

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/17/2018
NAME OF PROVIDER OR SUPPLIER PINEHURST HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374		
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F 000	INITIAL COMMENTS A complaint survey was conducted from 4/10/18 - 4/17/18. Immediate jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F689 at scope and severity (J) CFR 483.21 at tag F656 at scope and severity (J) CFR 483.60 at tag F805 at scope and severity (J) The tags F689 and F600 constituted Substandard Quality of Care Immediate jeopardy began on 3/1/18 and was removed on 4/14/18	F 000			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		4/25/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/25/2018

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.

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F 600	<p>Continued From page 1</p> <p>Based on record review, and Physician, Speech Therapist (ST) and staff interviews, the facility neglected to provide necessary care and services for resident with dysphagia for 1 of 3 sampled residents reviewed (Resident #1).</p> <p>Immediate jeopardy began on 3/1/18, when Resident #1 was found unresponsive and was transferred to the hospital and died. The cause of death was cardiac arrest secondary to acute respiratory arrest with hypoxia and aspiration.</p> <p>Immediate jeopardy was removed on 4/14/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident # 1 was originally admitted to the facility on 5/9/15 with multiple diagnoses including Parkinson 's disease and history of cerebrovascular disease. The significant change in status Minimum data Set (MDS) assessment dated 1/21/18 indicated that Resident #1's cognition was intact and he had no swallowing disorder. The assessment further indicated that Resident #1 needed supervision/set up help with eating and he was not on mechanically altered diet.</p> <p>Review of Resident #1's hospital records revealed that he was discharged to the hospital on 2/2/18 due to cough.</p> <p>The hospital discharge summary dated 2/8/18 was reviewed. The notes revealed that on 2/3/18,</p>	F 600	<p>Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018. He was admitted with being at risk for aspiration and choking from the hospital. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluations showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking and re-hospitalization. Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining upon discharge. During the resident's hospital stay resident had an episode of choking and was identified as being at risk for aspiration. Resident's care plan failed to identify him being at risk for aspiration and choking. Resident's Kardex listed him as independent in his ability to eat. Resident's current diet order on 03/01/2018 was mechanical soft with honey thick liquids, magic cup, cut all rolls, Danish, bread, sandwiches into fourths or 1-2 inch pieces, and no peanut butter. On 03/01/2018 the dietary department provided Resident Number 1 with his current diet of mechanical soft with honey thick liquids, magic cup, cut all rolls, Danish, bread, sandwiches into fourths or 1-2 inch pieces, and no peanut butter. The dietary department utilizes the standard practice of a two-system check which requires the cook to prepare the plate and the aide will make sure that the</p>		

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F 600	<p>Continued From page 2</p> <p>Resident #1 was "near respiratory arrest secondary to choking on chicken during dinner. Heimlich maneuver was performed by vigilant nursing staff resulted in expelling of food bolus". The diet discharge instruction was "cardiac dysphagia diet with chopped meats and thickened liquids".</p> <p>Resident #1 was readmitted back to facility on 2/8/18 with new diagnosis of aspiration pneumonia. The diet ordered on admission was mechanical soft diet with honey thick liquids and speech therapy to evaluate and treat.</p> <p>Resident #1's care plan was last updated on 1/26/18. There was no care plan developed to address care to prevent choking/aspiration after readmission on 2/8/18.</p> <p>Resident #1's kardex (resident care guide) was reviewed. The kardex indicated that Resident #1 was on mechanical soft diet with nectar thick liquids and he was independent with eating. The kardex did not indicate that Resident #1 needed supervision during meals or was on restorative dining program.</p> <p>The dietary notes were reviewed. The last dietary note was dated 1/30/18 indicating Resident #1's diet was regular with thin liquids. There were no notes after his readmission on 2/8/18.</p> <p>The diet spreadsheet was reviewed. The menu for 3/1/18 dinner was beef tips with mushroom gravy for regular diet and ground beef with mushroom gravy for mechanical soft diet.</p> <p>The speech therapist notes were reviewed. The notes revealed that Resident #1 was evaluated</p>	F 600	<p>plate matches the food listed on the tray card prior to placing it in the serving cart. When the tray cart arrives on the hall the person passing the trays will make sure that the food matches the diet order on the tray card before giving it to the resident. If the tray card does not match the play the person serving the plate will take the plate back to the kitchen to be corrected. The Administrator interviewed the certified nursing assistant on 04/12/2018 who states that on 03/01/2018 she did not know about the 2 system check. On 04/12/2018 the Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses re-educated 100% of staff on the two system check for meal trays. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018. The resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18 the resident died after being extubated per family request.</p> <p>1. On 03/01/2018 there were no other concerns with mechanical soft diets being served and there is no reason to believe he would be the only one on that day to receive the wrong diet and the Dietary Manager reports she monitored the meal prior to the end of her shift and there was adequate amounts of chopped meat and pureed meat. The Dietary Manager <input type="checkbox"/> standard practice is to monitor the tray line to ensure that the food form is correct. The Dietary Manager monitored</p>		

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F 600	<p>Continued From page 3</p> <p>on 2/8/18 and was treated for dysphagia from 2/8/18 through 2/28/18. The resident was a high risk for choking/aspiration related complications due to his impulsiveness and history of choking. Resident #1 was referred to nursing for restorative dining and/or staff supervision during meals. The recommended diet was mechanical soft diet with honey thick liquids.</p> <p>The ST progress and discharge summary dated 3/1/18 was reviewed. The notes revealed that Resident #1 safely consumed mechanical soft exhibiting severe impairment, primarily non oral nutrition, high risk of aspiration, required supervision with oral intake due to aspiration risk and significant weight loss, and trial oral intake via therapeutic feedings due to impulsivity. He was at risk of aspiration of both consistencies due to impulsivity of intake. He was discharged as long term care resident with restorative dining.</p> <p>The nurse's notes dated 3/1/18 at 7:11 PM revealed "resident was sitting in room and staff took meal tray in and sat while resident ate. Staff walked out of room when finished with meal and then went back in and found resident slumped over and came for writer. His eyes opened, not breathing or had no pulse. Placed resident on the bed and writer started cardiopulmonary resuscitation (CPR) and crash cart brought in and started using ambu bag and oxygen at 6:10 PM. Back board was placed under resident. West side nurse helped. Emergency Medical Service (EMS) arrived and started working with resident and 30 minutes later obtain blood pressure and heart beating. Transported to hospital".</p> <p>The hospital history and physical for Resident #1 dated 3/1/18 were reviewed. The records</p>	F 600	<p>the consistency and the amount of food available to ensure there is enough for the residents at that meal, there were 2 aides and a cook serving the meal on 03/01/2018 to ensure that all diets were served appropriately. An audit was completed by the Administrator on supervised 2 residents in restorative to make sure diets matched their tray. All residents had their trays match their tray card on 04/12/2018. There were no supervised residents during meals.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/11/2018. There were changes in at least one area for each resident's care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident's room by the MDS Nurses on 04/11/2018.</p> <p>3. A 100 % in-service was completed with all staff on making sure that food served to resident's matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on</p>		

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F 600	<p>Continued From page 4</p> <p>revealed that Resident #1 presented to the emergency room due to cardiac arrest. "Pt. supposedly was witnessed drinking cologne and subsequently had some sort of arrest. High quality cardio pulmonary resuscitation (CPR) was immediately initiated. Pt. had a return of spontaneous circulation (ROSC) in the field but subsequently had another episode of arrest. He was intubated and brought to the emergency department where ROSC was once again achieved". The physical examination revealed he has rales in the right upper field, the right middle field, left upper field and the left middle field. The chest x-ray showed "subtle bibasilar infiltrates are present and may be due to aspiration".</p> <p>The chest x-ray final result dated 3/2/18 revealed "bilateral infiltrates are noted and appear stable. Findings are worrisome for pneumonia".</p> <p>The gastroenterology consult dated 3/2/18 revealed "attempted to place nasogastric tube (NGT) but unable to pass. Went back of throat and ok to push but kept curling up. Recommended esophagogastroduodenoscopy (EGD, a procedure that visualizes the upper part of the gastrointestinal tract down to the duodenum) at bedside in the morning if stable and to try to place NGT".</p> <p>The EGD result dated 3/3/18 revealed food was found in the upper third of the esophagus.</p> <p>The hospital discharge summary dated 3/4/18 revealed that when EGD was performed on 3/3/18, large food bolus was found impacted in the proximal esophagus. The computerized tomography (CT) scan of head performed on 3/4/18 revealed findings consistent with severe</p>	F 600	<p>special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse. The Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses in <input type="checkbox"/>serviced all Nursing Staff on providing supervision during meals, cuing residents during the meal, the signs and symptoms of choking, and all staff were in-serviced on what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the nurse on 4/13/18.</p> <p>An audit tool that monitors tray cards matching what is on the plate will be completed by the Administrative staff and hall nurses during rounds 3 times a week for 4 weeks, bi-weekly for 4 weeks, monthly for 2 months, and turned into the Administrator for review. If there are any issues with the trays they will be corrected as it is identified.</p> <p>The Administrator will bring the tools to the weekly QAPI Committee meeting for review of the audit tools weekly for 8 weeks and monthly for 2 months. The Monthly QAPI Committee will review the minutes of the weekly meetings for 4 months to determine the continued need and frequency of monitoring.</p> <p>The Dietary Manager will audit the tray line to ensure that the tray cards match</p>		

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F 600	<p>Continued From page 5</p> <p>diffuse cerebral edema consistent with anoxic brain injury. A decision was made to extubate Resident #1. He passed away on 3/4/18 at 4:51 PM.</p> <p>On 4/10/18 at 1:51 PM, a family member was interviewed. The family member stated that he/she went back to the facility to pick up Resident #1's belongings. She/he was informed by Nurse #1 that NA #1 stepped out of the room while the resident was eating and when she came back few minutes later to pick up the tray, she found the resident slumped over.</p> <p>On 4/10/18 at 2:30 PM, the ST was interviewed. She stated that she started treating Resident #1 for dysphagia upon his readmission on 2/8/18. She indicated that resident choked on a piece of chicken at the hospital and was discharged to the facility on soft diet with thickened liquids. His behavior and his mental status had changed during his readmission of 2/8/18. He was very impulsive and no desire to learn. She treated him once a day during lunch meal. He needed supervision during meals because he had no safety awareness.</p> <p>On 4/10/18 at 3:45 PM, Restorative Aide (RA) #1 was interviewed. She stated that she was the head of the restorative program. She indicated that Resident #1 refused to go to restorative dining, he was on 1:1 with the staff during meals. RA #1 did not have documentation that Resident #1 was refusing to go to restorative dining.</p> <p>On 4/10/18 at 3:50 PM, Nurse Aide (NA) #1 was interviewed. She was assigned to Resident #1 on 3/1/18, second shift. She stated that she was assigned to Resident #1 on 3/1/18 for the first</p>	F 600	<p>the plate 3 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The Audit will be turned into the Administrator weekly for review. Any concerns will be addressed as they are identified. The Administrator will bring the audits to the weekly QAPI meeting for review weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The QAPI Committee will review the minutes from the weekly meeting at the monthly meeting for the continued need and frequency of monitoring for 4 months.</p> <p>The Clinical Supervisor will monitor Care plans and Kardex 3 times a week, Bi-weekly for 4 weeks, and monthly for 2 months to ensure that they are being updated timely. The audits will be turned into the Administrator or the Director of Nursing weekly for review for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The Administrator or the Director of Nursing will bring the audits to the weekly QAPI meetings for review weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months.</p> <p>The monthly QAPI Committee will review the minutes of the weekly QAPI meeting for the continued need and frequency of monitoring for 4 months.</p>		

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F 600	<p>Continued From page 6</p> <p>time after his readmission from the hospital. She indicated that Nurse #1 informed her that Resident #1 needed 1:1 during meals. She served the dinner tray around 6 PM in the resident's room and stayed with him until he was finished eating. She indicated that the resident was able to feed himself. He had chunks of beef (not ground beef) on his tray about ¾ to an inch thick and thickened liquids. He consumed about 80% of his food and 50% of his liquids. He did not cough during the meal observation. NA #1 left the room with the resident's tray and proceeded to feed another resident. She stated that after 15 minutes she went back to the resident's room to remove the empty cups from his drawer and she found him slumped over to his right side and not breathing. She went to get Nurse #1.</p> <p>On 4/10/18 at 5:45 PM, the Dietary Manager (DM) was interviewed. She stated that Resident #1 was on mechanical soft diet and honey thick liquids. She verified the menu on 3/1/18 as beef tips (1/2 to ¾ inches in size) for regular diet and ground beef for the mechanical soft diet. She stated that staff used the food processor to grind the meat for the soft diet. The DM was not able to find dietary notes after the resident's readmission to the facility on 2/8/18.</p> <p>On 4/10/18 at 5:27 PM, Nurse #3 was interviewed. She stated that she had been working at the facility for almost 3 months and had known Resident #1. He was independent with eating and he did not need any supervision during meals.</p> <p>On 4/10/18 at 5:29 PM, Nurse #4 was interviewed. She stated that she had been</p>	F 600			

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F 600	<p>Continued From page 7</p> <p>working at the facility for 4 months and he remembered Resident #1. He was independent with eating with set up help only and he didn't need any supervision.</p> <p>On 4/10/18 at 5:32 PM, NA #2 was interviewed. NA #2 had been working at the facility for 2 years on second shift. She used the kardex to care for the resident. She indicated that she remembered Resident #1 and he was independent with eating with set up help only and he didn't need any supervision during meals.</p> <p>On 4/11/18 at 8:30 AM, the ST was again interviewed. She stated that she had referred Resident #1 to restorative dining. The ST was unable to remember the date of the referral and she could not find her referral form to nursing. She had talked to the Restorative Aide who indicated that the resident refused restorative dining. The ST indicated that she expected the staff to sit and to watch him while he eats when he refused to go to restorative dining. She attended the morning meetings with the department heads and she had shared with them her concerns with Resident #1 the need for supervision during meals. The ST stated that she discharged Resident #1 from therapy on 2/28/18 and she recommended to continue restorative dining.</p> <p>On 4/11/18 at 8:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse indicated that she attended the morning meetings and the ST had discussed the need for supervision and restorative dining for Resident #1 due to his risk for choking/aspiration. The MDS Nurse indicated that she didn't get the chance to update his care plan and his kardex to address risk for choking</p>	F 600			

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F 600	<p>Continued From page 8</p> <p>/aspiration. The MDS Nurse indicated that Resident #1 was on restorative dining after his readmission on 2/8/18 but he refused to go at times so a staff member has to sit and watch him while he ate in his room.</p> <p>On 4/11/18 at 8:50 AM, the Physician of Resident #1 was interviewed. He stated that he expected the facility to follow the recommendations of the ST regarding supervision with eating and to serve diet as ordered. The Physician stated that he didn't know if the food in his esophagus had caused the resident's death.</p> <p>On 4/11/18 at 9:01 AM, NA # 3 was interviewed. She was assigned to Resident #1 on first shift. She stated that Resident #1 was on restorative dining and he never refused to go to restorative dining. She brought him to restorative dining every breakfast and lunch when she was assigned to him.</p> <p>On 4/11/18 at 9:04 AM, Restorative Aide #2 was interviewed. She stated that she worked Monday through Friday on 7-3 shift. She was in the restorative dining room during breakfast and lunch. She indicated that Resident #1 had been to restorative dining once (didn't remember the date) and the ST was working with him. She indicated that she didn't have any documentation regarding restorative dining for Resident #1.</p> <p>On 4/11/18 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that the ST attended the morning meetings every morning with the department heads. She discussed Resident #1 being high risk for choking/aspiration due to his impulsiveness/compulsiveness and he needed to be in restorative dining or needed</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>supervision with meals, but these (restorative dining and supervision during meals) had not been formally implemented or ordered. It was on 3/1/18 when she informed Nurse #1 and the NAs that Resident #1 had to be supervised during meals but she could not remember the time. The DON verified that Resident #1 was not on restorative dining nor was on 1:1 with staff during meals prior to 3/1/18.</p> <p>On 4/11/18 at 1:30 PM, Nurse # 1 was interviewed. Nurse #1 stated that she was assigned to Resident #1 on 3/1/18. She stated that she was busy passing medications (little after 6 PM) when NA #1 called her to the resident's room. She found the resident slumped over, not breathing and no pulse. She called the code and cardio pulmonary resuscitation (CPR) was initiated. Emergency Medical Services (EMS) was called and when they arrived they took over the CPR. Nurse #1 stated that NA #1 informed her that she sat with the resident during supper and when he finished eating she took the tray out. Nurse #1 indicated that the resident refused restorative dining and the Director of Nursing (DON) informed them that Resident #1 needed 1:1 during meals, but she could not remember the date and time.</p> <p>On 4/12/18 at 12:34 PM, the DM was again interviewed. She stated that before she left on 3/1/18, she checked to make sure the dietary staff has everything they needed and they had enough food for soft diet and pureed diet. She also stated that she normally observed the tray line but she did not observe the whole process.</p> <p>On 4/12/18 at 5:02 PM, NA #1 was again interviewed. NA #1 stated that Resident #1</p>	F 600			

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F 600	<p>Continued From page 10</p> <p>received beef tips on 3/1/18, ½ to ¾ in size solid meat during dinner. She indicated that she had received an in-service on the 2 way system on 4/11/18 by checking the dietary card against the food consistency served on the tray. She indicated that she didn't know the 2 way system prior to the in-service.</p> <p>On 4/11/18 at 2:32 PM, the Administrator and the Director of Nursing were informed of the Immediate jeopardy. On 4/13/18 at 7:00 PM, the facility provided the following credible allegation of Immediate jeopardy removal:</p> <p>Resident number 1 was hospitalized from 2/2/18 to 2/8/18. During the resident ' s hospital stay, the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018 with a diagnosis of aspiration pneumonia. He was admitted with being at risk for aspiration and choking from the hospital. Speech therapy reported that resident has impulsive behaviors and placed a whole dinner roll in the oral cavity at one time. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluation showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking, and re-hospitalization due to his impulsive behavior of placing large amount of food(such as a whole roll) in his mouth at one time . Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues in a</p>	F 600			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 11 note on 2/27/18 when he is discharged from therapy on 2/28/18 due to the need of constant supervision. There is no documentation to show that resident number 1 received constant supervision during his meals from 2/8/2018 through 3/1/18. Resident ' s care plan failed to identify him being at risk for aspiration and choking. Resident ' s Kardex listed him as independent in his ability to eat when he needed supervision during eating. Resident ' s current diet order on 03/01/2018 was mechanical soft with honey thick liquids, magic cup, cut all rolls, Danish, bread, sandwiches into fourths or 1-2 inch pieces, and no peanut butter. On 03/01/2018 the dietary department provided Resident Number 1 with his current diet of mechanical soft with honey thick liquids, magic cup, cut all rolls, Danish, bread, sandwiches into fourths or 1-2 inch pieces, and no peanut butter. The dietary department utilizes the standard practice of a two-system check which requires the cook to prepare the plate and the aide will make sure that the plate matches the food listed on the tray card prior to placing it in the serving cart. When the tray cart arrives on the hall the person passing the trays will make sure that the food matches the diet order on the tray card before giving it to the resident. If the tray card does not match the tray the person serving the plate will take the plate back to the kitchen to be corrected. The Administrator interviewed the certified nursing assistant on 04/12/2018 who states that on 03/01/2018 she did not know about the 2 system check. On 04/12/2018 the Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses re-educated 100% of staff on the two system check for meal trays. The interdisciplinary team made a verbal recommendation for restorative and supervision	F 600			

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F 600	<p>Continued From page 12</p> <p>during meals during morning meeting after resident number 1 was readmitted on 2/8/2018. The recommendation for restorative for resident number 1 was not done in writing and was not implemented consistently. A Restorative care referral was not completed for resident number 1 on his discharge by the speech therapist and given to the Director of Nursing which contributed the lack of implementation of restorative for resident number 1. The Restorative Program did not have resident number 1 ' s information for restorative dining and supervised meals in written form. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018 due to an episode on non-responsiveness. The hospital records show that Resident number 1 had a large bolus of food impacted in the proximal esophagus. The Resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18, the resident died after being extubated per family request.</p> <p>1. On 03/01/2018 there were no other concerns with mechanical soft diets being served and there is no reason to believe he would be the only one on that day to receive the wrong diet and the Dietary Manager reports she monitored the meal prior to the end of her shift and there was adequate amounts of chopped meat and pureed meat. The Dietary Manager ' s standard practice is to monitor the tray line to ensure that the food form is correct. The Dietary Manager monitored the consistency and the amount of food available to ensure there is enough for the residents at that meal, there were 2 aides and a cook serving the meal on 03/01/2018 to ensure that all diets were</p>	F 600			

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F 600	<p>Continued From page 13</p> <p>served appropriately. An audit was completed by the Administrator on supervised residents and 2 residents in restorative to make sure diets matched their tray. All residents had their trays match their tray card on 04/12/2018.</p> <p>2. There were no other residents on supervised meals. An Audit was completed by the Administrator on 04/12/2018 on the residents that have been referred to restorative dining from therapy and there were no concerns with their recommendations being followed. Restorative dining has 2 residents that attend the restorative dining program 2 meals a day and the certified nursing assistants will feed the 3rd meal each day. Any resident that is identified as needing supervision during meals will have a care plan written addressing their needs by the MDS Nurses, the Director of Nursing, and / or the Assistant Director of Nursing, a Kardex placed in their closet by the MDS Nurses, the Director of Nursing, and /or the Assistant Director of Nursing. The MDS Nurses completed a 100% in-service with nursing staff on Kardex being updated anytime there is a change in a residents needs and placed in the resident ' s closet. The Kardex must be checked prior to care for changes on 04/13/18. The Business Office Manager will bring all intent to discharge forms to morning meeting to review therapy recommendations. The Speech therapist will bring all written referrals for restorative care or supervision during meal time to the morning meeting for review. The Clinical Nurses will receive a copy of the referrals so a care plan may be written and the Kardex updated. Any referral for restorative or supervision during meal time will be addressed in the care plan by the clinical team after morning meeting. The Director of Nursing will notify the Restorative</p>	F 600			

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F 600	<p>Continued From page 14</p> <p>Manager/Nursing staff of new referrals by giving the restorative manager the care plan to add the resident to the restorative program and the Clinical Nurses will update the Kardex and place it in the resident ' s closet for the nursing staff. The week-end manager will review all hospital information on week-end admissions to determine the need for supervised dining and implement supervised dining for those that require it.</p> <p>3. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/11/2018. There were changes in at least one area for each resident ' s care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident ' s room by the MDS Nurses on 04/11/2018.</p> <p>4. A 100 % in-service was completed with all staff on making sure that food served to resident ' s matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse. The</p>	F 600			

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F 600	Continued From page 15 Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses in -serviced all Nursing Staff on providing supervision during meals, cuing residents during the meal, the signs and symptoms of choking, and all staff were in-serviced on what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the nurse on 4/13/18. The credible allegation was validated on 4/17/18 at 11:35 AM as evidenced by nursing staff interviews and review of the in-service records regarding providing supervision during meals, cuing residents during meals, observing signs and symptoms of choking and what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the nurse and the 2 way system (checking the dietary card and food serve are matching) and abuse/neglect. In-service records and interview with dietary staff were conducted and they had received in-service on special diet and tray line. In-service records and interview with non-licensed staff revealed they received in-service on abuse and neglect. An observation was conducted on 4/17/18 at 12:35 PM, during lunch and residents who needed supervision during meals were supervised, residents on mechanically soft diet received ground meat and the food served matched with their dietary cards.	F 600			
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		4/25/18	

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F 656	Continued From page 16 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), 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. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656			

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F 656	<p>Continued From page 17</p> <p>Based on record review, observation and staff interviews, the facility failed to develop a care plan to address care to prevent choking/aspiration related complications for 1 of 3 sampled residents reviewed with dysphagia (Resident #1). Resident #1 was found unresponsive right after dinner and was sent to the hospital and died. The cause of death was cardiac arrest secondary to acute respiratory arrest with hypoxia and aspiration.</p> <p>Immediate jeopardy began on 3/1/18, when Resident #1 was found unresponsive and was transferred to the hospital.</p> <p>Immediate jeopardy was removed on 4/14/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included:</p> <p>Resident # 1 was originally admitted to the facility on 5/9/15 with multiple diagnoses including Parkinson's disease and history of cerebrovascular disease. The significant change in status Minimum data Set (MDS) assessment dated 1/21/18 indicated that Resident #1's cognition was intact and he had no swallowing disorder. The assessment further indicated that Resident #1 needed supervision/set up help with eating and he was not on mechanically altered diet.</p> <p>Review of Resident #1's hospital records revealed that he was discharged to the hospital on 2/2/18 due to cough.</p>	F 656	<p>Resident number 1 was hospitalized from 2/2/18 to 2/8/18. During the resident's hospital stay the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018. He was admitted with a diagnosis of aspiration pneumonia. Speech Therapy reported that resident has impulsive behaviors and placed a whole roll in the oral cavity at one time. He was admitted with being at risk for aspiration and choking from the hospital. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluations showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking and re-hospitalization. Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues on 2/27/2018 when he is discharged on 2/28/18. The Director of Nursing educated the Nurses that Resident number 1 should be supervised when eating using the restorative dining program and certified nursing aides in the evening as a nursing intervention. On 2/22/18 the Restorative aide states resident number 1 refused to attend restorative dining and continued to do so throughout his stay. Resident's care plan failed to identify him being at risk for aspiration, choking, and needing</p>		

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F 656	<p>Continued From page 18</p> <p>The hospital discharge summary dated 2/8/18 was reviewed. The notes revealed that on 2/3/18, Resident #1 was "near respiratory arrest secondary to choking on chicken during dinner. Heimlich maneuver was performed by vigilant nursing staff resulted in expelling of food bolus". The diet discharge instruction was "cardiac dysphagia diet with chopped meats and thickened liquids".</p> <p>Resident #1 was readmitted back to facility on 2/8/18 with new diagnosis of aspiration pneumonia. The diet ordered on admission was mechanical soft diet with honey thick liquids and speech therapy to evaluate and treat.</p> <p>Resident #1's care plan was last updated on 1/26/18. There was no care plan developed after his readmission on 2/8/18 to address care to prevent choking/aspiration related complications.</p> <p>The nurse's notes dated 3/1/18 at 7:11 PM revealed that Resident #1 was found slumped over. Emergency Medical Service (EMS) was called and he was transported to the hospital.</p> <p>The hospital history and physical for Resident #1 dated 3/1/18 was reviewed. The records revealed that Resident #1 presented to the emergency room due to cardiac arrest. The physical examination revealed he has rales in the right upper field, the right middle field, left upper field and the left middle field. The chest x-ray showed "subtle bibasilar infiltrates are present and may be due to aspiration".</p> <p>The EGD (Esophagogastroduodenoscopy - a procedure that visualizes the upper part of the gastrointestinal tract down to the duodenum)</p>	F 656	<p>supervised dining as directed by the Director of Nursing and the Interdisciplinary team. Resident's Kardex listed him as independent in his ability to eat when he needed supervision during eating.. On 03/01/2018 Resident was noted to be unresponsive after eating dinner and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018 due to an episode of non-responsiveness. The hospital records shows that Resident Number 1 had a large bolus of food impacted in the proximal esophagus. The Resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18, the resident died after being extubated per the family request. Resident number 1 did not have his care plan revised due to Pinehurst Healthcare and Rehab Center standing practice that once a resident is discharged for any reason we do not document in their chart until they return.</p> <p>On 3/16/18 Pinehurst Healthcare and Rehabilitation Center's QAPI Committee reviewed the existing care plans to identify if the care plans reflected the current condition of the resident. The QAPI team identified that there were concerns with the care plans due to care plans not being reviewed and revised. The care plans were not being reviewed and revised by the MDS nurses. 100% of care plans were reviewed by the MDS Nurses and the Director of Nursing beginning on 03/17/2018 until 04/12/2018.</p>		

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F 656	<p>Continued From page 19</p> <p>result dated 3/3/18 revealed food was found in the upper third of the esophagus.</p> <p>On 4/11/18 at 8:01 AM, MDS Nurse #2 was interviewed. She stated that she was updating all the resident's care plans and she didn't get the chance to update Resident #1's care plan to address care to prevent choking/aspiration.</p> <p>On 4/11/18 at 8:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse indicated that she attended the morning meetings every morning Monday through Friday and the ST (Speech Therapist) had discussed the need for supervision and restorative dining for Resident #1 due to his risk for choking/aspiration. The MDS Nurse indicated that she didn't get the chance to update his care plan and his kardex to address care to prevent choking/aspiration.</p> <p>On 4/11/18 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that she expected the MDS Nurses to develop a care plan to address care to prevent choking/aspiration related complication when a resident was admitted/readmitted from the hospital with history of choking.</p> <p>On 4/11/18 at 2:32 PM, the Administrator and the Director of Nursing were informed of the Immediate jeopardy.</p> <p>On 4/13/18 at 7:00 PM, the facility provided the following credible allegation of Immediate jeopardy removal:</p> <p>Resident number 1 was hospitalized from 2/2/18 to 2/8/18. During the resident's hospital stay the resident had an episode of choking and was</p>	F 656	<p>1. There was no audit completed from 4/10/18 to 4/12/18 due to the 100% review and revision of all care plans for all residents being completed by the MDS Nurses and the Assistant Director of Nursing from 03/17/2018 to 04/12/2018. There was at least one area in every care plan that required a correction. Recent changes in the MDS Nurse position helped cause the breakdown of the Care Planning process. The MDS Nurses will review and revise each care plan every time an MDS is completed. At each resident's annual care plan the MDS Nurses will purge the care plan and write a new care plan. Every time a care plan is updated the Kardex will be updated and placed in the resident's closet by the MDS Nurses.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/12/2018. There were changes in at least one area for each resident's care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident's room by the MDS Nurses on 04/11/2018. A 100 % in-service was completed with all staff on making sure that food served to resident's matches</p>		

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NAME OF PROVIDER OR SUPPLIER PINEHURST HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BLAKE BOULEVARD PINEHURST, NC 28374		
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F 656	Continued From page 20 identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018. He was admitted with a diagnosis of aspiration pneumonia. Speech Therapy reported that resident has impulsive behaviors and placed a whole roll in the oral cavity at one time. He was admitted with being at risk for aspiration and choking from the hospital. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluations showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking and re-hospitalization. Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues on 2/27/2018 when he is discharged on 2/28/18. The Director of Nursing educated the Nurses that Resident number 1 should be supervised when eating using the restorative dining program and certified nursing aides in the evening as a nursing intervention. On 2/22/18 the Restorative aide states resident number 1 refused to attend restorative dining and continued to do so throughout his stay. Resident ' s care plan failed to identify him being at risk for aspiration, choking, and needing supervised dining as directed by the Director of Nursing and the Interdisciplinary team. Resident's Kardex listed him as independent in his ability to eat when he needed supervision during eating. On 03/01/2018 Resident was noted to be unresponsive after eating dinner and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018 due to an episode of	F 656	what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse. An audit tool that monitors care plans being updated with each MDS or for any change will be completed by the clinical supervisor, the MDS nurses, the Administrator or the Director of Nursing 3 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months and turned into the Administrator or the Director of Nursing for review. If there are any issues with the care plans they will be corrected as the issue is identified. The Administrator will bring the tools to the weekly QAPI Committee meeting for review of the audit tools weekly for 8 weeks and monthly for 2 months. The Monthly QAPI Committee will review the minutes of the weekly meetings for 4 months to determine the continued need and frequency of monitoring.		

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F 656	<p>Continued From page 21</p> <p>non-responsiveness. The hospital records shows that Resident Number 1 had a large bolus of food impacted in the proximal esophagus. The Resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18, the resident died after being extubated per the family request. Resident number 1 did not have his care plan revised due to Pinehurst Healthcare and Rehab Center standing practice that once a resident is discharged for any reason we do not document in their chart until they return.</p> <p>On 3/16/18, Pinehurst Healthcare and Rehabilitation Center's QAPI Committee reviewed the existing care plans to identify if the care plans reflected the current condition of the resident. The QAPI team identified that there were concerns with the care plans due to care plans not being reviewed and revised. The care plans were not being reviewed and revised by the MDS nurses. 100% of care plans were reviewed by the MDS Nurses and the Director of Nursing beginning on 03/17/2018 until 04/12/2018.</p> <p>1. There was no audit completed from 4/10/18 to 4/12/18 due to the 100% review and revision of all care plans for all residents being completed by the MDS Nurses and the Assistant Director of Nursing from 03/17/2018 to 04/12/2018. There was at least one area in every care plan that required a correction. Recent changes in the MDS Nurse position helped cause the breakdown of the Care Planning process. The MDS Nurses will review and revise each care plan every time an MDS is completed. At each resident 's annual care plan the MDS Nurses will purge the care plan and write a new care plan. Every time</p>	F 656			

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F 656	<p>Continued From page 22</p> <p>a care plan is updated the Kardex will be updated and placed in the resident ' s closet by the MDS Nurses.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/12/2018. There were changes in at least one area for each resident ' s care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident ' s room by the MDS Nurses on 04/11/2018. A 100 % in-service was completed with all staff on making sure that food served to resident ' s matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse.</p> <p>The credible allegation was validated on 4/17/18 at 11:35 AM as evidenced by MDS Nurses interviews and review of the in-service records regarding revising and updating of care plans and Kardex. Kardex and care plan were reviewed and reflected resident's current condition.</p>	F 656			

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F 689 SS=J	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Physician, Speech Therapist (ST) and staff interviews, the facility failed to supervise a resident every meals as recommended by the Speech Therapist (ST) for 1 of 3 sampled residents reviewed with dysphagia (Resident #1). Resident #1 was found unresponsive right after dinner and was sent to the hospital and died. The cause of death was cardiac arrest secondary to acute respiratory arrest with hypoxia and aspiration.</p> <p>Immediate jeopardy began on 3/1/18, when Resident #1 was found unresponsive and was transferred to the hospital.</p> <p>Immediate jeopardy was removed on 4/14/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.</p> <p>Findings included:</p> <p>Resident # 1 was originally admitted to the facility on 5/9/15 with multiple diagnoses including</p>	F 689	<p>Resident number 1 was hospitalized from 2/2/18 to 2/8/18. During the resident's hospital stay, the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018 with a diagnosis of aspiration pneumonia. He was admitted with being at risk for aspiration and choking from the hospital. Speech therapy reported that resident has impulsive behaviors and placed a whole dinner roll in the oral cavity at one time. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluation showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking, and re-hospitalization due to his impulsive behavior of placing large amount of food (such as a whole roll) in his mouth at one time. Resident received speech therapy until 02/28/2018 when he was</p>	4/25/18	

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F 689	<p>Continued From page 24</p> <p>Parkinson's disease and history of cerebrovascular disease. The significant change in status Minimum data Set (MDS) assessment dated 1/21/18 indicated that Resident #1's cognition was intact and he had no swallowing disorder. The assessment further indicated that Resident #1 needed supervision/set up help only with eating and he was not on mechanically altered diet.</p> <p>Review of Resident #1's hospital records revealed that he was discharged to the hospital on 2/2/18 due to cough.</p> <p>The hospital discharge summary dated 2/8/18 was reviewed. The notes revealed that on 2/3/18, Resident #1 was "near respiratory arrest secondary to choking on chicken during dinner. Heimlich maneuver was performed by vigilant nursing staff resulted in expelling of food bolus". The diet discharge instruction was "cardiac dysphagia diet with chopped meats and thickened liquids".</p> <p>Resident #1 was readmitted back to facility on 2/8/18 with new diagnosis of aspiration pneumonia. The diet ordered on admission was mechanical soft diet with honey thick liquids and speech therapy to evaluate and treat.</p> <p>Resident #1's care plan was last updated on 1/26/18. There was no care plan developed after his readmission on 2/8/18 to address care to prevent choking and aspiration related complication.</p> <p>Resident #1's kardex (resident care guide) was reviewed for his readmission to the facility on 2/08/18. The kardex indicated that Resident #1</p>	F 689	<p>discharged from therapy. Speech therapy recommended restorative dining continues in a note on 2/27/18 when he is discharged from therapy on 2/28/18 due to the need of constant supervision. There is no documentation to show that resident number 1 received constant supervision during his meals from 2/8/2018 through 3/1/18. Resident number 1 was supervised by a certified nursing assistant during his dinner meal on 3/1/18. The certified nursing assistant states she remained in the room throughout the meal and there were no signs of distress, complications, or universal signs of choking. The Director of Nurses educated the hall nurses that Resident number 1 should be supervised when he is eating using the restorative dining program for 2 meals a day and certified nursing aides in the evening as a nursing intervention. The Director of Nursing did not complete the education on an in-service form and does not remember the date. On 2/22/18 the speech therapist documented in her note that the restorative aides reported that resident refused to participate in the restorative dining program. The interdisciplinary team made a verbal recommendation for restorative and supervision during meals during morning meeting after resident number 1 was readmitted on 2/8/2018. The recommendation for restorative for resident number 1 was not done in writing and was not implemented consistently. A Restorative care referral was not completed for resident number 1 on his</p>		

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F 689	<p>Continued From page 25</p> <p>was independent/set up help only with eating. The kardex did not indicate that Resident #1 needed supervision during meals.</p> <p>The speech therapist notes were reviewed. The notes dated:</p> <p>2/8/18 at 4:16 PM - "Treatment of swallowing dysfunction and or oral function for feeding. Patient (Pt) completed dysphagia therapy session during lunch meal of mechanical soft solid and nectar thick liquids (NTL). ST asked Pt several questions re: hospitalization and change of diet, patient did not respond to ST's questions, appears psychological in nature. Pt did not actively participate in any type of communication. ST observed Pt on multiple trials of soft solids and NTL. Pt completed MBS (modified barium swallow) during hospital stay, with overt aspiration on thin liquids, transient penetration of NTL. Further therapy to address potential strengthening of airway closure to increase safety of intake of thin liquids".</p> <p>2/9/18 at 5:40 PM -"ST completed meal tray set up and verbal cues to utilize small bites, masticate thoroughly and take small sips. Pt does not respond or acknowledge ST in any way. Pt quickly consumed multiple bites of mechanical soft solid and ground meats in succession, not utilizing safe swallow strategies. Patient then consumed NTL via straw in rapid succession without adequately swallowing the entire bolus. Pt audibly penetrating /aspiration as there are rattles in respiration during and after the swallow. ST attempted to provide maximum verbal and physical cues to remove straw from patient ' s cup/mouth during the event however he quickly pulled away. Pt agitated, wheeled away from</p>	F 689	<p>discharge by the speech therapist and given to the Director of Nursing which contributed the lack of implementation of restorative for resident number 1. The Restorative Program did not have resident number 1's information for restorative dining and supervised meals in written form. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018 due to an episode on non-responsiveness. The hospital records show that Resident number 1 had a large bolus of food impacted in the proximal esophagus. The Resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18, the resident died after being extubated per family request.</p> <p>1. There were no other residents on supervised meals. An Audit was completed by the Administrator on 04/12/2018 on the residents that have been referred to restorative dining from therapy and there were no concerns with their recommendations being followed. Restorative dining has 2 residents that attend the restorative dining program 2 meals a day and the certified nursing assistants will feed the 3rd meal each day. Any resident that is identified as needing supervision during meals will have a care plan written addressing their needs by the MDS Nurses, the Director of Nursing, and / or the Assistant Director of Nursing, a Kardex placed in their closet by the MDS Nurses, the Director of Nursing, and /or the Assistant Director of Nursing. The</p>		

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F 689	<p>Continued From page 26 ST".</p> <p>2/26/18 at 9:55 pm - (activity date 2/12/18) "Pt seen for dysphagia therapy during late afternoon snack of NTL and mechanical soft solid. Pt initially states he will not consume NTL due to consistency preferences. Pt eventually obliged, demonstrates mild need to throat clear following 50% of trials. Pt does not fully clear audible residue. Pt consumed soft solid snacks with deficits of oral or pharyngeal phase, however consistency is very soft and moist".</p> <p>2/26/18 at 9:50 PM - (activity date 2/13/18) "Pt completed dysphagia therapy session during lunch meal of mechanical soft solid and NTL. On this date, Pt demonstrated no significant deficits of oral or pharyngeal phase for intake of solid. Pt observed to consume NTL in rapid manner via straw resulting in immediate throat clear and wet respirations. Pt unable /does not attempt to clear airway with throat clear or cough as directed by ST. Nursing made aware due to increased risk of aspiration-related complications".</p> <p>2/15/18 at 9:26 PM - "Pt completed dysphagia therapy session during lunch meal of mechanical soft solid and NTL. Prior to set up and consumption of meal, ST educated patient on deficits observed during prior sessions severely impacting safety of intake and ability to be upgraded to pre-morbid diet. Pt. does not acknowledge these deficits. Similar to previous session, Pt observed to consume entirely of meal in rapid, consecutive, large bites. Pt consumed a roll in a single bite. ST provided maximum cues to remove but Pt did not. Pt consumed a cup of NTL via cup rim without taking a break from consumption. Pt observed to have significant wet</p>	F 689	<p>MDS Nurses completed a 100% in-service with nursing staff on Kardex being updated anytime there is a change in a residents needs and placed in the residents closet. The Kardex must be checked prior to care for changes on 04/13/18. The Business Office Manager will bring all intent to discharge forms to morning meeting to review therapy recommendations. The Speech therapist will bring all written referrals for restorative care or supervision during meal time to the morning meeting for review. The Clinical Nurses will receive a copy of the referrals so a care plan may be written and the Kardex updated. Any referral for restorative or supervision during meal time will be addressed in the care plan by the clinical team after morning meeting. The Director of Nursing will notify the Restorative Manager/ Nursing staff of new referrals by giving the restorative manager the care plan to add the resident to the restorative program and the Clinical Nurses will update the Kardex and place it in the resident's closet for the nursing staff. The week-end manager will review all hospital information on week-end admissions to determine the need for supervised dining and implement supervised dining for those that require it.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing revised and reviewed 100% of care plans and Kardex's for all residents on 04/11/2018. There were changes in at least one area for each resident's care plan and Kardex. The Director of Nursing in-serviced the MDS</p>		

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F 689	<p>Continued From page 27</p> <p>aspiration following intake. ST asked Pt multiple questions about feeding habits, Pt does not respond. ST educated dietary department of need to maintain strict restrictions and limit Pt ability to take leftover food from dirty trays in the dining room. Further assessment of solids and liquids for safest intake is necessary".</p> <p>2/18/18 at 8:22 PM -"Pt completed dysphagia therapy session during lunch meal of mechanical soft and NTL. On this date, Pt continue to demonstrate significantly impulsive behavior for all intake. ST retrieved honey thick liquids (HTL) to assess improve safety of intake as Pt does not respond to verbal or physical cues to cease rapid impulsive intake of NTL. NTL intake consistently results in throat clear, cough, and wet aspirations, to which Pt does not make attempts to clear material effectively. Pt consumed 6 ounce (oz.) cup of HTL in similar fashion at NTL but unable to do so as rapidly due to consistency. Pt demonstrates no s/s (signs/symptoms) of aspiration. ST spoke with psychiatry services extensively to collaborate on best treatment approach. ST downgraded Pt to HTL due to ongoing signs/symptoms of aspiration and psychiatry recommendation that Pt will likely to continue significantly impulsive behavior due to high ammonia levels and history of severe alcoholism".</p> <p>2/19/18 at 9:21 PM -"Pt seen on this date for dysphagia therapy session in Pt private room with sister present. ST educated sister on purpose of ST to minimize risk of aspiration/choking episodes while maintaining optimal desire to consume solid/liquids. ST educated family on cause of choking episodes secondary to impulsivity and poor awareness of risk and</p>	F 689	<p>Nurses and the Assistant Director of Nursing on 04/11/2018 on reviewing and revising the care plan to reflect the residents current condition in all areas, if there is an acute change in condition the care plan must be reviewed and revised at that time. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing that anytime the care plan is revised the Kardex must be revised and a new Kardex hung in the resident's room by the MDS Nurses on 04/11/2018. A 100% in-service was completed with all staff on making sure that food served to the resident matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed on 04/11/2018 by the Director of Nursing, the Administrator, the Social Worker, the Activity Director, the Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on Neglect/Abuse on 04/11/2018. The Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses in-serviced all Nursing Staff on providing supervision during meals, cuing residents during the meal, the signs and symptoms of choking, and what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the nurse on 4/13/18. Diet orders will be reviewed during the clinical meeting going forward to ensure</p>		

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F 689	<p>Continued From page 28</p> <p>consequences of choking. Family verbalized agreement and good understanding of education received. Family able to verbalize Pt typical performance, impulsively consuming an entire glass of HTL without taking breath or using dry swallows to clear potential residue. ST attempted to physically remove Pt cup of HTL. Pt demonstrated need to clear throat and produce strong cough for approximately 45 seconds following intake of liquids. Pt demonstrated mostly functional intake of soft solid, cooked vegetable, mashed potatoes and sugar cookie, however family states they would pursue further diet downgrade versus a feeding tube if necessary".</p> <p>2/26/18 at 9:42 PM - (activity date 2/20/18) "Pt seen on this date for dysphagia therapy session in Pt room for lunch meal. ST arrived with Pt meal, provided set up. Pt sitting in wheelchair at bedside table. Pt observed to consume bowl of vegetable with the bowl at Pt lips, scooping vegetable into mouth in very large bites. Pt continued to scoop vegetable without fully masticating and swallowing trials. ST attempted to remove the bowl but Pt would not cooperate and consumed all vegetable into the oral cavity. Pt required an extended period of time to complete mastication and bolus prep due to large amount of food placed in the oral cavity. Typical of previous sessions, Pt consumed all of the HTL in one drinking attempt, taking large consecutive gulps until the cup was empty. Pt with audible wet respirations immediately following intake. Pt does not produce cough or throat clear as directed by ST"</p> <p>2/21/18 at 9:32 PM - "Pt seen for dysphagia therapy session during lunch meal of mechanical</p>	F 689	<p>that the care plan and kardex are updated accordingly. The care plan and Kardex will be updated to show the need of supervision or restorative dining by the MDS Nurses as needed.</p> <p>An audit tool that monitors tray cards matching what is on the plate will be completed by the Administrative staff during rounds 3 times a week for 4 weeks, b-weekly for 4 weeks, monthly for 2 months, and turned into the Administrator for review. The Director of Nursing will review supervision of dining by using a QI tool to monitor supervision / restorative dining documentation 3 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. Any identified concerns will be addressed as it is identified. If there are any issues with the trays they will be corrected as it is identified. The Administrator will bring the tools to the weekly QAPI Committee meeting for review of the audit tools weekly for 8 weeks and monthly for 2 months. The Monthly QAPI Committee will review the minutes of the weekly meetings for 4 months to determine the continued need and frequency of monitoring.</p>		

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F 689	<p>Continued From page 29</p> <p>soft solids and HTL. Pt consumed HTL glass of apple juice impulsively despite ST verbal cues and tactile cue to lower the glass. Pt pulled away from ST aggressively. PT transferred self to the wheelchair, wheeled self to the bathroom and retrieved a half glass of water from the sink. Pt consumed it immediately and in an impulsive manner. Pt cough immediately and continued to throat clear with obvious wet respirations. Pt returned to room and consumed solids from lunch tray. Further therapy to address improving Pt attendance to restorative dining to improve safety if he chokes during meal".</p> <p>2/22/18 at 8:48 PM - "Pt seen for dysphagia therapy session during afternoon snack of mechanical soft solids (2 packs of Sugar free cookies), pudding and HTL. Pt lying in bed on entry. Pt originally states he will not sit on edge of bed to eat snack and want ST to give all trials in bed. ST educated Pt on risk of consumption in bed. ST assisted Pt into upright sitting position. Once in safe sitting position Pt given 3 small lemon cookies on table, separated by several inches to attempt to dissuade him from impulsively consuming cookies. Pt picked up all cookies and shoved them into his mouth despite ST attempting to physically remove the cookies. ST cued Pt to spit out excess cookies while attempting to masticate such a large bolus. Pt would not. Once he began drinking TL, he did not stop. Pt throat cleared for 2-3 minutes following intake. ST provided cup of pudding, which Pt consumed in 4 bites. ST educated restorative dining aide on strategies to reduce risk of aspiration on both solids and liquids. Restorative aide reports Pt refuses to attend restorative dining".</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 30</p> <p>2/28/18 at 8:52 PM - (activity date 2/23/18) "Pt completed dysphagia session in Pt private room during lunch meal of mechanical soft solid and HTL. On this date, Pt significantly impulsive in all areas including transfer to wheelchair, use of utensils and condiments on lunch tray as well intake of solids and liquids. ST attempted to provide education re: choking and aspiration risks. Pt did not respond to ST or appear to comprehend any education given. Pt consumed HTL in large, consecutive gulps resulting in cough following the straw. Pt does not appear to acknowledge education if he is safer in impulsive intake, he could be downgraded back to NTL. Further therapy indicated to improve behavioral safety".</p> <p>2/25/18 at 9:23 PM - "Pt completed dysphagia therapy session on 2/23/18 in Pt ' s private room during lunch meal of mechanical soft solid and HTL."</p> <p>2/26/18 at 9:14 PM -"Pt completed lunch meal in Pt private room for lunch meal of mechanical soft solid and HTL. Pt observed to search for straw in bedside table for several minutes prior to intake. ST educated Pt on likely inability to consume liquids through the straw as well as history of unsafe intake from the straw. Pt conceded and proceeded to pick up the cup and consume entire contents in several large consecutive gulps. Pt began throat clearing during intake and swallow but did not stop taking consecutive gulps. Following swallow of final large gulp, Pt required hard throat clear and cough to clear material from the airway/pharynx. ST attempted to provide education re: safety of swallowing however Pt demonstrated no understanding or desire to learn information. Pt observed to consume solids in</p>	F 689			

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F 689	<p>Continued From page 31</p> <p>mostly safe and functional manner to given food selection. Pt did not retrieve water from the faucet of the bathroom on this date".</p> <p>2/27/18 at 4:57 PM - "Pt completed dysphagia therapy session during lunch meal of mechanical soft solid and HTL in restorative dining room. On this date, Pt demonstrate considerably improved impulsivity, taking appropriate size bites and drinks at an appropriate rate. Pt appears to be less concerned with rapid rate of intake and seeking out next step of daily sequence. ST educated Pt on improved overall behavior significantly improving safety of by mouth (po) intake. ST recommends ongoing attendance in restorative dining to improve overall safety of po intake".</p> <p>2/28/18 at 5:00 PM - "Pt completed dysphagia therapy session in restorative dining room for intake of mechanical soft solids and HTL. On this date, Pt demonstrate good improvement in safety of po intake, demonstrating no impulsive intake of solids, however Pt observed to take multiple large drinks of HTL. There is no overt signs/symptoms of aspiration. Pt does not respond to ST throughout therapy session".</p> <p>The ST progress and discharge summary dated 3/1/18 was reviewed. The notes revealed that the end of goal status was not met as "Pt safely consumes mechanical soft exhibiting severe impairment, primarily non oral nutrition, high risk of aspiration, requires supervision with oral intake due to aspiration risk and significant weight loss, and trial oral intake via therapeutic feedings due to impulsivity. Pt is at risk of aspiration of both consistencies due to impulsivity of intake. Pt</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 32</p> <p>discharged as long term care resident with restorative dining".</p> <p>The nurse's notes dated 3/1/18 at 7:11 PM revealed "resident was sitting in room and staff took meal tray in and sat while resident ate. Staff walked out of room when finished with meal and then went back in and found resident slumped over and came for writer. His eyes opened, not breathing or had no pulse. Placed resident on the bed and writer started cardiopulmonary resuscitation (CPR) and crash cart brought in and started using ambu bag and oxygen at 6:10 PM. Back board was placed under resident. West side nurse helped. Emergency Medical Service (EMS) arrived and started working with resident and 30 minutes later obtain blood pressure and heart beating. Transported to hospital".</p> <p>The hospital history and physical records for Resident #1 dated 3/1/18 were reviewed. The records revealed that Resident #1 presented to the emergency room due to cardiac arrest. "Pt. supposedly was witnessed drinking cologne and subsequently had some sort of arrest. High quality CPR was immediately initiated. Pt. had a return of spontaneous circulation (ROSC) in the field but subsequently had another episode of arrest. He was intubated and brought to the emergency department where ROSC was once again achieved". The physical examination revealed he has rales in the right upper field, the right middle field, left upper field and the left middle field. The chest x-ray showed "subtle bibasilar infiltrates are present and may be due to aspiration".</p> <p>The chest x-ray final result dated 3/2/18 revealed "bilateral infiltrates are noted and appear stable.</p>	F 689			

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F 689	<p>Continued From page 33</p> <p>Findings are worrisome for pneumonia".</p> <p>The gastroenterology consult dated 3/2/18 revealed "attempted to place nasogastric tube (NGT) but unable to pass. Went back of throat and ok to push but kept curling up. Recommended Esophagogastroduodenoscopy (EGD, a procedure that visualizes the upper part of the gastrointestinal tract down to the duodenum, at bedside in the morning if stable and to try to place NGT".</p> <p>The EGD result dated 3/3/18 revealed food was found in the upper third of the esophagus.</p> <p>The hospital discharge summary dated 3/4/18 revealed that when EGD was performed on 3/3/18, large food bolus was found impacted in the proximal esophagus. The computerized tomography (CT) scan of head performed on 3/4/18 revealed findings consistent with severe diffuse cerebral edema consistent with anoxic brain injury. "Decision was made to compassionately extubate patient. He was extubated and failed to take any spontaneous breaths. Patient passed peacefully at 4:51 PM on 3/4/18".</p> <p>On 4/10/18 at 12:35 PM, a lunch meal observation was conducted in the restorative dining room. There were two residents with doctor's orders for mechanically altered diet with thickened liquids. The dietary cards matched with the consistency of food on their trays. Residents with orders for mechanical soft diet received ground meat on their tray.</p> <p>On 4/10/18 at 1:51 PM, a family member was interviewed. The family member stated that</p>	F 689			

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F 689	<p>Continued From page 34</p> <p>he/she went back to the facility to pick up Resident #1's belongings. She/he was informed by Nurse #1 that NA #1 stepped out of the room while the resident was eating and when she came back few minutes later to pick up the tray, she found the resident slumped over.</p> <p>On 4/10/18 at 2:30 PM, the ST was interviewed. She stated that she started treating Resident #1 for dysphagia upon his readmission on 2/8/18. She indicated that resident choked on a piece of chicken at the hospital and was discharged to the facility on soft diet with thickened liquids. His behavior and mental status had changed during his readmission of 2/8/18. He was very impulsive and no desire to learn. Treated him once a day during lunch meal. He needed supervision during meals because he had no safety awareness.</p> <p>On 4/10/18 at 3:45 PM, Restorative Aide (RA) #1 was interviewed. She stated that she was the head of the restorative program. She indicated that Resident #1 refused to go to restorative dining, he was on 1:1 with the staff during meals. RA #1 did not have documentation that Resident #1 was refusing to go to restorative dining.</p> <p>On 4/10/18 at 3:50 PM, Nurse Aide (NA) #1 was interviewed. She was assigned to Resident #1 on 3/1/18, second shift. She stated that she was assigned to Resident #1 on 3/1/18 for the first time after his readmission from the hospital. She indicated that Nurse #1 informed her that Resident #1 needed 1:1 during meals. She served the dinner tray around 6 PM in the resident's room and stayed with him the whole meal. She indicated that the resident was able to feed himself. He had chunks of beef (not ground beef) on his tray about ¾ to an inch thick and</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 35</p> <p>thickened liquids. He consumed about 80% of his food and 50% of his liquids. He did not cough during the meal observation. After he finished eating, he turned around and opened his bedside drawer, took a bottle of cologne and drank from it. She noticed empty cups inside his drawer and he would not allow her to take them out. She indicated that she thought she informed Nurse #2 that she observed the resident drinking from the cologne bottle. NA #1 left the room with the resident's tray and proceeded to feed another resident. She stated that after 15 minutes she went back to the resident's room to remove the empty cups from his drawer and she found him slumped over to his right side and not breathing. She went to get Nurse #1.</p> <p>On 4/10/18 at 5:27 PM, Nurse #3 was interviewed. She stated that she had been working at the facility for almost 3 months and had known Resident #1. He was independent with eating and he did not need any supervision during meals.</p> <p>On 4/10/18 at 5:29 PM, Nurse #4 was interviewed. She stated that she had been working at the facility for 4 months and he remembered Resident #1. He was independent with eating with set up help only and he didn't need any supervision during meals.</p> <p>On 4/10/18 at 5:32 PM, NA #2 was interviewed. NA #2 had been working at the facility for 2 years on second shift. She used the kardex to care for the resident. She indicated that she remembered Resident #1 and he was independent with eating with set up help only and he didn't need any supervision during meals.</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>On 4/11/18 at 8:01 AM, MDS Nurse #2 was interviewed. She stated that she was updating all the resident's care plans and she didn't get the chance to update Resident #1's care plan and kardex to address his risk for choking/aspiration following his readmission to the facility on 2/08/18.</p> <p>On 4/11/18 at 8:30 AM, the ST was again interviewed. She stated that she had referred Resident #1 to restorative dining. The ST was unable to remember the date of the referral and she could not find her referral form to nursing. She had talked to the Restorative Aide who indicated that the resident refused restorative dining. The ST indicated that she expected the staff to sit and to watch him while he eats in his room when he refused to go to restorative dining. She attended the morning meetings with the department heads and she had shared with them her concerns with Resident #1 the need for supervision during meals. The ST stated that she discharged Resident #1 from therapy on 2/28/18 and she recommended to continue restorative dining.</p> <p>On 4/11/18 at 8:40 AM, MDS Nurse #1 was interviewed. The MDS Nurse indicated that she attended the morning meetings and the ST had discussed the need for supervision and restorative dining for Resident #1 due to his risk for choking/aspiration. The MDS Nurse indicated that she didn't get the chance to update his care plan and his kardex to address risk for choking/aspiration. The MDS Nurse indicated that Resident #1 was on restorative dining after his readmission on 2/8/18 but he refused to go at times so a staff member had to sit and watch him while he ate in his room.</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 37 On 4/11/18 at 8:50 AM, the Physician of Resident #1 was interviewed. He stated that he expected the facility to follow the recommendations of the ST regarding supervision with eating. The Physician stated that he didn't know if the food in his esophagus had caused the resident's death. On 4/11/18 at 9:01 AM, NA # 3 was interviewed. She was assigned to Resident #1 on first shift. She stated that Resident #1 was on restorative dining and he never refused to go to restorative dining. She brought him to restorative dining every breakfast and lunch when she was assigned to him. On 4/11/18 at 9:04 AM, Restorative Aide #2 was interviewed. She stated that she worked Monday through Friday on 7-3 shift. She was in the restorative dining room during breakfast and lunch. She indicated that Resident #1 had been to restorative dining once (didn't remember the date) and the ST was working with him. She indicated that she didn't have any documentation regarding restorative dining for Resident #1. On 4/11/18 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that the ST attended the morning meetings with the department heads. She discussed Resident #1 being high risk for choking/aspiration due to his impulsiveness/compulsiveness and he needed to be in restorative dining or needed supervision with meals, but these (restorative dining and supervision during meals) had not been formally implemented or ordered. It was on 3/1/18 when she informed Nurse #1 and the NAs that Resident #1 had to be supervised during meals but she could not remember the time. The DON	F 689			

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F 689	<p>Continued From page 38</p> <p>verified that Resident #1 was not on restorative dining nor was on 1:1 with staff during meals prior to 3/1/18.</p> <p>On 4/11/18 at 1:30 PM, Nurse # 1 was interviewed. Nurse #1 stated that she was assigned to Resident #1 on 3/1/18. She stated that she was busy passing medications (little after 6 PM) when NA #1 called her to the resident's room. She found the resident slumped over, not breathing and no pulse. She called the code and cardio pulmonary resuscitation (CPR) was initiated. EMS (Emergency Medical Services) was called and when they arrived they took over the CPR. Nurse #1 stated that NA #1 informed her that she sat with the resident during supper and when he finished eating she took the tray out. Nurse #1 indicated that the resident refused restorative dining and the DON informed them that Resident #1 needed 1:1 during meals, but she could not remember the date and time.</p> <p>On 4/11/18 at 2:32 PM, the Administrator and the Director of Nursing were informed of the immediate jeopardy.</p> <p>On 4/13/18 at 7:00 PM, the facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Resident number 1 was hospitalized from 2/2/18 to 2/8/18. During the resident's hospital stay, the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018 with a diagnosis of aspiration pneumonia. He was admitted with being at risk for aspiration and choking from the hospital.</p>	F 689			

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F 689	Continued From page 39 Speech therapy reported that resident has impulsive behaviors and placed a whole dinner roll in the oral cavity at one time. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluation showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking, and re-hospitalization due to his impulsive behavior of placing large amount of food(such as a whole roll) in his mouth at one time . Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues in a note on 2/27/18 when he is discharged from therapy on 2/28/18 due to the need of constant supervision. There is no documentation to show that resident number 1 received constant supervision during his meals from 2/8/2018 through 3/1/18. Resident number 1 was supervised by a certified nursing assistant during his dinner meal on 3/1/18. The certified nursing assistant states she remained in the room throughout the meal and there were no signs of distress, complications, or universal signs of choking. The Director of Nurses educated the hall nurses that Resident number 1 should be supervised when he is eating using the restorative dining program for 2 meals a day and certified nursing aides in the evening as a nursing intervention. The Director of Nursing did not complete the education on an in-service form and does not remember the date. On 2/22/18 the speech therapist documented in her note that the restorative aides reported that resident refused to participate in the restorative dining program. The interdisciplinary team made a verbal	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345370	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/17/2018
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F 689	<p>Continued From page 40</p> <p>recommendation for restorative and supervision during meals during morning meeting after resident number 1 was readmitted on 2/8/2018. The recommendation for restorative for resident number 1 was not done in writing and was not implemented consistently. A Restorative care referral was not completed for resident number 1 on his discharge by the speech therapist and given to the Director of Nursing which contributed the lack of implementation of restorative for resident number 1. The Restorative Program did not have resident number 1 's information for restorative dining and supervised meals in written form. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018 due to an episode of non-responsiveness. The hospital records show that Resident number 1 had a large bolus of food impacted in the proximal esophagus. The Resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse anoxic injury, on 3/4/18, the resident died after being extubated per family request.</p> <p>1. There were no other residents on supervised meals. An Audit was completed by the Administrator on 04/12/2018 on the residents that have been referred to restorative dining from therapy and there were no concerns with their recommendations being followed. Restorative dining has 2 residents that attend the restorative dining program 2 meals a day and the certified nursing assistants will feed the 3rd meal each day. Any resident that is identified as needing supervision during meals will have a care plan written addressing their needs by the MDS Nurses, the Director of Nursing, and / or the</p>	F 689			

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F 689	<p>Continued From page 41</p> <p>Assistant Director of Nursing, a Kardex placed in their closet by the MDS Nurses, the Director of Nursing, and /or the Assistant Director of Nursing. The MDS Nurses completed a 100% in-service with nursing staff on Kardex being updated anytime there is a change in a residents needs and placed in the resident's closet. The Kardex must be checked prior to care for changes on 04/13/18. The Business Office Manager will bring all intent to discharge forms to morning meeting to review therapy recommendations. The Speech therapist will bring all written referrals for restorative care or supervision during meal time to the morning meeting for review. The Clinical Nurses will receive a copy of the referrals so a care plan may be written and the Kardex updated. Any referral for restorative or supervision during meal time will be addressed in the care plan by the clinical team after morning meeting. The Director of Nursing will notify the Restorative Manager/Nursing staff of new referrals by giving the restorative manager the care plan to add the resident to the restorative program and the Clinical Nurses will update the Kardex and place it in the resident's closet for the nursing staff. The week-end manager will review all hospital information on week-end admissions to determine the need for supervised dining and implement supervised dining for those that require it.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing revised and reviewed 100% of care plans and Kardex's for all residents on 04/11/2018. There were changes in at least one area for each resident's care plan and Kardex. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on 04/11/2018 on reviewing and revising the care plan to reflect the</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 42</p> <p>residents current condition in all areas, if there is an acute change in condition the care plan must be reviewed and revised at that time. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing that anytime the care plan is revised the Kardex must be revised and a new Kardex hung in the resident's room by the MDS Nurses on 04/11/2018. A 100% in-service was completed with all staff on making sure that food served to the resident matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed on 04/11/2018 by the Director of Nursing, the Administrator, the Social Worker, the Activity Director, the Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on Neglect/Abuse on 04/11/2018. The Director of Nursing, the Assistant Director of Nursing, and the MDS Nurses in-serviced all Nursing Staff on providing supervision during meals, cuing residents during the meal, the signs and symptoms of choking, and what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the nurse on 4/13/18.</p> <p>The credible allegation was validated on 4/17/18 at 11:35 AM as evidenced by nursing staff interviews and review of the in-service records regarding providing supervision during meals, cuing residents during meals, observing signs and symptoms of choking and what to do if you see a resident eating or drinking a non-food item to include notification and assessment by the</p>	F 689			

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F 689	Continued From page 43 nurse. An observation was conducted in the restorative dining room and main dining room on 4/17/18 at 12:35 PM, during lunch and residents who needed supervision during meals were supervised.	F 689			
F 805 SS=J	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record review, observation and Physician, Speech Therapist (ST)and staff interviews, the facility failed to serve food in a form ordered by the physician for 1 of 3 sampled residents reviewed with dysphagia (Resident #1). Resident #1 was found unresponsive right after dinner and was sent to the hospital and died. The cause of death was cardiac arrest secondary to acute respiratory arrest with hypoxia and aspiration. Immediate jeopardy began on 3/1/18, when Resident #1 was served food in regular consistency instead of mechanical soft as ordered. Immediate jeopardy was removed on 4/14/18. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.	F 805	Resident number1 was hospitalized from 2/2/18 to 2/8/18. During the residents hospital stay, the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018 with a diagnosis of aspiration pneumonia. Speech Therapy reported resident has impulsive behaviors and placed a whole roll in his mouth at one time. He was admitted with being at risk for aspiration and choking from the hospital. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluations showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking and re-hospitalization due to his behavior of putting a whole roll in his mouth or large	4/25/18	

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F 805	<p>Continued From page 44</p> <p>Findings included:</p> <p>Resident # 1 was originally admitted to the facility on 5/9/15 with multiple diagnoses including Parkinson's disease and history of cerebrovascular disease. The significant change in status Minimum data Set (MDS) assessment dated 1/21/18 indicated that Resident #1's cognition was intact and he had no swallowing disorder. The assessment further indicated that Resident #1 needed supervision/set up help with eating and he was not on mechanically altered diet.</p> <p>Review of Resident #1's hospital records revealed that he was discharged to the hospital on 2/2/18 due to cough.</p> <p>The hospital discharge summary dated 2/8/18 was reviewed. The notes revealed that on 2/3/18, Resident #1 was "near respiratory arrest secondary to choking on chicken during dinner. Heimlich maneuver was performed by vigilant nursing staff resulted in expelling of food bolus". The diet discharge instruction was "cardiac dysphagia diet with chopped meats and thickened liquids".</p> <p>Resident #1 was readmitted back to facility on 2/8/18 with new diagnosis of aspiration pneumonia. The diet ordered on admission was mechanical soft diet with honey thick liquids and speech therapy to evaluate and treat.</p> <p>Resident #1's care plan was last updated on 1/26/18. There was no care plan developed after his readmission on 2/8/18 to address care to prevent choking and aspiration related complication.</p>	F 805	<p>amounts of food. Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues in a note on 2/27/18 when he is discharged from therapy due to his impulsive behaviors and placing a whole roll in his mouth at one time. The Director of Nursing educated the hall nurses that resident number 1 should be supervised when he is eating using the restorative dining program and certified nursing assistants for the evening meal as a nursing intervention. Nursing staff monitored resident number 1 for the need of cueing and signs of complications, distress, or universal signs of choking such as grabbing his throat as evidenced by the Certified Nursing Assistant being instructed to supervise him during his meal by the Hall Nurse. The Certified Nursing Assistant stated to the Administrator that she was instructed to monitor resident for eating on 03/1/2018 by the hall nurse. The Hall Nurse stated to the Administrator that she told the Certified Nursing Assistant to monitor resident for eating during his meal on 03/01/2018. Resident number 1's chart contains a note that the Certified Nursing Assistant monitored resident during his meal on 03/01/2018. Resident's care plan failed to identify him being at risk for aspiration and choking. Resident's Kardex listed him as independent in his ability to eat. Resident's current diet order on 03/01/2018 was mechanical soft with honey thick liquids, magic cup, cut all rolls, Danish, bread, sandwiches cut into</p>		

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F 805	<p>Continued From page 45</p> <p>Resident #1's kardex (resident care guide) was reviewed. The kardex indicated that Resident #1 was on mechanical soft diet with nectar thick liquids.</p> <p>The dietary notes were reviewed. The last dietary note was dated 1/30/18 indicating the resident's diet was regular with thin liquids. There were no notes after his readmission on 2/8/18.</p> <p>The diet spreadsheet was reviewed. The menu for 3/1/18 dinner was beef tips with mushroom gravy for regular diet and ground beef with mushroom gravy for mechanical soft diet.</p> <p>The Speech Therapist (ST) progress and discharge summary dated 3/1/18 was reviewed. The notes revealed that patient (Pt) safely consumes mechanical soft exhibiting severe impairment, primarily non oral nutrition, high risk of aspiration, requires supervision with oral intake due to aspiration risk and significant weight loss, and trial oral intake via therapeutic feedings due to impulsivity. Pt is at risk of aspiration of both consistencies due to impulsivity of intake. Pt discharged as long term care resident with restorative dining.</p> <p>The nurse's notes dated 3/1/18 at 7:11 PM revealed that Resident #1 was found slumped over right after dinner in his room. Cardio pulmonary resuscitation (CPR) was initiated and he was sent to the hospital.</p> <p>The hospital history and physical dated 3/1/18 revealed that Resident #1 was presented to the Emergency Department (ED) due to cardiac arrest. The physical examination revealed that</p>	F 805	<p>fourths or 1-2 inch pieces, and no peanut butter. The Dietary Cook states that on 03/01/2018 the dietary department provided a mechanical soft tray to resident number 1. The dietary department utilizes the standard practice of a two-system check which requires the cook to prepare the plate and the aide will make sure that the plate matches the food listed on the tray card prior to placing it in the serving cart. When the tray cart arrives on the hall the person passing the trays will make sure that the food matches the diet order on the tray card before giving it to the resident. If the tray card does not match the plate the person serving the plate will take the plate back to the kitchen to be corrected. The Dietary Manager monitored the tray line for the consistency and the amount of available food for special diets prior to her shift ending on 03/01/2018. The dietary department was able to provide the appropriate diet to all residents without any other concerns. There is no reason to believe that he was received the wrong diet. The Certified Nursing Assistant states she remembered that his beef tips on his tray were about 1/2 to 3/4 inch in size on 04/12/18 but she cannot remember anything else that he had. This is a change from what she reported earlier so it is possible she is unable to remember correctly. The Dietary Manager stated on 4/12/18 that she made sure there was enough ground for all the mechanical soft diets. There is no reason to believe that resident number 1 did not receive his correct diet. She stayed in his room until</p>		

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F 805	<p>Continued From page 46</p> <p>Resident #1 had rales in the right and left upper and middle fields. The chest x-ray result showed subtle bibasilar infiltrates which might be due to aspiration.</p> <p>The hospital discharge summary dated 3/4/18 revealed that when esophagogastroduodenoscopy (EGD), a procedure that visualizes the upper part of the gastrointestinal tract down to the duodenum) was performed on 3/3/18, a large food bolus was found in the proximal esophagus. The computerized tomography (CT) scan of the head performed on 3/4/18 revealed findings consistent with severe diffuse cerebral edema consistent with anoxic brain injury. A decision was made to extubate Resident #1. He was extubated and passed away on 3/4/18.</p> <p>On 4/10/18 at 12:35 PM, a lunch meal observation was conducted in the restorative dining room. There were two residents with doctor's orders for mechanically altered diet with thickened liquids. The tray cards matched with the consistency of food on their trays. Residents with orders for mechanical soft diet received ground meat on their tray.</p> <p>On 4/10/18 at 2:30 PM, the ST was interviewed. She stated that she started treating Resident #1 for dysphagia upon his readmission on 2/8/18. She indicated that resident choked on a piece of chicken at the hospital and was discharged to the facility on soft diet with thickened liquids and she expected the facility to serve diet as ordered.</p> <p>On 4/10/18 at 3:50 PM, Nurse Aide (NA) #1 was interviewed. She was assigned to Resident #1 on 3/1/18, second shift. She stated that on 3/1/18</p>	F 805	<p>he had finished eating and took his tray out of the room with her when he finished eating. Certified Nursing Assistant states there were no complications, distress, and no universal signs of choking when she exited the room. Prior to exiting the room the Certified Nursing Assistant states that Resident Number 1 was going through his drawers and actually attempted to close her hand in the drawer. The Certified Nursing Assistant states that she saw Resident Number 1 take a sip of something and she thought it was cologne. The Certified Nursing Assistant stated to the hall nurse on 03/01/2018 that she saw Resident Number 1 take a sip of something out of his drawer and thought it was cologne. The Hall Nurse was involved in doing C.P.R. and did not go check to see if the resident had cologne in his drawer. The Hall Nurse asked her if she saw him drink it and the Certified Nursing Assistant told her she thought she did. The Hall Nurse reported to EMS that it was possible that Resident Number 1 drank cologne on 03/01/2018. The Certified Nursing Assistant proceeded to feed another resident and then returned to Resident Number 1's room to find him slumped over. The Hall Nurse states that from the time she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal to the time the Certified Nursing Assistant came to ask her to look at him was around 20 to 30 minutes. The Certified Nursing Assistant stated the Hall Nurse told her to supervise resident number 1 during his evening meal. The</p>		

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F 805	<p>Continued From page 47</p> <p>was her first time assigned to the resident after his readmission from the hospital. She served the dinner tray around 6 PM in the resident's room. He had chunks of beef (not ground beef) on his tray about ¾ to an inch thick and thickened liquids. He consumed about 80% of his food and 50% of his liquids. He did not cough during the meal observation. After he finished eating, he turned around and opened his bedside drawer, took a bottle of cologne and drank from it.</p> <p>On 4/10/18 at 5:45 PM, the Dietary Manager (DM) was interviewed. She stated that Resident #1 was on mechanical soft diet and honey thick liquids. She verified the menu on 3/1/18 as beef tips (1/2 to ¾ inch in size) for regular diet and ground beef for the mechanical soft diet. She stated that staff used the food processor to grind the meat for the soft diet.</p> <p>On 4/11/18 at 8:50 AM, the Physician of Resident #1 was interviewed. He stated that he expected the facility to follow the diet as ordered. The Physician stated that he didn't know if the food in his esophagus had caused the resident's death.</p> <p>On 4/11/18 at 10:10 AM, the Director of Nursing (DON) was interviewed. She stated that the ST attended the morning meetings every morning with the department heads. She discussed Resident #1 being high risk for choking/aspiration due to his impulsiveness. His diet order was mechanical soft diet and she expected the dietary department to serve the diet as ordered.</p> <p>On 4/12/18 at 12:34 PM, the DM was again interviewed. She stated that before she left on 3/1/18, she checked to make sure the dietary staff has everything they needed and they had</p>	F 805	<p>Hall Nurse reports that she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal on 03/01/2018 because the Director of Nursing had told the Nurses to supervise him during meals for a nursing intervention. The Hall Nurse states she can't remember when she was told to supervise Resident Number 1 by the Director of Nursing. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018.</p> <p>1. Resident number 1 was readmitted from the hospital on 02/08/2018 with being at risk for aspiration and choking. Speech Therapy worked with Resident number 1 from 02/08/2018 until discharge from therapy on 02/28/2018 for oropharyngeal dysphagia. Resident number1 had a diet order of Mechanical Soft and nectar thick liquids on 02/08/2018. Resident number 1 had a diet of mechanical soft with honey liquids on 02/16/2018. Resident had his diet changed by the speech therapist to mechanical soft with honey liquids, magic cup, cut all rolls, Danish, bread, sandwiches cut into fourths or 1 □ 2 inch pieces, and no peanut butter on 02/20/2018. Speech therapy completed a bedside dysphagia evaluation for resident number 1 on 02/08/2018 which showed that resident number one was at risk for aspiration, aspiration-related complications, choking, and re-hospitalization. Resident number 1 was on antibiotic therapy (Augmentin</p>		

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F 805	<p>Continued From page 48</p> <p>enough food for soft and pureed diet. She also stated that she normally observed the tray line but she did not observe the whole process.</p> <p>On 4/12/18 at 5:02 PM, NA #1 was again interviewed. NA #1 stated that Resident #1 received beef tips on 3/1/18, ½ to ¾ inch in size solid meat during dinner. She indicated that she had received an in-service on the 2 way system (kitchen staff and the cook prepare the tray according to the tray/dietary card and nursing staff check the tray against the tray/dietary card before serving and if there was a concern, the nursing staff would bring the tray back to the kitchen to be corrected) on 4/11/18. She indicated that she didn't know the 2 way system prior to the in-service that she had to check the tray and to compare the food served with the dietary card before serving the tray to the resident.</p> <p>On 4/11/18 at 2:32 PM, the Administrator and the Director of Nursing were informed of the immediate jeopardy.</p> <p>On 4/13/18 at 7:00 PM, the facility provided the following credible allegation of immediate jeopardy removal:</p> <p>Resident number #1 was hospitalized from 2/2/18 to 2/8/18. During the resident's hospital stay, the resident had an episode of choking and was identified as being at risk for aspiration. Resident number 1 was re-admitted to Pinehurst Healthcare and Rehabilitation Center on 02/08/2018 with a diagnosis of aspiration pneumonia. Speech Therapy reported resident has impulsive behaviors and placed a whole roll in his mouth at one time. He was admitted with</p>	F 805	<p>875/125 mg 1 tab Q 12 hours for 5 days) for possible aspiration from 02/08/2018 to 02/12/2018. On 03/01/2018 Resident number 1 received a tray with the correct diet per his tray card from the Dietary Staff. The Dietary Manager made sure that there was enough ground meat for all the mechanical soft diets. The Dietary Cook states that he fixes all residents plates per the order on the tray card. The Dietary Manager's standard practice is to monitor the tray line to ensure that the food form is correct. A facility Certified Nursing Assistant. took Resident number 1's tray into his room on 03/01/2018 and supervised him while he ate due to his behavior of placing large amounts of food in his mouth at the same time. The Hall Nurse told the Certified Nursing Assistant to supervise Resident Number 1 because the Director of Nursing told the Nurses that he needed to be supervised for a nursing intervention due to his behaviors of putting large amounts of food in his mouth. The Hall Nurse states that the Certified Nursing Assistant told her that she supervised him during his meal with no complications. The Certified Nursing Assistant stated on 04/12/2018 that she remembered that his beef tips on his tray were about ½ to ½ inch in size but she cannot remember anything else that he had. She stayed in his room until he had finished eating and took his tray out of the room with her when he finished eating. Certified Nursing Assistant reported there were no complications, distress, and no universal signs of choking when she exited the room. Prior to exiting the room</p>		

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F 805	Continued From page 49 being at risk for aspiration and choking from the hospital. Speech Therapy began to work with him on 02/08/2018 for oropharyngeal dysphagia. Speech Therapy completed a bedside dysphagia evaluation on 02/08/2018. The bedside dysphagia evaluations showed that the resident needed speech therapy due to him being at risk for aspiration, aspiration-related complications, choking and re-hospitalization due to his behavior of putting a whole roll in his mouth or large amounts of food. Resident received speech therapy until 02/28/2018 when he was discharged from therapy. Speech therapy recommended restorative dining continues in a note on 2/27/18 when he is discharged from therapy due to his impulsive behaviors and placing a whole roll in his mouth at one time. The Director of Nursing educated the hall nurses that resident number 1 should be supervised when he is eating using the restorative dining program and certified nursing assistants for the evening meal as a nursing intervention. The Director of Nursing did not complete the education on an in-service form and does not remember the date. The Certified Nursing Assistant stated to the Administrator that she was instructed to monitor resident for eating on 03/1/2018 by the hall nurse. The Hall Nurse stated to the Administrator that she told the Certified Nursing Assistant to monitor resident for eating during his meal on 03/01/2018. Resident number 1's chart contains a note that the Certified Nursing Assistant monitored resident during his meal on 03/01/2018. Resident's care plan failed to identify him being at risk for aspiration and choking. Resident's Kardex listed him as independent in his ability to eat when he should have been listed as supervised due to behaviors. Resident's current diet order on 03/01/2018 was mechanical soft with honey thick	F 805	the Certified nursing Assistant reports that Resident Number 1 was going through his drawers and actually attempted to close her hand in the drawer. The Certified Nursing Assistant reported that she saw Resident Number 1 take a sip of something and she thought it was cologne. The Certified Nursing Assistant reported it to the hall nurse on 03/01/2018 that she saw Resident Number 1 take a sip of something out of his drawer and thought it was cologne. The Hall Nurse asked her if she saw him drink it and the Certified Nursing Assistant told her she thought she did. The Hall Nurse reported to EMS that it was possible that Resident Number 1 drank cologne on 03/01/2018. The Certified Nursing assistant proceeded to feed another resident and then returned to Resident Number 1's room to find him slumped over. The Hall Nurse states that from the time she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal to the time the Certified Nursing Assistant came to ask her to look at him was around 20 to 30 minutes. The Hall Nurse reports that she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal on 03/01/2018 because the Director of Nursing had told the Nurses to supervise him during meals for a nursing intervention. The Hall Nurse states she can't remember when she was told to supervise Resident Number 1 by the Director of Nursing. When the certified nursing assistant left the room she took the tray with her and proceeded to assist another resident. The certified nursing		

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F 805	Continued From page 50 liquids, magic cup, cut all rolls, Danish, bread, sandwiches cut into fourths or 1-2 inch pieces, and no peanut butter. The Dietary Cook states that on 03/01/2018 the dietary department provided a mechanical soft tray to resident number 1. The dietary department utilizes the standard practice of a two-system check which requires the cook to prepare the plate and the aide will make sure that the plate matches the food listed on the tray card prior to placing it in the serving cart. When the tray cart arrives on the hall the person passing the trays will make sure that the food matches the diet order on the tray card before giving it to the resident. If the tray card does not match the plate the person serving the plate will take the plate back to the kitchen to be corrected. The Dietary Manager monitored the tray line for the consistency and the amount of available food for special diets prior to her shift ending on 03/01/2018. The dietary department was able to provide the appropriate diet to all residents without any other concerns. There is no reason to believe that resident number 1 was received the wrong diet. The Certified Nursing Assistant states she remembered that his beef tips on his tray were about 1/2 to 3/4 inch in size on 04/12/18 to the Administrator but she cannot remember anything else that he had. This is a change from what she reported earlier so it is possible she is unable to remember correctly. The Dietary Manager stated on 4/12/18 that she made sure there was enough ground for all the mechanical soft diets. There is no reason to believe that resident number 1 did not receive his correct diet. She stayed in his room until he had finished eating and took his tray out of the room with her when he finished eating. Certified Nursing Assistant states there were no complications, distress, and no universal signs of	F 805	assistant returned after she had finished feeding another resident to find him slumped over. An order was obtained to send Resident number 1 to the hospital on 03/01/2018 by the charge nurse. The Family was notified by the charge nurse on 03/01/2018. A 100% audit was completed on 04/12/2018 by the Hall Nurses to ensure that all tray cards matched the trays being served to the residents. The result showed that all tray cards matched the resident's trays being served on 04/12/2018. The Dietary Manager and the Cook state that resident was given the diet that is on his tray card. Dietary Manager re-educated dietary staff on the tray line on 04/12/18 and The Director of Nursing, the MDS Nurses, and the Assistant Director of Nursing re-educated the nursing staff on the tray line process on 04/12/18. The certified nursing assistant thinks that resident number 1 had beef tips that were 1/2 to 3/4 on an inch in size but can't remember anything else about his meal on 03/01/18. 100% in-service was completed with nursing staff on the 2system tray line process on 04/12/18. 2. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/11/2018. There were changes in at least one area for each resident's care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute		

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F 805	Continued From page 51 choking when she exited the room. Prior to exiting the room the Certified Nursing Assistant states that Resident Number 1 was going through his drawers and actually attempted to close her hand in the drawer. The Certified Nursing Assistant stated to the hall nurse on 03/01/2018 that she saw Resident Number 1 take a sip of something out of his drawer and thought it was cologne. The Hall Nurse was involved in doing C.P.R. and did not go check to see if the resident had cologne in his drawer. The Hall Nurse asked her if she saw him drink it and the Certified Nursing Assistant told her she thought she did. The Hall Nurse reported to EMS that it was possible that Resident Number 1 drank cologne on 03/01/2018. The Certified Nursing Assistant proceeded to feed another resident and then returned to Resident Number 1's room to find him slumped over. The Hall Nurse states that from the time she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal to the time the Certified Nursing Assistant came to ask her to look at him was around 20 to 30 minutes. The Certified Nursing Assistant stated the Hall Nurse told her to supervise resident number 1 during his evening meal. The Hall Nurse reports that she told the Certified Nursing Assistant to supervise Resident Number 1 during his meal on 03/01/2018 because the Director of Nursing had told the Nurses to supervise him during meals for a nursing intervention. The Hall Nurse states she can't remember when she was told to supervise Resident Number 1 by the Director of Nursing. On 03/01/2018 Resident was noted to be unresponsive and C.P.R. was initiated. Resident was discharged to the hospital on 03/01/2018. The resident was intubated. The CT of the head showed the resident had diffuse cerebral edema and diffuse infarct from diffuse	F 805	change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident's room by the MDS Nurses on 04/11/2018. 3. A 100 % in-service was completed with all staff on making sure that food served to resident's matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse. An audit tool that monitors tray cards matching what is on the plate will be completed 3 times a week for 4 weeks, bi-weekly for 4 weeks, monthly for 2 months, and turned into the Administrator for review. If there are any issues with the trays they will be corrected as it is identified. The Administrator will bring the tools to the weekly QAPI Committee meeting for review of the audit tools weekly for 8 weeks and monthly for 2 months. The Monthly QAPI Committee will review the minutes of the weekly		

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F 805	<p>Continued From page 52</p> <p>anoxic injury. On 3/4/18 the resident died after being extubated per family request.</p> <p>1. A 100% audit was completed on 04/12/2018 by the Hall Nurses to ensure that all tray cards matched the trays being served to the residents. The result showed that all tray cards matched the resident ' s trays being served on 04/12/2018. The Dietary Manager and the Cook state that resident was given the diet that is on his tray card. Dietary Manager re-educated dietary staff on the tray line on 04/12/18 and The Director of Nursing, the MDS Nurses, and the Assistant Director of Nursing re-educated the nursing staff on the tray line process on 04/12/18. 100% in-service was completed with nursing staff on the 2system tray line process on 04/12/18.</p> <p>2. The MDS Nurses and the Assistant Director of Nursing reviewed and revised 100% of care plans for all residents on 04/11/2018. There were changes in at least one area for each resident's care plan. The Director of Nursing in-serviced the MDS Nurses and the Assistant Director of Nursing on Care plans addressing the residents current condition in all areas and if there is an acute change in condition the care plan must be reviewed and revised at that time and any time a care plan is reviewed and revised the Kardex for the resident will be updated and the new copy placed in the resident ' s room by the MDS Nurses on 04/11/2018.</p> <p>3 A 100 % in-service was completed with all staff on making sure that food served to resident's matches what is on the tray card prior to serving the food to the resident by the MDS Nurses, the Activity Director, and the Social Worker on 04/11/2018. The Dietary Manager</p>	F 805	<p>meetings for 4 months to determine the continued need and frequency of monitoring. The Dietary Manager will audit the tray line to ensure that the tray cards match the plate 3 times a week for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The Audit will be turned into the Administrator weekly for review. Any concerns will be addressed as they are identified. The Administrator will bring the audits to the weekly QAPI meeting for review weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 2 months. The monthly QAPI Committee will review the minutes from the weekly meeting at the monthly meeting for the continued need and frequency of monitoring for 4 months.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 805	<p>Continued From page 53</p> <p>in-serviced 100% of dietary staff on special diets with return demonstration on 04/11/2018. A 100% in-service was completed 04/11/2018 by Director of Nursing, The Administrator, The Social Worker, The Activity Director, The Housekeeping Supervisor, the Dietary Manager, and the Therapy Manager on neglect/abuse.</p> <p>The credible allegation was validated on 4/17/18 at 11:35 AM as evidenced by review of in-service records and nursing staff interviews regarding in-service on 2 way system (checking dietary card and the food serve on their tray match) and dietary staff interview regarding special diets and tray line. An observation was conducted on 4/17/18 at 12:35 PM, during lunch and food consistency matched with their dietary cards.</p>	F 805			