Resident 1 was assessed by the facility's SLP on [DATE] and SLP did not recommend supervision during mealtimes. DON stated, SLP should have obtained and reviewed Resident 1's [DATE] and [DATE] hospital SLP evaluations and recommendations to make an accurate assessment and provide the proper recommendation. DON stated, Resident 1's [DATE] Tray Ticket and [DATE] MDS code for eating assistance was broad (vague). DON stated, a care plan was not developed for Resident 1 to address the type of assistance Resident 1 required during meals. DON stated, individualized care plans were required to include specific interventions to provide the appropriate level of assistance to prevent choking. DON stated, the aspiration could have been avoided had Resident 1 been provided proper supervision during dinner on [DATE].<br><br>During an interview on [DATE] p.m. at 3:39 p.m. with Administrator (ADM), ADM stated, the expectation and standard of practice to ensure residents were provided the appropriate level of care was to review all pertinent (relevant) information available. ADM stated, staff was required to obtain all necessary information to accurately assess the needs of Resident 1 and make the appropriate recommendations. ADM stated, staff was required to develop resident centered care plans with specific interventions. ADM stated, Resident 1's information should have been thoroughly reviewed and a resident centered care plan should have been developed with specific interventions to address the needs of Resident 1 during mealtime. ADM stated, the aspiration could have been avoided had Resident 1 been adequately supervised during dinner on [DATE].<br><br>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated ,d+[DATE], the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Policy Interpretation and Implementation . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/34273953/ titled, Interventions to prevent aspiration in older adults with dysphagia living in nursing homes: a scoping review, dated [DATE], the professional review indicated, Dysphagia is [a] highly prevalent condition in older adults living in nursing homes. There is also evidence indicating that aspiration is one of the major health risks for these older adults, which is more likely to result in respiratory infections, aspiration pneumonia and sudden bolus death . Interventions to prevent aspiration in older adults with dysphagia living in nursing homes included: more bedside evaluation, modification of dietary, creating an appropriate environment for swallowing, providing appropriate feeding assistance, appropriate posture or maneuver for swallowing, appropriate rehabilitation program, medication treatment, and stimulation treatment . Nursing home residents respond well to person-centered interventions that have a comprehensive consideration of their degree of aspiration risk, health condition, individual feelings and cognitive state. |