STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT SPRUCE PINES	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/21/25 through 01/24/25. Additional information was obtained offsite on 01/27/25. The survey team returned onsite on 02/07/25 to gather additional information. The survey team agained returned onsite on 02/11/25 to validate the credible allegation. Therefore, the exit date was changed to 02/11/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HSYM11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 01/21/25 through 01/24/25. Additional information was obtained offsite on 01/27/25. The survey team returned onsite on 02/07/25 to gather additional information. The survey team agained returned onsite on 02/11/25 to validate the credible allegation. Therefore, the exit date was changed to 02/11/25. Event ID# HSYM11. The following intakes were investigated: NC00211395, NC00211562, NC00214601, NC0000218154, and NC00226339. 12 of the 12 complaint allegations did not result in a deficiency. Immediate Jeopardy was identified at: CFR 483.65 at tag F825 at a scope and severity (J) Immediate Jeopardy began on 12/19/24 and was removed on 02/05/25.	F 000		
F 655	Baseline Care Plan	F 655		2/22/25

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

Electronically Signed | 02/21/2025

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 655 SS=D	Continued From page 1 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 2 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to develop an accurate baseline care plan for a resident (Resident #70) when the care plan did not include the type of thickened liquids ordered for Resident #70. This deficient practice occurred for 1 of 1 resident reviewed for baseline care plans. Findings included: Resident #70 was admitted to the facility on 12/17/24. The admission Minimum Data Set (MDS) dated 12/23/24 revealed Resident #70 was cognitively intact. He was coded on the MDS as having a mechanically altered diet. A diet order dated 12/17/24 read, regular diet, mechanical soft texture, nectar thick liquids. The order was discontinued on 12/19/24. A baseline care plan dated 12/17/24 read under dietary: Diet order, regular mechanical soft thickened liquids. A diet order dated 12/19/24 read, regular diet, puree texture, nectar thick liquids. The order was discontinued on 1/13/25. A hospital discharge summary for Resident #70	F 655	On 2/5/25, the comprehensive care plan was updated by a licensed nurse to include honey thickened liquids for resident #70. All new admissions have the potential to be affected by the deficient practice. On 2/20/25, all admissions for the last 21 days (1/31/25 - 2/20/25) who do not yet have a comprehensive care plan, were evaluated by the director of nursing to ensure no initial baseline care plans were incorrect for thickened liquid consistency. The audit was completed on 2/20/25, and no additional issues identified. On 2/5/25, the Administrator educated the director of nursing and unit managers on the following information: All new admissions must have an accurate baseline care plan and that it must include the consistency of thickened liquids if applicable. It is the responsibility of the director of nursing or unit manager to ensure the completion of the baseline care plan and ensure accuracy. The director of nursing or designee will audit all admissions for 8 weeks to ensure that all residents receive an initial baseline	

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F 655	Continued From page 3 dated 1/13/25 revealed he was admitted to the hospital on 1/8/25 and was discharged on 1/13/25. His discharge diagnoses included: esophageal dysphagia (difficulty swallowing), aspiration pneumonia (lung infection that occurs when food/liquid is inhaled into the lungs), and acute hypoxic (low blood oxygen level) respiratory failure secondary to aspiration pneumonia. The discharge summary said Resident #70 was discharged on a puree diet with honey thick liquids. A diet order dated 1/13/25 read, regular diet, puree texture, honey thick liquids. A care plan dated 12/17/24 and revised on 1/14/25 read: Resident #70 has a nutritional problem or potential nutritional problem and is reliant on thickened liquids and pureed food at this time. The care plan intervention said to provide and serve diet as ordered. An interview was conducted with the Minimum Data Set (MDS) nurse on 1/24/25 at 2:42 PM. He explained baseline care plans were completed by the admitting nurse. He further explained he reviewed the baseline care plans to make sure they were completed and then used it for the basis of the comprehensive care plan. He said the care plan should read diet as ordered or thickened liquids as ordered. He stated staff would have to ask the nurse what Resident #70's diet/ thickened liquid order was if it was not on the care plan. The MDS Nurse thought it would be best for the diet order and the type of thickened liquids a resident was supposed to receive to be included in the care plan. An interview was conducted on 1/24/25 at 5:37	F 655	care plan that accurately reflects the appropriate thickened liquid consistency as applicable. The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The director of nursing is responsible for this plan of correction. Date of compliance is 2/22/25.	

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F 655	Continued From page 4 PM with Nurse #4. She recalled completing Resident #70's admission on 12/17/24. Nurse #4 said she had completed the baseline care plan when she did his admission. She stated she should have put the type of thickened liquids ordered for Resident #70 on the care plan but did not think about it. An interview was conducted with the Director of Nursing on 1/24/25 at 11:53 AM. She explained the baseline care plan could be done by any nurse on admission and then it was reviewed by the MDS nurse. The DON said staff would have to look at Resident #70's dietary ticket or ask the nurse to look up the order to see what type of thickened liquids Resident #70 was supposed to have if it was not listed on the care plan. She stated the type of thickened liquids Resident #70 received should have been listed on the care plan. An interview was conducted with the Administrator on 1/24/25 at 3: 10 PM. The Administrator stated the care plan should match the physician orders and the kitchen dietary ticket; she stated they should all match. She said the care plan should have said what type of thickened liquids were ordered for Resident #70.	F 655		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		2/22/25

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F 689	Continued From page 5 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and Physician Assistant (PA) interviews, the facility failed to provide thickened liquids as ordered to a resident (Resident #70) when Nurse Aide (NA) #1 gave Resident #70 nectar thick liquids to drink instead of honey thick liquids. Resident #70 required honey thick liquids due to his risk of aspiration and history of aspiration pneumonia. This deficient practice occurred for 1 of 3 residents reviewed for accident hazards. The findings included: Resident #70 was admitted to the facility on 12/17/24. He was re-admitted to the facility on 1/13/25 following hospitalization. The admission minimum data set (MDS) dated 12/23/24 revealed Resident #70 was cognitively intact. The MDS documented he had no behavior or rejection of care. The MDS indicated Resident #70 required substantial/ maximal assistance from staff with eating. He was coded on the MDS as having a mechanically altered diet. The hospital discharge summary for Resident #70 dated 1/13/25 revealed he was admitted to the hospital on 1/8/25 and was discharged on 1/13/25. His discharge diagnoses included: esophageal dysphagia (difficulty swallowing), aspiration pneumonia (lung infection that occurs when food/liquid enters the lungs), and acute hypoxic (low blood oxygen level) respiratory failure secondary to aspiration pneumonia. The discharge summary said Resident #70 was discharged on a puree diet with honey thick	F 689	On 1/21/25, the nectar thick liquids were removed from resident #70□s bedside by the Unit Manager. Resident #70 was then provided with the correct consistency of honey thickened liquids by the Unit Manager.¿ All residents who receive thickened liquids have the potential to be affected by the deficient practice. On 2/4/25, All residents in the facility that require thickened liquids were audited by the Director of Nursing (DON) to ensure the correct consistency of liquids were provided at bedside. No new issues identified. On 2/5/25 education was initiated by the DON for all nursing staff on the requirement to ensure that the correct consistency of thickened liquid is present at bedside. Nursing staff were also educated that the residents□ need for thickened liquid, as well as the appropriate consistency for the thickened liquids, is found on the Kardex and that thickened liquids for placement at bedside are found in the nourishment room or the kitchen. Newly hired or agency staff will receive this training prior to working a shift in the facility. The DON/designee will audit all residents	

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F 689	Continued From page 6 liquids and would get speech therapy (ST) at rehab. A diet order dated 1/13/25 read, regular diet, puree texture, honey thick liquids. Resident #70 had a care plan revised on 1/14/25 that read: Resident #70 has a nutritional problem or potential nutritional problem and is reliant on thickened liquids and puree food at this time. The care plan intervention said to provide and serve diet as ordered. On 1/22/24 the Kardex for Resident #70 was reviewed and revealed it did not indicate the type of thickened liquids he was supposed receive. A continuous observation was completed on 1/21/25 from 12:58 PM to 1:14 PM of NA #1 assisting Resident #70 in his room with his lunch meal. NA #1 setup Resident #70's meal tray. She checked his meal tray card. His head of bed was elevated in an upright position. He had a clear cup with thickened liquids on his tray. Resident #70 was observed as he attempted to drink the thickened liquids out of the cup through a straw, he said nothing was coming out of the cup. NA #1 exited the room at 1:07 PM and returned to the room at 1:08 PM with a small clear plastic cup. NA #1 went to a red hydration cooler sitting on top of Resident #70's dresser, removed a carton from the cooler, and poured the thickened liquid from the carton into the small plastic cup. NA #1 put a straw in the cup and gave it to Resident #70. Resident #70 was observed as he drank the thickened liquid from the cup using the straw. After drinking the liquid Resident #70 was heard coughing. Resident #70's meal ticket was reviewed with NA #1. His meal ticket indicated	F 689	with thickened liquids 5 x per week for 8 weeks to ensure that all residents have the correct consistency of thickened liquid at bedside. The DON will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The DON is responsible for this plan of correction. Date of compliance is 2/22/25.	

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F 689	Continued From page 7	F 689		

honey thick liquids were ordered. The carton of thickened liquids from the cooler was reviewed with NA #1, it was the only carton present in the cooler and had an open date of 1/21/25 written on the carton. NA #1 confirmed "nectar thick liquid" was printed on the carton of lemon water. She confirmed the liquids sent by the kitchen on his meal tray were honey thick liquids. NA #1 was interviewed at 1:10 PM and stated she was unsure about the nectar thickened liquids in the hydration cooler located in Resident #70's room. She explained she had not looked on the carton to check what type of thickened liquid it was, but had assumed it was the correct thickened liquid for Resident #70 since the carton was in his cooler. NA #1 reported she did not know Resident #70 that well and would go get NA #2 who was more familiar with him. NA #1 exited the room at 1:13 PM to retrieve NA #2. NA #1 returned to Resident #70's room at 1:14 PM with NA #2. NA #1 removed the nectar thick liquids from Resident #70's meal tray and continued to assist him with his meal.

An interview was conducted with NA #2 on 1/21/25 at 1:15 PM. NA #2 reported she did not know when Resident #70 had been placed on honey thick liquids but stated he could not drink the honey thick liquid out of his cup using a straw because they were too thick. NA #2 explained Resident #70 did not do well with honey thick liquids because he became frustrated when he tried to drink it. NA #2 added she thought Resident #70 did better with nectar thick liquids because he could drink them easier. NA #2 said she had not spoken to anyone about Resident #70's thickened liquids. She further explained that the carton of nectar thickened liquids was already in Resident #70's hydration cooler when she

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F 689	Continued From page 8	F 689		

arrived to work this morning.

An interview was conducted with Nurse #3 on 1/21/25 at 1:28 PM. Nurse #3 was the assigned nurse for Resident #70. Nurse #3 reviewed Resident #70's physician orders and confirmed he had honey thick liquids ordered. Nurse #3 stated Resident #70 should only have honey thick liquids and should not be given nectar thick liquids or have them in the cooler in his room. Nurse #3 explained that nectar thick liquids were not thick enough for Resident #70 and if he was given fluids that were not thick enough, he could aspirate. Nurse #3 stated he would remove the carton of nectar thick liquids from Resident #70's room.

An interview was conducted with NA #3 on 1/22/25 at 3:23 PM. NA #3 worked the night shift on Monday night 1/20/25 on 300 hall and was Resident #70's assigned NA. She explained she refilled Resident #70's bedside hydration cooler with thickened liquids on night shift. NA #3 said there had not been thickened liquids in the nourishment room Monday night and she had asked Nurse #2 for thickened liquids for Resident #70. She said Nurse #2 had gone to the kitchen to get thickened liquids for Resident #70. NA #3 recalled Nurse #2 gave her a carton of nectar thick lemon water. NA #3 said she had assumed the thickened liquids Nurse #2 had given her for Resident #70 was what he was supposed to have. She said she thought Resident #70 was supposed to have nectar thick liquids.

An interview was conducted with Nurse #2 on 1/24/25 at 8:17 AM. Nurse #2 explained NA #3 had asked her for thickened liquids for Resident #70 on Monday night because she could not find

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F 689	Continued From page 9	F 689		

the thickened liquids in the nourishment room. Nurse #2 reported she went to the kitchen and got a container of thickened liquids and gave it to NA #3 for Resident #70. Nurse #2 said she had looked at the carton and it said, "thickened liquid". She did not recall what type of thickened liquids were labeled on the carton but said she had thought it would okay since it had said thickened on the carton. Nurse #2 stated she knew Resident #70 had returned from the hospital on thickened liquids but did not know what type of thickened liquids he was supposed to have. She did not know he had honey thick liquids ordered.

An interview was conducted on 1/21/25 at 3:37 PM with the Speech Therapist (ST). The ST said she had received a ST referral or been asked to evaluate Resident #70 before today. The ST explained she had been asked to see Resident #70 today after the incident at lunch where he had been given nectar thick liquids instead of honey thick liquids. The ST stated she had completed a bedside swallow study. She reported she trialed nectar thick liquids and a safety straw today during the bedside swallow study. She stated Resident #70 had shown signs of aspiration with nectar thick liquids, which were coughing. The ST stated Resident #70 needed honey thick liquids. The ST explained honey thick liquids would be very difficult to drink out of a straw and should be drunk using cup sips.

An interview was conducted on 1/23/25 at 9:38 AM with the PA. The PA reported Resident #70 had a choking/ aspiration episode at the facility on 1/7/25 and was sent to the hospital for evaluation. She explained Resident #70 had been admitted to the hospital with aspiration pneumonia and had returned to the facility on 1/13/25. She explained

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F 689	Continued From page 10 prior to his hospitalization he had nectar thick liquids ordered but he had been changed to honey thick liquids during his hospitalization. The PA stated Resident #70 was ordered to receive honey thick liquids. The PA said nectar thick liquid was not as thick as honey thick liquid, she said it was not as risky as thin liquid, but was not what Resident #70 should have had. She explained Resident #70 was high risk for aspiration. An interview was conducted with the Director of Nursing (DON) on 1/23/25 at 8:54 AM. The DON stated Resident #70 had been changed to honey thick liquids during his hospitalization and had honey thick liquids ordered when he returned from the hospital on 1/13/25. The DON said she was not sure why Resident #70 had nectar thick liquids in the hydration cooler in his room. She said Resident #70 should not have been given nectar thick liquids and that he needed honey thick liquids to help prevent aspiration. An interview was conducted with the Administrator on 1/24/25 at 3:10 PM. The Administrator stated Resident #70 should have received honey thick liquids and staff should have been aware of what liquids he was supposed to receive.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		2/22/25

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F 759	Continued From page 11 Based on observations, record review, staff, Physician Assistant (PA), and Pharmacist interviews the facility failed to maintain a medication error rate of less than 5% by having 3 errors out of 35 opportunities which resulted in an 8.57% medication error rate. This affected 1 of 4 residents observed for medication administration (Resident #19). Findings included: Resident #19 was admitted to the facility on 9/26/24. Her medical diagnoses included: hypertension (high blood pressure), angina (chest pain), chronic obstructive pulmonary disease (COPD) (chronic respiratory disease), and gastro-esophageal reflux disease (GERD). A Physician's order dated 9/26/24 read, may crush medications unless contraindicated. A physician's order dated 9/27/24 read Isosorbide Mononitrate (cardiac medication) extended release (ER) 24-hour 30 milligram (mg) oral tablet, give one tablet by mouth one time a day for angina. The manufacturer's package insert instructions for the administration of Isosorbide Mononitrate dated 2/2025 included: Isosorbide Mononitrate extended-release tablets should not be chewed or crushed A physician's order dated 9/26/24 read Mucinex (medication that thins mucus) extended release (ER) 12-hour 600 milligram (mg) oral tablet, give one tablet by mouth two time a day for congestion.	F 759	On 1/23/25, the incorrectly crushed medications were not administered to the resident, and the nurse was educated by the Director of Nursing (DON) that resident #19□s Pantoprazole Sodium, Isosorbide Mononitrate extended release (ER), and Mucinex ER cannot be crushed as crushing will deliver the medication at once rather than over time. This education was provided following the finding of the incorrectly crushed medications. All residents that require crushed or altered medication administration are at risk for this deficient practice. On 2/3/25 all medication orders for residents requiring crushed medications were evaluated by the DON to ensure that medications that should not be crushed, are not ordered. Any medications that require crushing were evaluated by the consultant pharmacist and the medical director. If the medication could not be substituted for another medication, or the medication is not offered in a crushable or liquid form, the medical director and pharmacist reviewed the medication to determine the effectiveness of the medication if crushed. Those residents with medications deemed still effective being crushed received orders to crush these medications per the facility policy on crushed medications with monitoring by a licensed nurse for adverse effects put in place. Education with the DON and Unit	

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F 759	Continued From page 12 The manufacturer's package insert instructions for administration of Mucinex ER 600 mg dated 9/2023 included: do not crush, chew, or break tablet. A physician's order dated 1/9/25 read Pantoprazole Sodium (medication for acid reflux) oral packet 40 mg, give 1 packet by mouth one time a day for GERD. The manufacturer's package insert instructions for administration of Pantoprazole Sodium delayed-release oral suspension dated 5/2024 included: Do not split, chew, or crush pantoprazole sodium for delayed-release oral suspension. An observation and interview was conducted on 1/23/25 at 8:00 AM of Nurse #5 preparing Resident #19's medication at the 300-hall medication cart. She placed the Isosorbide Mononitrate ER 30 mg tablet, Pantoprazole 40 mg tablet, and Mucinex 600 mg ER tablet into a medication cup along with all of Resident #19's other prepared medications. She placed the medications from the medication cup into a clear plastic pill crushing pouch. Nurse #5 placed the pouch containing Resident #19's medications into the pill crusher and crushed the medications. She emptied the crushed medications into a medication cup with applesauce. Nurse #5 entered Resident #19's room and approached her to administer the medications. Nurse #5 was stopped by the surveyor and asked to return to the medication cart. An interview was conducted with Nurse #5 at 8:10 AM. Nurse #5 explained she thought the directions for the pantoprazole had been	F 759	Managers was completed on 2/5/25 by the Administrator. Education included that when entering new medication orders, the medication must be verified against the do not crush list from the facility pharmacy. If the medication cannot be crushed, a warning will be entered by the DON or Unit Manager in the indication section of the electronic medication administration record (eMAR). If the resident cannot swallow a medication in its whole form and there is a warning not to crush, this medication order will be reviewed by the facility provider to determine if an alternative medication is available or if the benefits of taking the medication when crushed outweigh the warning no crushing. Once the determination has been made by the medical provider, the instructions will be entered accordingly into the indication section of the eMAR for licensed nurses and Certified Medication Aides (CMA) to follow. The DON and Unit Managers will then add a prompt for observation monitoring for adverse effects that could result from crushing the medication against pharmacy and/or manufacturer recommendations. Education was initiated for all nurses and CMAs on 2/5/25 by DON. This education included that nurses must look in the indication section of eMAR to ensure that there is no warning against crushing the medication prior to administering. If a medication should not be crushed and the resident cannot take it safely without crushing, there will be a notation in the indication section of the eMAR to crush	

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F 759	Continued From page 13 mistakenly entered as a packet instead of a tablet. She said the blister card of pantoprazole tablets was what was on hand on the medication cart for Resident #19 and she thought it was okay to give the tablet. She did not know if the pantoprazole had been ordered as a packet because Resident #19 needed her medications crushed. Nurse #5 said she thought it was okay to crush the ER tablets because they were tablets and not a capsule. She thought since it was a tablet the ER medication would not be released all at once if they were crushed and it was okay to crush them. Nurse #5 then said she was not sure. She said if she was not sure if a medication could be crushed, she would ask Unit Manager (UM) #1 or call the pharmacy. Nurse #5 said she was going to go ask UM #1 about the medication. On 1/23/25 at 8:13 AM Nurse #5 returned to the 300-hall medication cart with UM #1 and an interview was conducted with UM #1. UM #1 stated ER medications and should not be crushed because all the medication would be released at one time. UM #1 said she did not think pantoprazole tablets could be crushed. An interview was conducted with the Director of Nursing (DON) on 1/23/25 at 8:54 AM. The DON explained if ER medication were crushed it would change the release time of the medication. She said ER medications were intended to be slow release and if they were crushed the medication would be released all at one time. The DON stated she did not think Isosorbide Mononitrate ER should be crushed but was not sure about the Mucinex ER tablet and Pantoprazole tablet. She thought a pharmacist had told her in the past it was okay to crush Mucinex ER tablets, but she was not sure and would have to check. She said	F 759	and administer this medication and they will be prompted to observe and document monitoring for adverse effects post administration. Newly hired or agency staff will receive this training prior to working a shift in the facility. The DON/designee will audit a medication order on a resident with crushed medications 5 x per week for 8 weeks to ensure that the medication has been verified against the do not crush list and that if it should not be crushed, that it has been reviewed by the provider, warnings are in the indication section, observations in place if indicated, and that the licensed nurse of CMA administers per the order. The DON will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The DON is responsible for this plan of correction. Date of compliance is 2/22/25.	

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F 759	Continued From page 14	F 759		

she did not know why Nurse #5 had thought it was okay to crush Resident #19's Isosorbide Mononitrate ER tablet.

On 1/23/25 at 9:38 AM an interview was conducted with the PA. The PA stated ER medications should not be crushed because the medication would be released all at one time. She said to her knowledge Isosorbide Mononitrate ER, Pantoprazole, and Mucinex ER should not be crushed but crushing it would not be significant or have an impact to the resident.

An interview was conducted with the Pharmacist on 1/23/25 at 12:06 PM. The Pharmacist said you do not crush ER medications. She stated Isosorbide Mononitrate ER should not be crushed or chewed. She said if the Isosorbide Mononitrate ER was crushed it would be released all at one time. The Pharmacist explained if the medication was released in the body all at one time it could cause lightheadedness from a decrease in blood pressure or heart rate. She was not sure about the potential impact it could have and could not say if it could be significant or not. The Pharmacist further stated, pantoprazole tablets and Mucinex ER tablets were not supposed to be crushed because the medication would be released all at one time. She said the Pantoprazole tablet packet insert said not to crush the medication and that the medication should not be crushed. The Pharmacist explained if the Pantoprazole tablet was crushed it would decrease the bio availability of the medication, which meant it would make the medication less effective. The Pharmacist stated Mucinex ER tablets were formulated with an ER side. She stated if the Mucinex ER tablet was crushed the medication would not be released over time and

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F 759	Continued From page 15 would not treat the patient's symptoms over time the way it was intended. The Pharmacist further explained Mucinex ER was formulated to release over 12 hours to treat symptoms over a 12 hour period of time and if the tablet was crushed it would not provide the 12 hours of symptom management. An interview was conducted with the Administrator on 1/24/25 at 3:10 PM. She said nurses should follow physician orders when administering medication. She said ER medications should not be crushed because the medication would be released all at once. The Administrator said the pharmacy or physician should be consulted about if it was okay to crush ER medications.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		2/22/25

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F 761	Continued From page 16 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure the 400-hall medication cart was secured while unattended. This was for 1 of 5 medication carts observed (400 hall). Findings included An observation on 1/22/25 at 1:52 PM revealed the 400-hall medication cart was unattended and unlocked with the lock in the outward position. The medication cart was located directly outside the nurses' station and across the hall from a resident activity room. A continuous observation of the medication cart occurred on 1/22/25 from 1:52 PM to 2:03 PM in which 16 facility staff passed the unlocked cart. A resident was observed sitting in their wheelchair approximately 10 feet from the cart while unlocked. Nurse #1 who was assigned to the 400 hall nurses cart arrived back to the medication cart on 1/22/25 at 2:03 PM, locked the cart and was interviewed. Nurse #1 stated she had placed the medication cart by the nurses' station and did not double check that the cart was locked. She stated she normally locked the cart and should have locked the cart before leaving it unattended. The Director of Nursing (DON) stated on 1/24/25 at 11:58 AM the medication cart should be locked	F 761	On 1/22/25, the nurse that left a cart unlocked was educated by the Director of Nursing (DON) on safe medication administration including locking medication cart and medication administration with observation and return demonstration by Registered Nurse Unit Manager. On 1/22/25, a walking round audit was completed by the DON to visualize all medication carts and ensure that no other carts were unlocked if unattended. There were no other issues identified. On 1/22/25, all nurses were educated by the DON on the safe medication administration requirement to lock the medication cart before walking away and leaving the cart unattended. Newly hired or agency staff will receive this training prior to working a shift in the facility. The DON/designee will audit all medication carts 5 x per week for 8 weeks by completing a walking round to ensure that all medication carts are locked and secured if unattended. The DON will review these audits in the	

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F 761	Continued From page 17 if unattended by a nurse or not within the eye site of a nurse. The DON said any staff who had noticed an unlocked and unattended medication cart should report it to her and lock the cart. The Administrator stated on 1/24/25 at 3:16 PM that Nurse # 1's medication cart should have been locked when unattended by the nurse.	F 761	monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The DON is responsible for this plan of correction. Date of compliance is 2/22/25.	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide drinks consistent with the resident's needs for 1 of 1 sampled resident (Resident #70) reviewed for drinks available to meet resident needs. The findings included: Resident #70 was re-admitted to the facility on 1/13/25. A diagnosis of dysphagia (difficulty swallowing) was listed on Resident #70's 1/13/25 hospital discharge summary. A diet order dated 1/13/25 read, regular diet, puree texture, honey thick liquids. Resident #70 had a care plan revised on 1/14/25	F 807	On 1/21/25, the dietary manager obtained honey thickened liquids from a sister facility, and the unit manager removed nectar thick liquids from resident #70 room and replaced them with honey thick liquids. On 2/1/25 all residents in the facility with orders for thickened liquids were assessed by the dietary manager to ensure that the appropriate thickened liquids were available in the facility for residents. No additional issues were noted. All residents requiring thickened liquids	2/22/25

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F 807	Continued From page 18 that read: Resident #70 has a nutritional problem or potential nutritional problem and is reliant on thickened liquids and puree food at this time. The care plan intervention said to provide and serve diet as ordered. An observation was completed on 1/21/25 at 1:10 PM of the hydration cooler in Resident #70's room. The cooler contained a carton labeled nectar thick lemon water. The carton was dated with an open date of 1/21/25. An interview was conducted with Nurse Aide (NA) #2 on 1/21/25 at 1:15 PM. NA #2 explained that the carton of nectar thickened liquids was already in Resident #70's hydration cooler when she arrived at work this morning. An interview was conducted with Nurse #3 on 1/21/25 at 1:28 PM. Nurse #3 was the assigned nurse for Resident #70. Nurse #3 reviewed Resident #70's physician orders and confirmed he had honey thick liquids ordered. Nurse #3 stated Resident #70 should only have honey thick liquids and should not be given nectar thick liquids or have them in the cooler in his room. Nurse #3 said he would remove the carton of nectar thick liquids from Resident #70's room. An interview was conducted with NA #3 on 1/22/25 at 3:23 PM. NA #3 worked the night shift on Monday night 1/20/25 on 300 hall and was Resident #70's assigned NA. She explained Resident #70 had asked for something to drink and was saying he was thirsty Monday night. NA #3 reported there had not been any thickened liquids in the hydration cooler in Resident #70's room. NA #3 stated there had not been thickened liquids in the nourishment room Monday night	F 807	have the potential to be affected by the deficient practice. On 2/5/25, education was initiated by the DON for all nursing staff on the requirement to ensure that the correct consistency of thickened liquid is present at bedside. On 2/5/25, education was completed by the Administrator for the dietary manager that thickened liquid consistencies must be assessed weekly when submitting orders to ensure that adequate amounts of thickened liquid is ordered in the appropriate consistencies for current residents. The director of nursing will audit all residents requiring thickened liquids 5x a week for 8 weeks to ensure proper thickened liquids are available in the facility and at bedside. The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The Administrator is responsible for this plan of correction. Date of compliance is 2/22/25.	

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F 807	Continued From page 19	F 807		

and she had asked Nurse #2 for thickened liquids for Resident #70. She said Nurse #2 had gone to the kitchen to get thickened liquids for Resident #70. NA #3 recalled Nurse #2 gave her the carton of nectar thick lemon water for Resident #70.

An interview was conducted with Nurse #2 on 1/24/25 at 8:17 AM. Nurse #2 explained NA #3 had asked her for thickened liquids for Resident #70 on Monday night because she could not find the thickened liquids in the nourishment room. She reported Resident #70 was saying he was very thirsty. Nurse #2 said she looked and could not find any thickened liquids in the nourishment room or on 100 hall. Nurse #2 reported she went to the kitchen to look for thickened liquids and she had only been able to find one container of thickened liquids. She stated the facility usually had packets of thickener, but she was unable to find any thickener packets. Nurse #2 reported she gave the container of thickened liquids she had found in the kitchen to NA #3 for Resident #70. Nurse #2 recalled she had looked at the carton and it said, "thickened liquid". She did not recall what type of thickened liquids were labeled on the carton but had thought it would be okay since it had said thickened on the carton and Resident #70 was saying he was thirsty. Nurse #2 said she told a dietary staff member Tuesday morning about needing thickened liquids. She did not recall who she had told.

An interview was conducted with the Dietary Manager on 1/22/24 at 1:29 PM. The DM stated the facility ran out of pre-thickened honey thick liquids Monday night. He said he had ordered honey thick liquids on 1/21/25 when he became aware the facility had run out. The DM reported he contacted a sister facility this morning

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F 807	Continued From page 20 (1/21/25) after breakfast when he realized the facility was out of the pre thickened honey thick liquids and the sister facility had provided a supply of honey thick liquids and extra thickener packets to the facility. The DM said they had received the interim supply of honey thick liquids from the sister facility sometime after lunch on 1/21/25. He explained the facility had thickener packets available at the facility, not the pre-thickened honey thick liquids. He did not know why the staff could not locate the thickener packets. An interview was conducted with the Director of Nursing (DON) on 1/23/25 at 8:54 AM. The DON said she was not sure why Resident #70 had nectar thick liquids in the hydration cooler in his room. She explained Resident #70 should not have been given nectar thick liquids and that he needed honey thick liquids to help prevent aspiration. An interview was conducted with the Administrator on 1/24/25 at 3:10 PM. The Administrator stated Resident #70 should have received honey thick liquids. She said the facility should have had honey thick fluids available.	F 807		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		2/22/25

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F 812	Continued From page 21 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to clean and maintain the reach-in refrigerator, walk-in refrigerator and the steam table knobs in the kitchen. The facility also failed to remove expired tube feeding containers from 1 of 2 nourishment rooms. This practice had the potential to affect residents in the facility. Findings included a. An observation of the kitchen's reach-in refrigerator was made with the Dietary Manager (DM) on 1/21/25 at 10:38 AM. The observation found the inside floor of the refrigerator and the bottom of the inside side of the door contained splattered, sticky to touch red substance. The reach-in refrigerator's circulatory fan cover was observed covered with thick brown/gray debris that was crumbly to touch. b. On 1/21/25 at 10:46 AM the walk-in refrigerator ceiling was found to contain gray in color, loosely hanging debris. The debris was crumbly to touch and was in the back of the walk-refrigerator near the cooling fan.	F 812	a. On 1/24/25 after being made aware of the concern for the sticky substance in the reach-in cooler, the dietary manager thoroughly cleaned the reach-in cooler. b. On 1/24/25, after being made aware of the concern regarding dust on the fans in the reach-in cooler and the ceiling of the walk-in cooler, both coolers were cleaned by the Dietary Manager, and the dust was removed. c. On 1/24/25, after being made aware of the concern regarding the grease build-up on the knobs for the steam table, the Dietary Manager removed the knobs and cleaned each of them. d. On 1/23/25, after being made aware of the concern regarding out-of-date tube feeding supplies in the nourishment room, the expired tube feeding was discarded by the Dietary Manager. a. On 2/5/25, the Dietary Manager completed an audit of all coolers to	

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F 812	Continued From page 22 c. On 1/21/25 at 10:49 AM each of the six the steam table knobs used to turn on and adjust the temperature of the steam table were found with a build-up substance that was sticky to touch. On 1/23/25 at 11:24 AM a follow-up observation of the kitchen found the reach-in refrigerator, walk-in refrigerator, and steam table knobs remained unchanged. d. On 1/23/25 at 4:00 PM the main nourishment room was observed with the DM. The nourishment room contained 21 8 oz tube feeding cartons with an expiration date of 10/1/24. The DM stated during the observation that Central Supply staff stocked and maintained the tube feeding inventory. The Central Supply Manager was interviewed on 1/23/25 at 4:06 PM. She stated Central Supply staff stocked the tube feeding containers, checked expiration dates and removed expired tube feeding containers. She stated the tube feeding containers were checked monthly for expiration when the nourishment room was stocked. The Central Supply Manager stated she had overlooked the expired tube feedings. On 1/24/25 at 11:39 AM the DM stated the reach-in refrigerator was cleaned on a weekly basis and was not cleaned the previous week. He stated the debris on the ceiling of the walk-in cooler was overlooked and was not included in a cleaning schedule. The DM said the steam table knobs were not included on a cleaning schedule and had been overlooked. The Administrator stated on 1/24/25 at 3:16 PM the kitchen should have been clean and tidy and	F 812	ensure they were free from sticky substances and other spills. The coolers were found to be clean. b. On 2/5/25, the Dietary Manager completed an audit of all cooler fans and ceilings to determine if there was any dust present. No additional dust was noted. c. On 2/5/25, the Dietary Manager completed an audit of all equipment knobs to determine if grease build-up was present. No issues were noted. d. On 2/5/25, the Dietary Manager completed an audit of perishable supplies in the nourishment room to ensure that no other items were out-of-date. No other issues were noted. All residents have the potential to be affected by the deficient practices. On or before 2/5/25, the Administrator or designee educated the Dietary Manager that equipment knobs must be on the assigned cleaning task schedule so that proper cleaning can take place. On or before 2/5/25, the Administrator or designee educated all dietary staff on the kitchen cleaning schedule and the requirement to complete the assigned cleaning tasks on a daily basis including coolers, fans, and equipment knobs. On 2/5/25, central supply staff received education on the requirement to ensure stock items placed in the nourishment	

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F 812	Continued From page 23 on a regular cleaning schedule.	F 812	room are not expired and that existing stock must be audited each time new stock is added to maintain only current (not expired) stock. Newly hired or agency staff will receive this training prior to working a shift in the facility. a. The Dietary Manager will complete an audit of all coolers 5 times per week for 8 weeks to ensure they are free from sticky substances and other spills. b. The Dietary Manager will complete an audit of all cooler fans and ceilings 5 times per week for 8 weeks to ensure they are free from dust. c. The Dietary Manager will audit all kitchen equipment knobs 1 time per week for 8 weeks to ensure that there is no grease build-up present and that they were cleaned according to the new task schedule for cleaning. d. The Central Supply Manager will complete an audit of perishable supplies in the nourishment room 1 time per week for 8 weeks to ensure that no items are out-of-date. The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee.	

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F 812	Continued From page 24	F 812	The Administrator is responsible for this plan of correction. Date of compliance is 2/22/25.	
F 825 SS=J	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff, Speech Therapist (ST), Physician Assistant (PA), and Medical Director, the facility failed to provide speech therapy evaluation and services to Resident #70 during his stay. Resident #70 was admitted to the facility from the hospital on 12/17/24 with a recent history of aspiration pneumonitis (a type of lung infection that is due to a relatively large amount of	F 825	On 1/21/25, when resident #70 had a coughing episode after consuming nectar thickened liquids, concerns for swallowing difficulties were communicated to the Speech Therapist by a licensed nurse. On 1/21/25, resident #70 received a speech therapy evaluation with recommendations to continue honey thick liquids until a fiberoptic endoscopic evaluation of	2/21/25

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F 825	Continued From page 25 material from the stomach or mouth entering the lungs) and acute hypoxic respiratory failure (a medical condition where the body rapidly fails to adequately oxygenate the blood, leading to a severe lack of oxygen in the tissues). Resident #70 required a mechanical soft diet with nectar thickened liquids when he was admitted on 12/17/24. On 12/18/24 Resident #70 was diagnosed with pneumonia at the facility and treated with a 7-day course of antibiotics. His diet was downgraded to puree with nectar thick liquids by Unit Manager (UM) #1 on 12/19/24. Resident #70 was not evaluated by speech therapy after his diet was downgraded. On 1/7/25 Resident #70 had a choking and aspiration episode at the facility and was sent to the emergency department. Resident #70 was admitted to the hospital and returned to the facility on 1/13/25. The hospital discharge summary indicated Resident #70 was to receive speech therapy and was diagnosed with esophageal dysphagia (difficulty swallowing), aspiration pneumonia, and acute hypoxic (low blood oxygen level) respiratory failure secondary to aspiration pneumonia. Speech therapy was not initiated upon readmission to the facility, and no one identified the absence of the service. This deficient practice occurred for 1 of 1 resident reviewed for rehabilitation services (Resident #70). Immediate jeopardy began on 12/19/24 when speech therapy did not evaluate Resident #70 after his diet had been downgraded by Unit Manager (UM) #1 due to staff reporting he had coughing when eating and was not doing well with his diet. Immediate jeopardy was removed on 2/5/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower	F 825	swallowing (FEES) examination could be completed. On 2/4/25, an audit was completed by the Rehab Program Manager/Speech Language Pathologist of all new admissions from 1/13/25 to 2/3/25 to ensure each new admission with orders for a modified diet was screened by Speech Therapy. Any residents identified as having a modified diet and not having a Speech Therapy screening resulted in a Speech referral for the resident to be screened (if resident is still in facility). On 2/4/25, the Administrator educated the DON and Unit Managers on the new process that when filling out the diet requisition on new admissions, a copy will be submitted to the DON and Speech Therapy for any resident with a modified diet. Diet requisitions will be reviewed 5 x weekly with the DON, Unit Managers, and the Rehab Director in the clinical morning meeting. During this meeting, it will be validated that each diet requisition has been received by Speech Therapy, and the Rehab Director will convey the date for screening. On 2/4/25, the Rehab Program Manager and all evaluating speech therapists were educated by the Regional Director of Rehabilitation Services on the new process for receiving diet requisitions on new admits and that this requisition alerts them that a modified diet is present. Education also included the requirement to screen all new admissions who are	

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F 825	Continued From page 26 scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective and to address the deficient practice. The findings included: A hospital progress note dated 12/14/24 read in part under problem list: "Aspiration event, currently consistent with aspiration pneumonitis, no evidence of subsequent pneumonia at this time but still early and could develop. Acute hypoxic respiratory failure, secondary to above." Under plan, the progress note indicated he was being treated with antibiotics and given the aspiration event would likely lean towards treating him with a 14-day course. The note indicated the 14-day course of antibiotics would be completed on 12/16/24. A review of the facility's hospital records for Resident #70 revealed a physician progress note dated 12/15/24 that read: "Speech-language pathology following; International dysphagia diet standardization initiative (IDDSI) level 4 puréed food, level 3 moderately thick/honey thick liquids". A hospital discharge summary for Resident #70 dated 12/17/24 indicated his hospital course was complicated by aspiration resulting in significant episode of respiratory distress. The hospital discharge summary reported he had been followed closely by speech therapy and was able to start back on a restricted International dysphagia diet standardization initiative (IDDSI) diet (a system for describing food textures and drink thicknesses for people with swallowing difficulties. The IDDSI framework helps to prevent	F 825	receiving a modified diet to determine if there is a need for speech therapy evaluation. For any admission where is identified through the screening process that they could benefit from speech therapy services would be promptly evaluated and treated to address rehabilitation needs. Any new or agency speech language pathologists will be educated prior to working their first shift. Any new or agency Director of Nursing or Unit Manager will be educated prior to working their first shift. The Rehab Program Manager will audit all new admissions 5 x per week for 8 weeks to ensure that a diet requisition was received for all new admissions who have a modified diet and that all residents having a modified diet were screened by the speech therapist to address rehabilitation needs. The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The Administrator is responsible for this plan of correction. Date of compliance is 2/21/25	

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choking and improve safety when eating and drinking.). The hospital discharge summary did not indicate the type of IDDSI diet. The hospital discharge summary indicated he was seen by palliative care during his hospital stay and would be discharged to the skilled nursing facility (SNF) with hospice.

Resident #70 was admitted to the facility on 12/17/24. His diagnoses included: chronic obstructive pulmonary disease (COPD), acute cholecystitis (inflammation of the gallbladder), acute metabolic encephalopathy (a brain condition that causes confusion), and muscle weakness.

A review of the facility admission physician orders did not reveal any orders for hospice services. There was an active order dated 12/17/24 that read: speech therapy may evaluate and treat as indicated.

A diet order dated 12/17/24 read, regular diet, mechanical soft texture, nectar thick liquids. Entered by Nurse #4.

A baseline care plan completed by Nurse # dated 12/17/24 read under dietary: Diet order, regular mechanical soft thickened liquids. Under dietary risks, risk for swallowing problems was marked. Under the section entitled therapy, speech therapy was marked.

A telephone interview was conducted on 1/24/25 at 5:37 PM with Nurse #4. She recalled completing Resident #70's admission on 12/17/24. She stated she would not have entered a modified diet order for mechanical soft with nectar thick liquids, unless she had found it

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somewhere in Resident #70's admission paperwork. She did not recall specifically where she had found the diet in his paperwork. She did not recall taking report from the hospital for Resident #70. She was not sure who had taken the report. Nurse #4 reported that if a diet order was not present in a resident's admission paperwork, she would call the hospital to ask what the diet was and then call the facility provider to clarify if they wanted to continue that diet. Nurse #4 reported she did not remember calling the hospital and doing that for Resident #70's diet. She said she did not recall calling the provider about his diet. Nurse #4 explained she did not do a therapy communication on admission for Resident #70 because typically admissions were talked about in the management morning meetings with therapy.

A progress note by the PA dated 12/18/24 indicated Resident #70 had been seen and evaluated for worsening cough and shortness of breath. The physical exam stated he had diffuse adventitious (abnormal lung sounds, like crackles or wheezes, can be heard widespread throughout a large area of the chest when listening with a stethoscope) breath sounds throughout the right side of his lungs. The note indicated a plan to obtain a chest x-ray due to right sided adventitious breath sounds and high risk for aspiration given swallowing dysfunction.

A chest x-ray was completed on 12/18/24 and read: patchy opacity in right mid lung may represent pneumonia.

A review of physician orders revealed the following antibiotic orders:

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-An order dated 12/18/24 for Doxycycline (antibiotic) 100 milligram (mg) oral tablet, give 100 mg by mouth every 12 hours for pneumonia for 14 doses.

-An order dated 12/19/24 for Amoxicillin (antibiotic) extended release (ER) oral tablet 1,000-62.5 mg tablet, give 2 grams by mouth two times a day for pneumonia for 7 days.

A progress note by the PA dated 12/19/24 indicated Resident #70 had been seen for follow up of his chest x-ray and cough. The note included a diagnosis of pneumonia, that he was high risk for aspiration pneumonia, and a plan for antibiotic treatment. The note read: "high risk for aspiration pneumonia given swallowing dysfunction and also at risk for healthcare associated pneumonia given recent prolonged hospitalization and intubation. Currently on doxycycline 100 mg by mouth twice daily for 7 days. Given patient risk factors and significant comorbidities we will add additional coverage with Augmentin 2 grams by mouth two times daily in conjunction with his doxycycline for 7 days."

The 12/17/24 regular diet, mechanical soft texture, nectar thick liquids order was discontinued on 12/19/24 by Unit Manager (UM) #1.

A new diet order dated 12/19/24 read, regular diet, puree texture, nectar thick liquids.

An interview was conducted on 1/24/25 at 1:01 PM with UM #1. She recalled downgrading Resident #70's diet to from mechanical soft texture to pureed texture because he had trouble with the mechanical soft diet. She said she had

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not completed a therapy referral communication form. UM #1 explained the order from 12/17/14 that read, speech therapy may evaluate as indicated was part of the facility's standard orders entered for all new admissions.
A follow up interview was conducted on 2/7/25 at 1:03 PM with UM #1. UM #1 reported a Nurse or NA had told her Resident #70 was not doing well on the mechanical soft diet and was coughing when eating it. She did not remember who had reported it to her. She explained she had not observed Resident #70 eating or drinking. UM #1 recalled Resident #70 had an increased cough on 12/18/24 and a chest x-ray was performed that had shown pneumonia. UM #1 explained she had downgraded Resident #70's diet on 12/19/24 because it had been reported to her, he had coughing when eating the mechanical soft diet, and she had thought his pneumonia might possibly be related to aspiration. She said she had not completed a therapy referral communication form because all orders, including diet changes were discussed during the morning meeting that was attended by the Director of Rehab, who was also the ST. UM #1 explained she attended the morning meetings and thought she recalled Resident #70's diet downgrade from 12/19/24 being discussed in the morning meeting. UM #1 stated she had assumed the ST would look at him, but did not remember the ST saying specifically she would. UM #1 stated she thought she probably should have done a therapy communication form and that it would have helped cover that she had told the ST about Resident #70's diet downgrade. She reported she had trusted the ST would follow up but did not ask her specifically. UM #1 reported she did not follow up with the ST to see if she had seen Resident #70.

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The admission Minimum Data Set (MDS) dated 12/23/24 revealed Resident #70 was cognitively intact. The MDS documented he had no behavior or rejection of care. The MDS indicated Resident #70 required substantial/ maximal assistance from staff with eating. He was coded on the MDS as having a mechanically altered diet. He was not coded on the MDS for a swallowing disorder or receiving speech therapy.

A physician's order was dated 12/30/24 for a chest x-ray for pneumonia follow up. The start date of the order was 1/3/25. The chest x-ray report dated 1/3/25 read: no acute process in the chest.

A nursing note dated 1/7/25 by Nurse #6 indicated Resident #70 was sent to the emergency department for evaluation due to an aspiration/choking incident.

A situation background assessment recommendation (SBAR) note dated 1/7/25 by Nurse #6 revealed Resident #70's had increased confusion, swallowing difficulty, shortness of breath, abnormal lung sounds (rales, rhonchi, wheezing), nausea/ vomiting, and abnormal pulse. The note stated Resident #70 "appears to have aspirated on apple juice. He vomited up some of the fluid and is now in respiratory distress." The note indicated the provider was notified with recommendations to send him to the emergency department. Oxygen was listed under intervention orders. The SBAR note indicated Resident #70's heart rate was 130, respiration rate was 25, and his oxygen saturation level was 78% with oxygen in place via nasal cannula.

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A telephone interview was conducted on 1/22/25 at 6:38 PM with Nurse #6. She remembered being Resident #70's assigned nurse on 1/7/25 and recalled the choking and aspiration incident. Nurse #6 recalled after dinner an NA alerted her Resident #70 as not doing well. She did not remember the name of the NA. Nurse #6 explained she went to Resident #70's room to assess him. She stated he had thrown up after dinner. She said his dinner meal tray had already been removed from his room. She recalled Resident #70 had a cup of thickened apple juice beside him on his bedside table. Nurse #6 stated she had not seen him drink the apple juice, but said what he had thrown up was the same color as the apple juice. Nurse #6 indicated she had assumed the apple juice had been what Resident #6 had drunk and that he had aspirated on the apple juice or the vomit.

A follow-up telephone interview was conducted with Nurse #6 on 2/7/25 at 11:37 PM. Nurse #6 recalled when she went to Resident #70's room to assess him he had not been doing well. She stated he was having difficulty breathing and was short of breath. She explained she checked his oxygen saturation level, and it was in the 70's. She recalled Resident #70 had already been wearing oxygen and she had turned the oxygen flow rate up, but she did not remember what she had turned it up to. Nurse #6 stated she had not seen his meal tray and that she did not remember what had been served for dinner that night. She stated Resident #70 was able to talk to her. She explained she could see inside his mouth when he was talking and there had not been anything in his mouth. Nurse #6 stated Resident #70 had not mentioned what he had been eating. She recalled his vomit had been yellowish in color with very

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small white pieces mixed in it.

An interview was conducted with Nurse Aide (NA) #5 on 2/7/25 at 12:03 PM. NA #5 recalled the chocking and aspiration incident from 1/7/25 with Resident #70. She reported she had been assisting him in his room with his dinner meal at the time of the incident. She recalled the only thing he had wanted to eat had been the puree fruit from his meal tray. She stated he did not have any coughing or issues when he ate the puree fruit. She did not remember what else had been served for dinner or was on his meal tray, but did recall he had puree food on his meal tray. NA #5 said she remembered Resident #70 had wanted something to drink and she gave him thickened apple juice. She reported that the apple juice had been nectar thick. NA #5 stated when she gave Resident #70 the thickened apple juice and he drank it he choked and started coughing. She reported he had been positioned sitting upright in bed. She said the first time she gave him the apple juice to drink he was able to cough and clear it. NA #5 reported he had wanted more juice and when she gave him the apple juice to drink the second time he started coughing and choking more, turned red in the face, and was unable to clear it. She remembered Resident #70 was able to talk and had said "I'm choking, I'm choking". NA #5 reported Resident #70 started to vomit, and she gave him a basin. She reported she stuck her head out Resident #70's door and asked NA #2 to get Nurse #6. She recalled Nurse #6 came to assess Resident #70 and sent him to the hospital. She recalled the vomit had been yellow in color and looked like the apple juice he had been drinking. She remembered there had not been food in the vomit. NA #5 recalled Resident #70 wore oxygen, and he had his

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oxygen on. NA #5 stated she had assisted Resident #70 with his meals prior to the incident. She reported he did not have problems with coughing or choking when he ate the puree food but said when he would drink the nectar thick liquids "it would go down wrong sometimes" and he would start coughing. She reported the coughing he had prior when he drank the thickened liquids was not as bad as during the choking incident and he was able to clear it. She reported the coughing happened more when he would drink the thickened liquids fast. NA #5 stated she had reported Resident #70's coughing when drinking the nectar thick liquids to a Nurse and told them she thought he may need thicker fluids, but she did not remember who she had reported it to or when she had reported it.

A hospital history and physical (H&P) note dated 1/8/25 indicated Resident #70 had presented to the emergency department of the local hospital and a chest scan had shown significant food bolus with severe dilation of esophagus. The note said lung imaging was also concerning for underlying aspiration. The note indicated his oxygen saturation upon arrival was 74% on 3 liters of oxygen via nasal cannula (Normal oxygen saturation is 95% or greater). The H&P note reported Resident #70 was subsequently started on BiPAP (a type of non-invasive ventilation using a machine that helps people breath by delivering pressurized air into the airways). It indicated his oxygen levels improved with BiPAP therapy. His white blood cell count was found to be elevated, and he was started on antibiotics. The H&P indicated Resident #70 had been transferred to the current hospital for further evaluation of the food bolus with gastroenterology.

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A hospital discharge summary dated 1/13/25 revealed Resident #70 had been admitted to the hospital on 1/8/25 and was discharged on 1/13/25. His discharge diagnoses included: esophageal dysphagia, aspiration pneumonia, and acute hypoxic respiratory failure secondary to aspiration pneumonia. The discharge summary indicated on 1/8/25 Resident #70 had a esophagogastroduodenoscopy (EGD) (a medical procedure that examines the upper gastrointestinal tract). It said, "no bolus seen (may have passed) but abnormal esophagus", "biopsies done showing inflammatory cells." The discharge summary said Resident #70 was discharged on a puree diet with honey thick liquids and would get speech therapy at rehab.

He was re-admitted to the facility on 1/13/25 following hospitalization.

There was not an order written for speech therapy by the facility from the 1/13/25 hospital discharge summary.

A review of the physician orders following the hospital readmission of 1/13/25 did not reveal any orders for hospice services. There was an order entered on 1/21/25 that was pending confirmation and read: "speech therapy to eval and treat as indicated."

A continuous observation was completed on 1/21/25 from 1:08 PM to 1:14 PM of NA #1 assisting Resident #70 in his room with his lunch meal. At 1:08 PM NA #1 went to a red hydration cooler sitting on top of Resident #70's dresser, removed a carton of thickened liquid from the cooler, and poured the thickened liquid from the carton into a small plastic cup. NA #1 put a straw

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in the cup and gave it to Resident #70. Resident #70 was observed as he drank the thickened liquid from the cup using the straw. After drinking the liquid Resident #70 was heard coughing. Resident #70's meal ticket was reviewed with NA #1. His meal ticket indicated honey thick liquids were ordered. The carton of thickened liquids from the cooler was reviewed with NA #1, it was the only carton present in the cooler and had an open date of 1/21/25 written on the carton. NA #1 confirmed "nectar thick liquid" was printed on the carton of lemon water. NA #1 was interviewed at 1:10 PM and stated she was unsure about the nectar thickened liquids in the hydration cooler located in Resident #70's room. She explained she had not looked on the carton to check what type of thickened liquid it was, but had assumed it was the correct thickened liquid for Resident #70 since the carton was in his cooler.

An interview was conducted on 1/21/25 at 3:37 PM with the Speech Therapist (ST). The ST said she had not received a speech therapy referral or been asked to evaluate Resident #70 before 1/21/25. The ST explained she had been asked to see Resident #70 on 1/21/25 after an incident at lunch where Resident #70 had been given nectar thick liquids instead of honey thick liquids. The ST reported she attended the morning meetings and new admissions were discussed in the morning meetings. The ST recalled Resident #70 had been admitted to the facility in December under long term care not short-term rehab. The ST said she had been told he was going to receive hospice at the facility during the morning meeting when he was admitted in December. The ST further explained, therapy did not evaluate or see hospice patients unless specifically asked to do so and therapy was approved by hospice. She

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recalled no one had communicated to her that Resident #70 had decided he did not want hospice and was not admitted to hospice. The ST reported all short stay residents were evaluated by all therapy disciplines, including speech therapy. She stated long-term care admission residents were not automatically evaluated on admission unless a therapy referral was submitted using the therapy communication form. She stated she had not received a therapy communication form or therapy referral for Resident #70 since he had been admitted on 12/17/24. The ST explained the order entered on 12/17/24 that read, speech therapy may evaluate as indicated was not an order for him to be evaluated by speech therapy. She explained it was part of the facility's standard admission orders that was entered for all residents on admission and allowed speech therapy to evaluate them if needed. The ST stated she had not been aware he had issues with aspiration during his December 2024 hospitalization, or that he had been treated for pneumonia in December after being admitted to the facility. The ST reported she had not been aware Resident #70's diet had been downgraded on 12/19/24 from mechanical soft to puree. The ST further stated she had not been aware Resident #70 had been hospitalized in January for aspiration pneumonia, had been changed from nectar thick liquids to honey thick liquids during his January hospitalization, or that his January hospital discharge summary indicated he needed speech therapy services. She stated it was possible Resident #70 could have needed honey thick liquids in December, but she did not know for sure because she did not see him. The ST stated she had completed a bedside swallow study today. She reported she trialed nectar thick

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liquids during the bedside swallow study and Resident #70 had shown signs of aspiration with nectar thick liquids, which were coughing. The ST stated Resident #70 needed honey thick liquids. The ST reported Resident #70 needed an instrumental swallow study, which was a fiberoptic endoscopic evaluation of swallowing (FEES) (a procedure that examines how well someone swallows) to further assess his swallowing.

An interview was conducted on 1/23/25 at 9:38 AM with the PA. The PA reported Resident #70 had aspiration that resulted in respiratory failure during his hospital stay in December before being admitted to the facility. The PA further explained, Resident #70 had been treated for pneumonia at the facility with antibiotic therapy starting on 12/18/24, she said his pneumonia was aspiration pneumonia. She said Resident #70 had a worsening cough and she ordered a chest x-ray because he had new symptoms, to check if there was anything else acute going on in the chest that could have caused an increased cough. She reported the chest x-ray had showed pneumonia. The PA explained it could take a while for pneumonia to clear off a chest x-ray. She stated it would be hard to differentiate if a pneumonia was new or old on a chest x-ray, but said regardless if someone had new/ worsening symptoms you would treat it the same with antibiotics. She explained if someone aspirated it would take a few days before the pneumonia would show up on a chest x-ray, she said it would not show up immediately. She reported it would have been too soon for aspiration pneumonia to show up on the 12/18/24 chest x-ray if Resident #70 had aspirated at the facility after being admitted on 12/17/24, she said it would not show up that

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quick. The PA stated Resident #70's diet consistency had been downgraded from mechanical soft to puree on 12/19/24. She recalled that no one had consulted with her about Resident #70's diet. The PA explained she had ordered a follow up chest x-ray that had been completed on 1/3/25, to ensure Resident #70's pneumonia had been resolved. She reported the chest x-ray from 1/3/25 had been negative. She stated Resident #70 had a choking and aspiration episode at the facility on 1/7/25 and was sent to the hospital for evaluation. The PA explained Resident #70 had been admitted to the hospital with aspiration pneumonia and had returned to the facility on 1/13/25. She further explained, prior to his hospitalization Resident #70 had nectar thick liquids ordered but he had been changed to honey thick liquids during his hospitalization. The PA had thought Resident #70 had been receiving speech therapy services at the facility. She said the discharge summary from Resident #70's January hospitalization clearly stated, he was supposed to receive speech therapy, and she was not aware that it was not taking place. The PA said Resident #70 should have been evaluated by speech therapy when he was originally admitted to the facility in December. She reported she expected for speech therapy to evaluate a resident typically within 2 days of admission or receiving a referral.

An interview was conducted with the Admissions Coordinator on 1/24/25 at 10:45 AM. She reported hospice services had been mentioned in the hospital paperwork for Resident #70 in December. She said Resident #70's spouse had been going back and forth at the hospital between doing therapy or hospice. She recalled Resident #70's spouse had called and spoken to

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her before he was admitted to the facility and said they wanted intensive therapy and did not want hospice. The Admissions coordinator remembered she had discussed it during the morning meeting about Resident #70 wanting therapy and not hospice.

A follow up interview with the ST was conducted on 1/24/25 at 11:00 AM. The ST reported she was present at the facility and would have attended the morning meetings on 12/17/24, 12/18/24 and 1/13/25. She reported that if she was unable to attend the morning meeting, she had someone from therapy attend the meeting in her place.

An interview was conducted with the Director of Nursing (DON) on 1/24/25 at 11:53 AM. The DON recalled hospice had been discussed with Resident #70 and his spouse the day after he was admitted on 12/18/24 and that they had not wanted hospice. The DON reported Resident #70 should have been evaluated by all therapy disciplines when he said he did not want hospice because he was a new admission. The DON stated she was not aware speech therapy had not evaluated Resident #70 and had not known he was not hospice. She reported the rehab director, who was also the ST attended the morning meetings. The DON recalled Resident #70 not wanting hospice and needing to be evaluated by therapy being discussed in the morning meeting. She reported on admission Resident #70's payor source had not been hospice so therapy could have evaluated him. The DON said in the morning meeting all residents who were admitted the day prior were discussed. The DON stated she could not say why therapy did not know they needed to evaluate him or that he was not

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hospice. The DON said a new admission resident that had a diet change should have been a trigger for speech therapy to evaluate them. She explained she had assumed speech therapy had evaluated Resident #70 but had not looked to make sure. The DON stated she could not say where the ball was dropped with Resident #70 not being evaluated by therapy.

An interview was conducted with the Administrator on 1/24/25 at 3:10 PM. The Administrator reported the facility went over admissions in their morning meeting and the rehab director attended the morning meetings. The Administrator explained the electronic documentation system used by therapy was different than the electronic documentation system used by the facility. She further explained that the facility could not access therapy's electronic system to see the notes or to see if someone had been evaluated by therapy. The Administrator said when Resident #70's diet had been downgraded from mechanical soft to puree on 12/19/24 it should have triggered an evaluation by speech therapy at that time.

An interview was conducted with the Medical Director on 1/24/25 at 4:09 PM. The Medical Director said residents who received a modified diet, thickened liquids, or had their diet downgraded should be evaluated by speech therapy. The Medical Director stated if Resident #70's diet had been downgraded then speech therapy should have seen him. The Medical Director reported it could take a while for pneumonia to clear off a chest x-ray. She explained, if someone aspirated, they might have symptoms, but it may take a few days for it to show up on a chest x-ray. She said Resident #70

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was admitted on 12/17/24 and the chest x-ray from 12/18/24 would probably have been too soon for aspiration pneumonia to show up on the chest x-ray if he had aspirated at the facility. The Medical Director said it would be hard to tell if Resident #70's pneumonia was new or old on his 12/18/24 chest x-ray, but clinically he was worse and that was why he was treated. She explained that you could not tell 100% if pneumonia was new or old on a chest x-ray unless it was in a different location or there was a negative chest x-ray prior to the one showing the pneumonia. The Medical Director said Resident #70 was at continued ongoing risk for aspiration. She could not say if having speech therapy involved would have made a difference in his aspiration risk or prevented his hospitalization in January.

A follow up interview was conducted with the PA on 2/7/25 at 2:15 PM. The PA explained that aspiration pneumonia occurred more prominently on the right side of the lungs because the right bronchus (large airway that carries air from the windpipe to the lungs) was shorter. She said aspiration pneumonia typically showed up on a chest x-ray as a right sided pneumonia. The PA further explained, she thought Resident #70's pneumonia from 12/18/24 had been aspiration pneumonia because of his background and all of his risk factors combined with his chest x-ray that had shown right side pneumonia. She said Resident #70's risk factors included his history of aspiration and dysphagia. The PA indicated she looked at the entire clinical picture and that was why she was more inclined to think aspiration was involved. She said Resident #70 had a modified diet and speech therapy was important to see if the modified diet he was on was the appropriate diet for him. The PA said puree food could

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potentially cause a food bolus that could get stuck in the esophagus but was unlikely to do so. She explained the imaging from the scan done during Resident #70's 1/8/25 hospitalization had indicated there was a concern something was seen in his esophagus, but the EGD was to identify what it was. She said the EGD was what was definitive and when the EGD had been performed a food bolus had not been seen. The PA said there was no way to know for sure if a food bolus had been present or not, but that it had not been seen on the EGD.

A follow up interview was conducted with the DON on 2/7/25 at 3:00 PM. The DON said Nurse #4 had called the hospital when Resident #70 was admitted in December and asked what his diet was supposed to be and had been told his diet was mechanical soft with nectar thick liquids. She reported she did not know who Nurse #4 had spoken to at the hospital. The DON thought anyone who received a modified diet should be evaluated by speech therapy to determine if the diet was appropriate and safe. The DON did not specifically remember Resident #70's downgraded diet from 12/19/24 being discussed during the morning meeting on 12/20/24, but the DON said she printed all the orders entered into the electronic computer system the prior day and reviewed them all during the morning meeting.

The facility's Administrator was informed of the immediate jeopardy on 2/7/25 at 4:57 PM.

The facility submitted the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance

On 12/17/24 Resident #70 was admitted to the facility from hospital with diagnosis of cholecystitis, and a diet order of mechanical soft and nectar thick liquids. Upon admission from the hospital, all documentation related to admission stated that Resident #70 would be receiving hospice services. With the presumed knowledge of this resident being under hospice services, speech therapy did not evaluate the resident. After admission to the facility Resident #70 and his wife made the decision to not elect hospice services. On 12/19/24 Resident #70 had a diet change from mechanical soft with nectar thick liquids to puree with nectar thick liquids. At the time of diet change speech therapy did not evaluate Resident #70. Meaning that resident #70 did not receive early interventions and services to help him achieve his highest level of well-being.

On 1/7/25, Nurse Aide reported to licensed nurse that Resident #70 was vomiting and coughing. Resident #70 was noted by this licensed nurse to be in bed with nausea and vomiting. After Resident #70 vomited, he was experiencing coughing and shortness of breath. Vital signs were assessed by the licensed nurse. Blood pressure was 124/66, respirations were 25, oxygen saturation was 78, and pulse was 130, and temperature was 98. The on-call provider was notified by the license nurse, and orders were received to send Resident #70 to the emergency department for evaluation and treatment and to apply oxygen as needed. Oxygen was applied by a licensed nurse and an attempt was made to notify the responsible party at this time. Upon leaving the hospital, Resident #70 had orders for nectar thick liquids. Resident

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#70 was admitted to the hospital with a diagnosis of esophageal dysphagia and acute hypoxic respiratory failure secondary to aspiration pneumonia. Resident #70 returned to the facility after hospitalization on 1/13/25 with oral antibiotic treatment for pneumonia and new orders for honey thick liquids. Speech therapy did not evaluate Resident #70 at this time. Because there was no speech intervention, the facility did not provide speech therapy expertise and services to Resident #70 allowing him to attain/maintain his highest practicable level of function and well-being due to potential negative outcomes related to swallowing deficits.

On 1/21/25, when Resident #70 had a coughing episode after consuming nectar thickened liquids, concerns for swallowing difficulties were communicated to the Speech Therapist by a licensed nurse. On 1/21/25, Resident #70 received a speech therapy evaluation with recommendations to continue honey thick liquids until a fiberoptic endoscopic evaluation of swallowing (FEES) examination could be completed.

On 1/27/25, a FEES study was completed for Resident #70. No changes were made to his liquid consistency status as a result of the study.

On 2/4/25, an audit was completed by the Rehab Program Manager/Speech Language Pathologist of all new admissions from 1/13/25 to 2/3/25 to ensure each new admission with orders for a modified diet were screened by Speech Therapy. Any residents identified as having a modified diet and not having a Speech Therapy screening resulted in a speech referral for the resident to be screened (if resident is still in facility).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 46	F 825		

All new admission residents who are on a modified diet are at risk of being affected.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 2/4/25 during an ad hoc Quality Assurance Process Improvement (QAPI) meeting, a root cause analysis was completed. It was identified through this analysis that the root cause for this failure was a need for specific notification to Speech Therapy services as part of the admission process. Because modified diets were not part of the current review for new admissions in the morning clinical meeting, a new process was indicated. The new process will include when the Director of Nursing (DON) or Unit Managers receive a new admission, in addition to providing diet requisitions to the dietary department, they must now submit copies of the diet requisition to both DON and Speech Therapy for any resident with a modified diet. Diet requisitions for modified diets will be reviewed 5 x weekly with the DON, Unit Managers, and the Rehab Director in the clinical morning meeting. During this meeting, it will be validated that each diet requisition has been received by Speech Therapy, and the Rehab Director will convey the date for speech therapy screening. Included in this meeting were the Administrator, DON, Unit Managers, and Rehab Director.

On 2/4/25, the Administrator educated the DON and Unit Managers on the new process that when filling out the diet requisition on new admissions, a copy will be submitted to the DON and Speech

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	345270	A. BUILDING _____ B. WING _____	C 02/11/2025

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Therapy for any resident with a modified diet. Diet requisitions will be reviewed 5 x weekly with the DON, Unit Managers, and the Rehab Director in the clinical morning meeting. During this meeting, it will be validated that each diet requisition has been received by Speech Therapy, and the Rehab Director will convey the date for screening.

On 2/4/25, the Rehab Program Manager and all evaluating speech therapists were educated by the Regional Director of Rehabilitation Services on the new process for receiving diet requisitions on new admits and that this requisition alerts them that a modified diet is present. Education also included the requirement to screen all new admissions who are receiving a modified diet to determine if there is a need for speech therapy evaluation. For any admission where is identified through the screening process that they could benefit from speech therapy services would be promptly evaluated and treated to address rehabilitation needs.

Any new or agency speech language pathologists, will be educated prior to working their first shift. Any new or agency Director of Nursing or Unit Manager, will be educated prior to working their first shift.

On 2/11/25 the facility's credible allegation of immediate jeopardy removal was validated by the following:

The immediate jeopardy removal plan was validated on 2/11/25 as evidenced by facility documentation and staff interviews. Review of education logs revealed the DON, UM, Rehab Manager, and ST had received education on

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F 825	Continued From page 48 2/4/25 on the process implemented by the facility to ensure communication with therapy and that Residents who were admitted/ readmitted with a modified diet were screened by speech therapy. Interviews were conducted with the DON, UM, Rehab Manager, and ST, they verbalized they had received education and were able to verbalize the new process for ensuring Residents admitted/ readmitted with a modified diet were screened by speech therapy. Review of the facility's audit of new admit/readmitted residents revealed residents who received a modified diet had been screened by speech therapy for the need of services. The IJ removal date of 2/5/25 was validated.	F 825		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain and repair 1 of 1 leaking steam cooker for 1 of 1 steam cooker observed. Findings included On 1/23/25 at 12:11 PM an observation of the kitchen's steam cooker found hot water dripping from the bottom of the steam cooker door while in use. The steam cooker was observed spewing steam out from each side of the closed steam cooker door when it was being used to heat food. The Dietary Manager (DM) stated the steamer	F 908	On 1/24/25, when made aware of repair needs for the steamer, the Maintenance Director contacted the repair company and made arrangements for repair to be done. Repair was completed on 1/30/25. On 1/30/25, repair vendor was in facility to evaluate the steamer from dietary. It was determined that castors and the pressure valve spring needed to be replaced. The castors were replaced on 1/30/25 and additional parts were ordered for the pressure spring valve on 1/30/25. Repair has been scheduled for 2/3/25.	2/22/25

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F 908	Continued From page 49 had been leaking water and steam since he had become the DM in August 2024. The DM said he had not informed the Maintenance Director the steamer needed repair since he became the DM, and he thought the door seal needed to be replaced to keep the steam and water from leaking out when in use. The DM stated when something needed to be repaired in the kitchen, he verbally communicated it to the Maintenance Director who would complete the repairs or outsource to complete the repairs. The Maintenance Director was interviewed on 1/24/25 at 11:26 AM. He stated the steam cooker seal had been repaired once before by the appliance service company in January 2024 who repaired the kitchen equipment when needed. The Maintenance Director stated he had not been aware of or notified that the steamer needed to be repaired. On 1/24/25 at 11:36 AM a second interview conducted in conjunction with an observation with the Maintenance Director found the steam cooker leaking steam. The Maintenance Director inspected the door seal, revealing it was not fully attached and stated the door seal needed to be replaced. The Maintenance Director stated he would call the appliance service company to repair the steamer. The Administrator was interviewed on 1/24/25 at 3:16 PM. She stated the Maintenance Director should have been notified the steamer needed to be repaired.	F 908	On 2/5/25, all dietary staff were educated by the Administrator to communicate concerns for equipment issues with the Maintenance Director immediately upon finding the issue by placing the concerns or repairs in the Maintenance Repair Logbook located at the main nurse station. The Dietary Manager will audit all kitchen equipment 1 time per week for 8 weeks to ensure that all equipment is in proper working order and that work orders have been placed with Maintenance for any repairs needed. The Administrator will review these audits in the monthly Quality Assurance Process Improvement (QAPI) meeting for 2 months or until substantial compliance is achieved. The audits will continue at the discretion of the QAPI committee. The Administrator is responsible for this plan of correction. Date of compliance is 2/22/25	