STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676352	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonemere Rehabilitation Center	11855 Lebanon Road Frisco, TX 75035

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report to the State agency when Resident #1 died in the facility after a choking episode in the facility's dining room. This failure could place residents at risk of neglect. Findings include : Record review of Resident #1's Admission Record, dated [DATE], reflected an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS assessment, dated [DATE], reflected her diagnoses included history of stroke, dysphagia (difficulty swallowing) following cerebrovascular disease (disease involving blood vessels in the brain), other speech and language deficits following a stroke, falls, hypertension (high blood pressure), and diabetes. She had severe cognitive impairment, she was totally dependent on staff for eating (helper does all of the effort) and all other ADLs, and she was on a mechanically altered diet. Record review of Resident #1's Care Plan reflected the following Special Instructions: Assist with Feeding Aspiration (accidental breathing in food or fluids) Precautions-Nectar Thick Liquids or Thin via 5cc (Blue) Provale Cup (specialized cup that only allows a small amount to be sipped at a time). An entry initiated [DATE] reflected: Focus: I am on a NAS/CC Diet, Thin liquids with provable cup, Minced texture, may have regular bread and desserts, No pureed vegetables, requires assistance with meals, refuses assistance frequently will not let anyone help with meals, eats with hands, may wear glove when eating. Interventions/Tasks included: Dietary Consult as needed; offer a varied menu with choices; offer other condiments to substitute for sugar/sweets and Salt. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another entry, dated [DATE], reflected: Focus: I am a DNR. Interventions/Tasks: If found absent of vital sign do not initiate CPR. Record review of Resident #1's Order Summary Report, dated [DATE], reflected the following orders were included: NAS/CC diet Minced & Moist texture, Nectar (Level 2 mildly thick) consistency. May have thin liquids via 5 cc (Blue) Provale cup. May have Regular bread and dessert. No pureed vegetables. The order was dated [DATE]. DNR. Order dated [DATE]. Record review of Resident #1's Progress Notes reflected the following entries: An entry, dated [DATE] at 8:33 PM, reflected, Resident was observed coughing during her dinner in the Dinning [sic] Room at [5:35 PM], Hemlock [sic] maneuver was applied immediately by this nurse, resident was observed not responsive, Resident was assisted to the room, help was called, resident was transferred to bed by nursing staff, assessment was done by RN and pulse was felt, oxygen applied at 3 Lpm via nasal canula. 911 called - they came immediately and took over. Resident was a DNR, MD notified, as well as resident's daughter and DON by staffing co-coordinator. The entry was signed by LVN A. An entry, dated [DATE] at 9:00 PM, reflected, 911 pronounced resident at [5:47 PM], 911 called medical examiner who came and pick resident remains in the presence of resident's daughter. The entry was signed by LVN A. Record review of a Speech Therapy Encounter Note, dated [DATE], reflected the following: .MBSS completed on [DATE] with recommendations for puree and thin liquids via controlled flow cup and no straw. Following 24-hour trial of puree texture pt requested to return to minced moist textured diet despite being educated regarding risks of aspiration, aspiration pneumonia and possible death. SLP left message on daughters VM regarding MBSS results, dietary recommendations and pt's request to return to MM texture. Pt agreed to continue on NTL while SLP trains pt in Provale cup and compensatory swallow strategies to reduce aspiration risks on thin liquids. During an interview on [DATE] at 10:45 AM, LVN B stated she had cared for Resident #1. She stated Resident #1 was unable to drink well by herself and had difficulty managing a cup. She stated Resident #1 was always fed by staff and had difficulty getting food into her mouth on her own. She stated the resident was at risk for aspiration and choking due to swallowing difficulties. LVN B stated Resident #1 would tell you, 'let me do it' and would try but you had to be there with her. LVN B stated she was not working at the time Resident #1 passed away but heard she had choked. She stated she cared for her during the day shift on [DATE] and did not recall her having any respiratory issues or anything else out of the ordinary. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA C on [DATE] at 10:56 AM, she stated she typically passed medications to Resident #1 during the day shift. She stated Resident #1 had to have her medications crushed and could choke on thin liquids. MA C stated she occasionally picked up extra shifts as a CNA and fed Resident #1 during meals. She stated whenever she cared for Resident #1, the nurse insisted they stayed with her anytime she was eating, even if she wanted to feed herself, she had to be there at all times because of her risk for choking or coughing. MA C stated she was working the day shift on [DATE] and was not in the facility at the time Resident #1 passed. She stated she had passed her medications that day and did not recall anything unusual occurring. During an interview on [DATE] at 11:19 AM, CNA D stated she worked at the facility for 5 years and regularly cared for Resident #1. She stated Resident #1 was always fed in the dining room and they offered her thickened liquids throughout the day. She stated she often fed Resident #1 and never noticed her coughing or choking. She stated someone was always sitting with her in the dining room because everyone knew she was at risk for choking. CNA D stated she cared for Resident #1 on the day she passed and did not recall anything out of the ordinary with her that day, she stated she was surprised and sad to learn she had died . During an interview on [DATE] at 12:36 PM, SLP E stated she began working at the facility in [DATE]. She stated Resident #1 was at risk for choking and aspiration. She stated Resident #1 and had a waiver in place since prior to her arrival that had been discussed with her family. She stated Resident #1 did well with her meal most of the time but wanted thin liquids rather than thickened. She stated they got a Provale cup for her which only allowed 5 cc at a time. She stated Resident #1 liked some of the foods pureed and would request it at times. SLP E stated Resident #1 would reach for food from other resident's plates at times so there was always someone with her at her table. She stated food was not left at the tables until staff were sitting and ready to feed the residents due to the risk for aspiration and choking. SLP E stated she was not present at the time Resident #1 had her choking episode. She stated she was not aware of any other incidents which involved Resident #1 or any other resident since she had been with the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on [DATE] at 1:05 PM revealed she was not in the facility at the time Resident #1 had the choking episode in the dining room on [DATE]. She stated she saw her in the TV area after lunch that day. She stated Resident #1 ate in the dining room [ROOM NUMBER]% of the time at a table with other residents who needed assistance with their meals. The DON stated Resident #1 received meals that were minced and moist and could occasionally pick something up and eat it, such as finger food, but was unable to manage the use of utensils. When asked about bread, the DON stated, if the food was soft, she did okay. The DON stated she was typically in the facility from 4:00 AM to 2:30 PM every day so she could see all three shifts. She stated she investigated the incident and spoke with everyone who was in attendance. The DON stated she was told it may have been a piece of bread and her charge nurse told her he thought a part of a sandwich possibly become lodged in her throat. The DON stated LVN A performed the Heimlich maneuver they took her out of the dining room and put her to bed, called 911, and administered oxygen. She stated she was aware Resident #1 had a DNR order but that did not mean do not treat and she felt they acted appropriately. The DON stated the paramedics arrived and initiated CPR. She stated LVN A informed them Resident #1 had a DNR order, but the paramedics continued until they spoke with her family for confirmation. She stated LVN A notified the family and they spoke with the paramedics and asked them to stop. The DON stated the police and coroner were there at the facility and took over her care. The DON stated the Administrator was made aware of the situation immediately after it occurred and had been speaking with staff throughout the incident. She stated staff sent her a text message, but she did not see it until the following morning. When asked why they had not reported the incident to the State, the DON stated she discussed it with the Administrator and neither of them suspected neglect, foul play, or anything done by anyone that could have caused the incident and they determined it did not warrant reporting . During an interview on [DATE] at 1:46 PM, LVN A stated he worked for the facility for about 1 year and 4 months. He stated he always worked the evening shift and typically cared for Resident #1. He stated Resident #1 had swallowing issues, was on a modified diet with thickened liquids and was fed by staff. LVN A stated, on [DATE], staff were feeding residents in the dining room which included Resident #1 who was at a table in her wheelchair. He stated CNA H was feeding Resident #1 when he entered the dining room and saw Resident #1 beginning to cough. He stated he rushed to her and thought he recalled seeing bread and mashed potatoes on her plate and she appeared to be choking. LVN A stated he performed the Heimlich on her which was not successful. He called for help and began moving her out of the dining room and she was still conscious at the time. He stated two other nurses met him near the dining room entrance and immediately began working with her, they attempted the Heimlich again and moved her to her room while he called 911. LVN A stated RN F placed Resident #1 on oxygen and LVN G was assisting with assessing her. He stated the paramedics arrived very quickly as he was still on the phone with the 911 operator when they arrived. He stated the paramedics moved Resident #1 to the floor and began CPR. He stated he informed the paramedics Resident #1 had a DNR order, but they continued CPR and told him they wanted to confirm it with her family. LVN A stated he called Resident #1's family and placed them on the phone with a paramedic, after which, they stopped CPR. LVN A stated the paramedics pronounced Resident #1 as deceased . He stated the police and Medical Examiner arrived and waited for Resident #1's family to arrive. LVN A stated the Medical Examiner removed Resident #1 from the facility after her family arrived. LVN A stated he had not fed Resident #1 himself recently but was not aware of her having any other issues of concern that day. He stated the Administrator was informed of the situation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:26 PM, RN F stated she began working at the facility in [DATE] and always worked 2:00 PM to 10:00 PM shift. She stated she was working on her hall on [DATE] when she heard someone calling for help from the dining room area. She stated she rushed over and saw LVN A moving Resident #1 out of the dining room. She stated she felt for a pulse, and one was present. She stated another nurse, LVN G assisted with getting her to her room while she ran to retrieve oxygen. She stated LVN A was calling 911. She stated Resident #1 was breathing at that point, she could see her chest rise and fall and did not attempt another Heimlich. She was told Resident #1 was DNR. She stated LVN G checked the resident's pulse oximeter (measures oxygen in the blood) and assisted placing oxygen on her. She stated she stayed with Resident #1 and the paramedic arrived quickly. She stated she left once the paramedics took over her care and returned to her residents. RN F stated staff were always present in the dining room due to risks for choking and aspiration. In an interview on [DATE] at 2:47 PM, LVN G stated she just began working at the facility on [DATE] and never took care of Resident #1. She stated she was working the 2:00 PM to 10:00 PM shift on [DATE]. She stated she was at the far end of the hall, heard someone yelling, and saw LVN A rushing Resident #1 out of the dining room in her wheelchair. LVN G stated she rushed over and attempted the Heimlich maneuver with no results. She stated they rushed her to her room and got her into bed. LVN A went to call 911 and RN F went to retrieve oxygen, and she attempted to get an oxygen reading on her but was unable to get a reading. She stated Resident #1 was not responsive but breathing at that point. She stated they placed her on oxygen and the paramedics arrived quickly. LVN G stated, after they arrived, she rushed out to assist with getting her paperwork together and learned it had already been retrieved. She stated, at that point, Resident #1 was in their care, and she went back to check on the other residents. She stated she regularly checked the dining room to ensure residents were getting assistance with meals and that the staff assisting them were taking it slow and monitoring the residents for any signs of aspiration or choking. LVN G stated she was not aware of any other incidents while she worked at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:43 PM, CNA H stated she worked at the facility for approximately 6 months on the 2:00 PM to 10:00 PM shift and assisted with feeding residents in the dining room. She stated she was with Resident #1 in the dining room on [DATE] during dinner. She stated they typically brought the residents to the dining room at about 4:45 PM and got them situated. They would sometimes provide drinks for them while they waited. She stated she fed Resident #1 several times before without any issues. CNA H stated the nurses typically checked the trays for accuracy and brought them to the CNAs when they were ready to feed them. Trays were never left with residents until they were there with them because residents could not be left alone with their food if at risk for choking. CNA H stated, on [DATE], she was sitting with Resident #1 and was situated between her table and an adjacent one, Resident #1 was the only one at her table. She stated Resident #1 had been joking that day and stated she wanted a strawberry [NAME], and someone brought her some thickened cranberry juice which made her laugh. She stated Resident #1 took some sips of her juice and began to cough. She stated she moved the juice away from her at that point to allow her to catch her breath. CNA H stated Resident #1 was fine when her tray arrived. She stated she recalled she was served minced meat with gravy on bread along with mashed potatoes. CNA H stated she mixed a little bit of the mashed potatoes with some of the minced meat and bread on a spoon and fed it to Resident #1. She stated Resident #1 began to cough and she called out for assistance. She stated LVN A was already approaching her when she turned around and went directly to the resident. She stated LVN A told her to call for help and he began administering the Heimlich maneuver. CNA H stated she called for a nurse who was walking by and LVN A was already moving her out of the dining room. She stated she saw another nurse arrive and she went back to the dining room to continue with the other residents. CNA H stated she had never seen anything like that happen before. She stated she was trained in CPR and the Heimlich and was last recertified in [DATE]. She stated they were trained never to leave residents unattended in the dining room because they could choke or aspirate. She stated she never saw Resident #1 cough during her meals or when she offered her drinks during her shift . In an interview on [DATE] at 4:47 PM, the Administrator stated he was contacted about the incident involving Resident #1 on [DATE]. He stated, from what he knew, LVN A noticed Resident #1 was choking or thought she was choking, performed the Heimlich maneuver and brought her to a flat area and called 911. He stated other nurses were there to assist him. He stated Resident #1 was a DNR and she still had a pulse. He stated EMS arrived quickly and initiated CPR. He stated LVN A provided them her DNR document, but they continued CPR because they wanted to hear from her family. The Administrator stated there were numerous staff present in the dining room and he did not believe there was anything suspicious or concerning. He stated the Medical Examiner arrived and Resident #1's family member arrived who lived 2 hours away. The Administrator stated a Nurse Manager, (QA/Staffing Coordinator), was present and was assisting and keeping him informed of the events. He stated there was nothing suspicious, they talked to all the staff involved and concluded the nurse took all the actions he was supposed to. He stated he read the Provider Letter, discussed everything with the DON again the next morning and reviewed all their processes. He stated EMS pronounced her death. When asked how he was certain there was no neglect or felt the need to report to the State, the Administrator stated they looked at everything, the QA/Staffing Coordinator said he checked her tray himself to ensure she had the correct meal, and they did not suspect any neglect. He stated they never heard anything back from the Medical Examiner or EMS and he felt they would have if they had suspected wrongdoing. The Administrator stated they had recently implemented a system that included nurse managers on duty to also serve as meal managers to ensure the meals were correct, on time, and staff were available and assisted the residents. He stated they implemented the system prior to the facility's last State Survey which was in [DATE] . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with the QA/Staffing Coordinator on [DATE] at 5:12 PM, he stated he was on duty on [DATE] when Resident #1 had the choking incident. He stated he checked her dinner tray when he was told she may have choked and stated she received the correct meal. He stated he observed sliced white bread with minced meat and gravy, mixed vegetables, and mashed potatoes. He stated someone called him and said they needed to get her DNR document printed. He stated he ran for the book to retrieve her document. The QA/Staffing Coordinator walked to a facility crash cart (a cart with medical supplies used during a life-threatening emergency) and identified the contents of the cart including a binder. The binder contained the names of the residents in the facility along with their code status (full resuscitation or Do Not Resuscitate) as well as copies of the resident's Do Not Resuscitate documents. The QA/Staffing Coordinator stated the documents were also available in the electronic record, but the binder allowed faster access in case the computers or printers were down. He stated, when he arrived, EMS was providing CPR and LVN A was on the phone with Resident #1's family member. He stated an EMS member got on the phone with Resident #1's family then stopped CPR and pronounced her death. He stated Resident #1 was on the floor and he assisted with moving her roommate from the room. The QA/Staffing Coordinator stated the Medical Examiner arrived and waited for Resident #1's family to arrive before leaving with her remains. The QA/Staffing Coordinator stated he kept the Administrator informed of all developments. He stated part of his duties in the facility was to back up the nurses in the dining rooms by checking trays for correct diets and textures and ensuring there was adequate staff to assist the residents. He stated he assisted with feeding residents as well whenever needed. He stated he had never encountered a situation such as the one involving Resident #1. He stated the risk for inadequate staff and failure to ensure the correct trays were passed included risks for aspiration or choking. During an interview on [DATE] at 6:38 PM, the Administrator stated he believed in reporting any suspected abuse or neglect occurring in his facility was very important and he did not believe neglect occurred related to Resident #1's death. He stated the risk of not reporting potential abuse or neglect was harm to the people for whom they provided care. During an interview on [DATE] at 6:45 PM, the DON stated she looked at every angle of Resident #1's death the following day when she learned about it and did not believe any neglect had occurred. She stated the risk of not reporting suspected abuse or neglect included repeating the same behaviors. Record review of the facility's policy and procedure titled Risk Management: Abuse, Neglect, exploitation, Mistreatment of Resident, or Misappropriation of Resident Property, dated revised [DATE], reflected the following: Policy: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment and misappropriation of residents property. These policies guide the identification, management and reporting of suspected, or alleged, abuse, neglect, mistreatment and exploitation . 1. The Administrator is responsible for designating an Abuse Coordinator . 3. The Administrator, DON and Risk Manager are responsible for the investigation and reporting of suspected, or alleged, abuse, neglect, and exploitation and misappropriation. 4. The Administrator, DON and Risk Manager are also ultimately responsible for the following . - Reporting . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reporting . Facility will be in compliance with Federal regulations and State specific reporting Requirements . An Immediate report will be filed with DADS for alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuses or result in serious bodily injury, or not later than 24 hours if the events that cause the a/legation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides/or jurisdiction in long-term care facilities) in accordance with State law through established procedures