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F 000	INITIAL COMMENTS A complaint survey was conducted from 06/04/25 through 06/05/25. Additional information was obtained offsite 06/06/2025 through 06/11/2025. Therefore, the exit date was changed to 06/11/2025. The following intake was investigated NC00231046 and resulted in immediate jeopardy. Event ID#YM4P11. 1 of 1 complaint allegation resulted in deficiency. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/19/2025 and was removed on 04/26/2025. A partial extended survey was conducted.	F 000		
F 689 SS=J	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 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Medical Director and Nurse Practitioner interviews, the facility failed to ensure the necessary supervision was provided to a severely	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/17/2025

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cognitively impaired resident to prevent an avoidable accident. Resident #1 was prescribed a puree diet and had a history of choking. On 3/19/25 Resident #1, who was known to have poor safety awareness, had a choking episode in the main lobby. Staff performed a back blow that produced a piece of bread from his mouth. He was assessed by the Nurse Practitioner (NP) and determined to return to his baseline. Following the 3/19/25 choking incident, all facility staff were educated on the importance of providing residents with diets per the physician order. On 4/22/25, while dinner trays were being picked up by the staff, Resident #1 took a hot dog off an unattended meal cart, put part of it in his mouth, and began to choke. Staff provided abdominal thrusts and were unable to dispel the food. Cardiopulmonary Resuscitation (CPR) was started when the resident became unresponsive and was pulseless. Emergency Medical Services (EMS) was called and were unable to revive Resident #1 who was pronounced deceased at 8:01 PM. The deficient practice affected 1 of 2 residents reviewed for supervision to prevent accidents (Resident #1).

The findings included:

A hospital discharge summary dated 1/24/25 ordered a level 1 dysphagia diet (all food are pureed smooth to a pudding consistency to ensure easy swallowing) and honey thick liquid with close supervision and assistance with feeding.

Resident #1 was admitted to the facility on 1/24/2025 with diagnoses of dysphagia (difficulty swallowing), cerebrovascular accident (stroke), weakness to both legs, and aphasia (difficulty or

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inability to express with language).

Review of the facility physician orders for 1/25/2025 revealed a diet of honey thickened fluids and pureed texture.

Resident #1's admission Minimum Data Set (MDS) assessment dated 1/31/2025 revealed he was severely cognitively impaired with no refusal of care. He had a therapeutic diet due to difficulty with swallowing and was independent with eating after setting up meal tray. He used a wheelchair for mobility and required supervision to stand.

A care plan was initiated on 2/20/2025. It focused on Resident #1's swallowing problem related to coughing or choking during meals. The goal was for no aspiration (when something you swallow "goes down the wrong way" and enters your airway [trachea or windpipe] or lungs) injury, maintain weight and nutrition and no choking episodes with eating. Interventions included all staff to be informed of Resident #1's special dietary and safety needs. There were no interventions related to supervision during meals.

An interview conducted on 6/5/25 at 5:22 PM with the MDS Coordinator revealed Resident #1's safety needs in the care plan were about supervising him and preventing him from accessing food he should not eat. He propelled in his wheelchair and looked for food, he exhibited behaviors of hunger by gestures. Information was on the electronic Kardex (care guide) for the nursing staff. The MDS Coordinator explained that the Kardex was deleted after the resident was discharged so the information on the Kardex was no longer available.

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The discharge speech therapy note revealed dated 3/14/2025 revealed Resident #1 refused treatment. Discharge recommendations from speech therapy was a nectar thick liquid with swallowing strategies implemented. Mechanical soft/ground textures (with strategies implemented). Strategies were alternate liquids and solids. Small bites, tuck the chin during swallowing. Upright posture thirty (30) minutes after meals. His goal was not met, and he remained on a honey-thick liquids and a pureed diet.

An interview with the Speech Therapist (ST) on 6/4/2025 at 2:04 PM revealed Resident #1 was able to eat a mechanical soft/ground diet if he used strategies. His diet was honey thick liquids and pureed diet and he was not upgraded because of noncompliance with the exercises to strengthen the muscles in his throat. The ST indicated Resident #1 was able to feed himself and propelled himself in a wheelchair. Resident #1 comprehended directions and he understood his diet and not eating foods that were not pureed. The ST stated Resident #1 He was discharged from speech therapy because he refused treatment. She stated she was not aware of his seeking food outside his prescribed diet.

On 6/4/2025 at 6:10 PM the Rehab (Rehabilitation) Manager indicated Resident #1 was able to walk short distances. He refused to do the swallowing exercises during meals and tore up the strategies the speech therapist had given him. The Rehab Manager stated Resident #1 He had awareness and was able to follow cues and instructions. His diet was not advanced, and he remained on his original ordered diet.

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The Activities Assistant was interviewed on 6/5/2025 at 11:56 AM. She revealed she had been sitting in the dining room watching television with Resident #1 on 3/19/2025 and did not recall the time. Resident #1 was taken out by an unidentified nurse aide. The Activities Assistant stated she did not provide Resident #1 with any food on 3/19/25 because she was not allowed to give residents food. The interview further revealed the Activities Assistant had no idea how or when Resident #1 had gotten food on 3/19/25.

Interview on 6/5/25 at 11:40 AM with Unit Manager #2 revealed on 3/19/25 she came off the elevator and entered the lobby and Resident #1 was on the floor and had a "blank look" on his face. She was not familiar with this resident. She did not recall what time it was or who was present except Nurse #50. Resident #1 was on his left side when Nurse #50 reached into his mouth and pulled out bread. Resident #1 was no longer in distress.

An interview with Nurse #50 on 6/5/2025 at 11:12 AM revealed on 3/19/25 he was working on the hall on first floor, and he saw a commotion in the lobby. He walked to the lobby and Resident #1 was lying on the floor. Nurse #50 did not recall which staff were present. He stated Resident #1 looked scared and he did a quick assessment, turned Resident #1 to his left side and did a back blow, and a piece of bread fell out of his mouth. The Nurse Practitioner assessed Resident # 1, then the EMS paramedics did an assessment. Resident #1 was back to his baseline and Nurse #50 helped Resident #1 back to his chair and returned to his hall.

A Nurse Practitioner note dated 3/19/25 with no

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time, revealed Resident #1 had choked on food in the lobby. Food was removed by finger sweep and Resident #1 returned to baseline.

A telephone interview on 6/9/2025 at 3:39 PM revealed the Nurse Practitioner indicated she responded to the choking episode on 3/19/2025. Resident #1's lungs were clear, and he was at his baseline.

A nursing note documented by Unit Manager (UM) #1 dated 3/19/2025 at 11:50 AM revealed Resident #1 had an "episode" where he was sliding out of the wheelchair with "seizure like" symptoms in the main lobby. He was lowered to the floor by a nurse aide and assessed by a nurse (not identified) and observed to have food in his mouth. The food was removed from his mouth, Emergency Medical Services responded. The Nurse Practitioner was in the building and was notified. Resident #1 returned to his baseline

Record review of the report dated 3/19/2025 identified as Incident Description, Nursing Description "Resident pushed by CNA (unidentified Nurse Aide) from dining room to hallway and noted he was sliding from wheelchair. CNA was assisting residents to the floor and noted resident having seizure-like activity." Immediate Action Taken: "Assessment completed resident actively coughing piece of bread noted in his mouth. Resident turned to his side, a slight strike on back and resident spit out a piece of bread. No loss of consciousness, respiratory status remains stable. NP (Nurse Practitioner) notified and evaluated, lungs clear and resident is no (sic) distress. EMS arrived and evaluated with same findings. Resident refused to transfer to the hospital." This document was

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completed by the Director of Nursing (DON).

An interview on 6/5/2025 at 11:05 AM with UM #1 indicated she could not recall which Nurse Aide (NA) wheeled Resident #1 out of the dining room on 3/19/25. UM #1 stated she saw Nurse #50 turn Resident #1 on his side and struck him on the back which produced the piece of bread out of his throat. Resident #1 returned to baseline and the Nurse Practitioner assessed him. Resident #1 refused to go to the hospital. The facility provided education to all staff, to provide the correct diet after the 3/19/25 choking incident.

An interview on 6/5/2025 11:05 AM Unit Manager #1 revealed she saw Resident #1 was returning from activities into the main lobby and he was coughing. An NA (could not remember who) was pushing the wheelchair, and Resident #1 was sliding down. Unit Manager #2 and Nurse #50 observed this, and they put him on the floor and turned him to the left side. Nurse #50 struck Resident #1 on the back and a piece of bread fell out of his mouth. He never lost consciousness, and he fully recovered to his baseline. He was assisted back to his wheelchair. Emergency Medical Services arrived, Nurse Practitioner listened to his lung sounds and she asked him to go to the hospital, and he refused.

An interview on 6/5/2025 at 12:40 PM with the Administrator revealed that activity staff had been educated by the Staff Development Coordinator (SDC) on the importance of providing the correct diet and the Activity Director was given the changes to residents' diets during the morning stand-up meeting after Resident #1's 3/19/25 choking incident.

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A record of training titled, "Resident Diets" conducted on 3/18/25 (sic) was conducted by the SDC. The training enforced the importance of providing residents with special diets as prescribed by the physician or other delegated provider. The provided signature sheet dated 3/19/2025 had the activity department personnel signatures and two nursing assistants. The facility produced further sign off sheets and identified them as training that occurred for all staff for the 3/19/2025 event.

An interview with the Activity Director by phone on 6/5/25 at 12:24 PM revealed the Activity Assistant was not permitted to give food to residents. The activity department had been educated on the diets of residents. The Activity Director stated she was not present when the episode occurred on 3/19/25. The SDC conducted education with the Activity Department on the importance of providing the correct diet. The Activity Director explained she was responsible for knowing each resident's diet order and the Activities Assistant was allowed to distribute food and fluids to residents once the Activity Director determined what was appropriate.

An Incident Description report dated 4/22/2025 revealed Nursing Description "CNA (unidentified nurse aide) noted resident with a hot dog bun in his hand with a bite out of it. Resident actively coughing and a piece of hot dog bun coughed out." Immediate Action Taken: Resident assessed, (staff not identified) actively coughing with strong cough and noted to cough out a piece of hot dog bun. Resident noted to become distressed and unable to produce a strong cough and face became red. Heimlich (abdominal thrusts) initiated and 911 called. Mouth sweeps

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unable to produce the remainder of bun. Resident became weak and placed on floor and Heimlich continued. Resident became unresponsive and breathless and cardiopulmonary resuscitation initiated until EMS arrived." Predisposing factors were impaired safety awareness and impaired memory. Injuries Report Post Incident, "No injuries observed post incident." This was documented by the DON.

The dinner menu on 4/22/2025 included chili dogs.

A telephone interview was conducted on 6/4/2025 at 4:48 PM with NA #1. She stated Resident #1 comprehended what he was told and followed directions. NA #1 stated Resident #1 was supervised because he was impulsive and stood up without warning. She stated on 4/22/2025 she had taken some bread from Resident #1 while she was picking up trays and she told him to go to his room. NA #1 indicated she went into room 114 and was held up. NA #1 recalled she came out of room 114 and observed NA #4 doing abdominal thrusts on Resident #1 while he was seated in his wheelchair. Then NA #4 got on the phone with 911 and she (NA #1) took over the abdominal thrusts then NA #5 did the abdominal thrusts. NA #1 said they passed Resident #1 from person to person and Resident #1 was not responding to the thrusts and was put onto the floor. NA #1 explained she did abdominal thrusts while she straddled Resident #1. Nurse #1 had NA #1 stop and checked for his pulse and Nurse #1 had NA #1 start chest compressions. Nurse #1 took over from NA #1 and did the chest compressions and then she (NA #1) took over chest compressions until EMS arrived. NA #1 stated she had never observed

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Resident #1 take food from a meal cart.

During a follow up interview on 6/5/2025 at 2:20 PM NA #1 stated she never saw a hot dog in Resident #1's hand, only bread.

An interview was conducted with NA #2 on 6/4/2025 at 5:13 PM. NA #2 stated on 4/22/25, she was assigned to monitor another resident on a one-to-one basis and was seated in the hall outside of room 106. NA #2 stated Resident #1 was monitored because he was impulsive and stood up from his wheelchair. He usually stayed by his door or in the lobby and he liked to watch TV. On 4/22/25 dinner was late, and Resident #1 was pointing at the kitchen indicating he was hungry. NA #2 indicated Resident #1 received and ate his meal on 4/22/25 and did not ask for other food. NA #2 recalled she and NA #3 were picking up meal trays and the meal cart was close to Resident #1's room (which was behind her). NA #2 observed Resident #1 propelling himself to room 106 and looked like he was choking. His eyes were wide, and his face was purple. Resident #1 handed her a piece of hot dog then he coughed up a piece of hot dog and he was choking. NA #2 indicated she yelled up to the nurses' station for help. NA #4 came down the hall from the nurse's station and NA #4 did abdominal thrusts. NA #1 came out of room 114 to the hallway outside of room 106, stood up Resident #1, and took over the abdominal thrusts while NA #4 called 911 on her cell phone. Then NA# 5 took over abdominal thrusts. The Director of Nursing checked his mouth for food and stated she didn't see anything else.

During an interview on 6/6/2025 at 10:24 AM NA #3 indicated that Resident #1 was supervised

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during his meals. In the past he had grabbed his roommate's food. She indicated that all staff were aware to watch Resident #1 when the meal carts were on the floor because he got food off the cart. On 4/22/2025 Resident #1 had his dinner in the dining room. NA #3 recalled she and NA #1 had gone into room 114 and when they came out of the room with the meal trays Resident #1 was in the hallway near NA #2 and Resident #1's face was purple. NA #3 and NA #2 yelled to Nurse #1 who was at the nursing station that Resident #1 was choking, and his face was purple. NA #5 tried abdominal thrusts and then NA #4 did abdominal thrusts. NA #5 took over abdominal thrusts and NA #4 called 911. The 911 dispatch was on the phone and NA #4 relayed what they said. NA #3 stated Resident #1 went limp, and the dispatch said to put him on the floor and do abdominal thrusts. NA #3 indicated NA #1 continued to do abdominal thrusts. NA #3 said she sat at Resident #1's head. The DON got the oxygen and put a nasal cannula on him. Then EMS arrived and took over.

A telephone interview was conducted on 6/5/2025 at 3:47 PM. NA #4 indicated that she had clocked in at 6:50 PM on 4/22/2025 and was at the nurse's station. NA #2 yelled something was wrong with Resident #1. She stated that NA #1 and NA #3 said they had told Resident #1 to get out of the meal cart on 4/22/25. NA #4 stated we all knew Resident #1 took food off meal carts. NA #4 stated that she called 911 on her cell phone and NA #7 had also called 911 from the nursing station.

Record review of the timecard punches on 4/22/25 confirmed NA # 4 had clocked in for work at 6:53 PM.

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An interview with NA #5 was conducted on 6/4/2025 at 4:00 PM. NA #5 revealed while the trays were being picked up from dinner on 4/22/25, Resident #1 was standing, and NA #1 did abdominal thrusts. NA #5 stated she tried abdominal thrusts and Resident #1 became unresponsive and was laid down on the floor. Nurse #1 started cardiac pulmonary resuscitation, and NA #4 called 911. NA #5 indicated she had never observed Resident #1 taking food from another resident and she did not know how Resident #1 got food on 4/22/25.

A telephone interview with Nurse #1 was conducted on 6/4/2025 at 4:28 PM. Nurse #1 stated she was at the nurses' station when NA #2 told her that something was wrong with Resident #1 on 4/22/25. Nurse #1 indicated she went down the hallway to Resident #1 and he pointed to his chest, was not able to speak, and was choking. NA #1 was administering abdominal thrusts. Then NA #5 took over and administered the abdominal thrusts. Resident #1 went limp and was lowered to the floor and NA #1 continued to administer abdominal thrusts. Nurse #1 stated she had NA #1 stop the abdominal thrusts and the pulse was checked. She felt no pulse and they switched to doing chest compressions until Emergency Medical Services took over. Nurse #1 indicated she had not ever seen Resident #1 take food off the meal cart or a resident's tray.

Record review of the late entry nursing note dated 4/22/25 authored by the Director of Nursing (DON) indicated at about 6:40 PM staff were observed in the hallway assisting the resident (Resident #1) who was in a standing position while abdominal thrusts were being performed.

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The staff informed the DON that while the staff were going room to room collecting trays Resident #1 had reached into the closed food cart and had taken a hot dog and bit a piece of it. A nurse aide coming out of a room realized he needed help and asked him to cough and spit out the food, but a piece of food was still lodged in his throat. Heimlich was immediately begun and 911 was called. While waiting, abdominal thrusts continued until the resident became unresponsive and chest compressions were started. EMS arrived and took over; the resident regained pulse and respirations on two separate occasions but vital signs were unable to be sustained. Resident #1 was pronounced dead at 8:08 PM.

An interview on 6/5/2025 at 9:02 AM revealed the Director of Nursing indicated that initially Resident #1 stayed in his room and after he had completed his occupational and physical therapy, he propelled his wheelchair. She had never observed him at the meal cart, and he had never asked her for food. The nursing staff have a Kardex (care guide) that included the type of diet for each resident. They were accessible by computer and a paper copy was at the nursing station. The Kardex was updated as the care plan was updated or after a change of the resident. The DON stated she was in the office with the SDC on 4/22/2025 (unable to recall time) and heard commotion on the hall. She observed NA #1 doing abdominal thrusts and Nurse Aide #4 was on the phone with 911. Nurse #1 did the mouth sweep and got a small piece of food. The DON recalled 911 had them put Resident #1 on the floor and continue abdominal thrusts. Nurse #1 started chest compressions and EMS arrived. Training was completed with nursing staff again after the 4/22/25 choking incident and currently

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no food carts were left unattended while meals were passed or trays picked up. Meal carts were brought up to the nursing station and the doors faced the wall until the carts were returned to the kitchen.

On 6/5/2025 at 1:42 PM during a follow up interview, the DON stated on 4/22/25 the doors of the food carts were closed to keep the heat on the food. She stated her investigation, determined he opened the door of the meal cart and took the hot dog, and it was a fluke. He had never tried to open the meal cart doors to her knowledge.

A telephone interview on 6/9/2025 at 3:39PM revealed the Nurse Practitioner indicated Resident #1 was very social. The NP stated the facility was aware of the possibility that he may choke. The facility educated the staff and had put interventions in place after the choking event in March to follow the residents' diets. The NP further stated Resident #1 understood directions and followed direction, but he did not realize the consequences of his actions.

The Emergency Medical Services (EMS) report dated 4/22/2025 revealed a call was received at 7:00 PM for a cardiac arrest from choking. EMS resuscitation services began at 7:08 PM. Initial assessment at 7:10 PM revealed Resident #1 was on his left side with no pulse or respirations. Suctioning at 7:13 PM and removal of foreign body air obstruction revealed no solid obstruction in the airway. Resident #1 had liquidized bread in the airway. Suction removed the material and intubation was successful at 7:16 PM. Resuscitation efforts continued until 8:01 PM when Resident #1 was pronounced deceased.

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The Medical Examiner death certificate dated 4/27/2025 revealed the cause of death was accidental and caused by an occlusion by a bolus (a blockage caused by a ball like mixture of food and saliva) of food.

An interview by telephone on 6/5/2025 at 4:11 PM Medical Director revealed speech therapy assessed Resident #1 and this was the diet that was followed. The Medical Director indicated Resident #1 was able to comprehend and follow direction and it was the facility's responsibility that Resident #1 did not have access to food that caused him to choke. The interview further revealed Resident #1 was compliant with his diet and the Medical Director was not aware of Resident #1 looking for foods he should not eat. The Medical Director stated Resident #1 was at high risk to choke.

The Administrator was notified of immediate jeopardy at 6/5/2025 at 7:13 PM.

The facility provided the corrective action plan with a completion date of 4/26/25.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #1 was admitted on 1/24/25 with diagnoses of, but not limited to, cerebral infarction (stroke), acute cerebral vascular insufficiency, hemiplegia (weakness of one side of the body) and hemiparesis (paralysis of one side of the body), altered mental status, depression, hypertension, congestive heart failure, and cardiomyopathy. The resident had a diagnosis of dysphagia (difficulty swallowing) and had a diet

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order of puree texture and honey thickened liquids consistency. The resident's score on the Brief Interview for Mental status indicated severe cognitive impairment. The resident was able to self-propel in the wheelchair. The resident had aphasia, but the speech therapist was unable to evaluate the degree of aphasia. In addition, the speech therapist notes increased impulsivity.

On 3/19/25 while NA began to push Resident #1 from the dining room into the hallway where Nurse #50 was walking down the hall and noted the resident sliding out of his wheelchair. NA informed Nurse #50 that the resident was having a seizure. NA #1 and Nurse #50 lowered the resident to the floor and turned him on his side. Nurse #50 assessed the resident and noted a piece of bread in his mouth. Nurse #50 called out to Unit Manager #1. When Unit Manager #1 arrived, the resident was lying on the floor on his side and no seizure activity was noted; however, noted Resident #1 was actively coughing. Unit Manager #1 noted Nurse #50 slightly hit the resident on his back and the resident spit out a piece of bread. The resident did not lose consciousness and respiratory status remained intact. The Nurse Practitioner was paged to the lobby to assess the resident. EMS arrived at the facility stating they were called for seizure activity. NP and EMS assessed resident noting lungs remained clear and resident was in no distress. Resident declined to go to the hospital. Resident's responsible party notified. Education was provided by the Director of Nursing and Staff Development Coordinator to the activities department regarding activities involving food to ensure that they provide food textures as ordered. In addition, activities were educated on ensuring that a thorough clean-up is completed

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post a food activity either by themselves or the environmental services department.

On 4/22/25 at approximately 5:00 pm dinner carts were delivered to the first floor, where Resident #1 resided. The food served for dinner that evening was a chili cheese dog on a bun. Resident #1 was in his room sitting on his bed in preparation for eating. Nurse Aide (NA) #1 provided his tray. The tray delivered was a pureed meal with honey-thick liquids per physician's order. At approximately 6:00 pm NAs began to collect the trays of residents who were finished eating. At approximately 6:15 pm NA #1 picked up Resident #1's tray. The resident was noted to have eaten 75-100% of his meal. NA #1 placed the tray on the meal cart and closed the cart door with the latch in place to secure the door in the closed position. This was the only cart on the hall near the resident's room. At approximately 6:40 pm NA #2 noticed Resident #1, who was in his wheelchair, was actively coughing and trying to expel something. NA #3 noted Resident #1 had a hot dog with a bun with a bite out of it in his hand. When Resident #1 saw NA #3 approaching, he immediately dropped the hotdog on the floor. NA #3 went to Resident #1 and stayed with him, while encouraging him to actively cough. The resident did spit out some pieces of bun. Several staff members (NAs) observed Resident #1 coughing and went to the aid of Resident #1. Resident #1 then became distressed unable to produce a strong cough and red faced. NA #4 stood him up and begun the Heimlich maneuver in an attempt to dispel what the resident was choking on. NA #1 took over the Heimlich and NA #4 called 911 from her personal cell phone exact time is unknown. Nurse #1 and #2 arrived to assist Resident #1 and Nurse #2

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attempted to sweep the mouth, to remove what the resident was choking on, without success. Resident #1 became weak; staff placed him on the floor and continued the Heimlich. A small piece of bun/hotdog was expelled. However, Resident #1 continued to be in distress as evidenced by his limp body and facial color change to a blue-gray. Resident #1 then became unresponsive and breathless. A code blue, indicating a resident requiring immediate resuscitation, was yelled and then called over the intercom system. Nurse #1, NA #1, and NA #5 initiated cardiopulmonary resuscitation (CPR) with chest compressions and breaths an ambu bag (a device used to force air into a person's lungs). There was no pulse or respirations noted at this time. Staff continued CPR, chest compressions and breaths for two minutes. They were able to get air into the resident's lungs as evidenced by the rise of the chest during breaths provided with the ambu bag. At 7:08pm Emergency Medical Services (EMS) arrived and relieved the staff by taking over CPR. EMS began attempts to resuscitate with the use of the LUCAS compression system, a device that provides mechanical chest compression to residents in cardiac arrest. EMS attempted suction to remove the obstruction without success. EMS was able to intubate the resident. EMS continued with attempts of resuscitation for approximately 8 cycles of CPR. All efforts of resuscitation ceased at approximately 8:15pm. Resident #1 was announced dead at this time. The cause of death on the death certificate was cardiac arrest.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

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Residents with altered diets, including pureed, mechanically altered, and thickened liquids, have the potential to be affected by the deficient practice. On 4/22/25 the Director of Nursing initiated an audit of resident diets to determine what residents were on altered diets, are ambulatory or can self-propel in a wheelchair, and potential food seekers. One resident was identified as a potential food seeker. This resident was placed on supervision during mealtimes until the meal trays were removed from the unit and during activities with food involvement. The resident has a roommate with a regular textured diet. The roommate does not have snacks stored in her room nor does she have the ability to purchase snacks. The supervision will be provided by the NA assigned to the resident during the presence of food for either the resident or the roommate, in the event there is more than one resident needing supervision for an NA, department heads will be assigned to supervise residents. The NA receives an assignment for supervision from the charge nurse at the beginning of the shift. This supervision was put into place on 4/23/25. Tray cart doors are to remain closed during tray pass and pick up except for when the staff member is taking or putting the tray away. When the tray cart is not in direct contact with a staff member, the tray cart door will be pushed up against the wall. This education was provided to staff by the Staff Development Coordinator and Director of Nursing, which was initiated on 4/22/25. Food availability is from meals, food activities or the vending machines. Snacks are kept in the nourishment rooms behind the nurses' station. Residents would need to have money to access food from the vending machines.

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 4/22/25 the Staff Development Coordinator and the Director of Nursing initiated education with facility staff to include nursing, dietary, environmental services and therapy department staff regarding monitoring of tray carts when they were out on the units to ensure the doors remain closed, cart against the wall, and monitoring residents who received alternate diets/thickened liquids and were ambulatory or were able to self-propel in a wheelchair to ensure they are not attempting to get in the tray cart or showing food seeking behaviors. The education included making sure residents who were on alternate/thickened liquids diet were not consuming inappropriate foods. Snacks are kept in the nourishment room accessible by staff. Staff who do not receive the education by 4/25/25 will not be allowed to work until the education is completed. Newly hired staff will receive the education during orientation from the Staff Development Coordinator. The Director of Nursing will be responsible for ensuring the education is complete for current staff and new hires. If a staff member identifies a resident with a food consistency they do not have ordered, the staff member will go to the resident and encourage them to spit it out while simultaneously calling for assistance. The IDT review diet orders during morning stand up and determines the residents that need monitoring. The Unit Managers deliver any new information to the charge nurse, who assigns the NA that will be responsible for monitoring the resident at risk. The Director of Nursing and Administrator are the

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second check to ensure the monitoring has been put in place.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

On 4/25/25 the facility had an ad hoc Quality Assurance Performance Improvement (QAPI) meeting, including the Interdisciplinary Team consisting of the Administrator, Director of Therapy, Unit Manager First Floor, Unit Manager Second Floor, Staff Development Coordinator, Environmental Services Director, Dietary Manager, MDS nurse, Director of Nursing, Regional Nurse Consultant. The Medical Director was notified via telephone. During the meeting it was determined the Director of Nursing, or the Administrator will conduct audits of residents who receive altered diets and are able to ambulate or self-propel in the wheelchair for monitoring during mealtimes and during food involved activities to look for food seeking behaviors and to ensure that the NA monitors are in place. The Director of Nursing and/or Administrator are monitoring NAs to ensure they are providing direct monitoring to the resident at risk. In addition, they are looking to see if the resident at risk is exhibiting food seeking behaviors. The audits will be conducted four times a week for two weeks, then two times a week for two weeks then weekly for eight weeks. Activities are provided with dietary orders of residents so that they may provide the appropriate consistency during activities that include food. The dietary staff provides alternate consistency to the activities department when altered food consistency is necessary. Activity staff keep an active resident diet order list. The active resident list is updated daily in morning

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F 689	Continued From page 21 stand up and provided to the Activities staff by the Director of Nursing. The Director of Nursing, or Administrator will forward the results of the audit to the Quality Assurance Performance Improvement Committee monthly for 3 months. The Quality Performance Improvement Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Administrator will be responsible for implementing the corrective action plan. Date of Immediate Jeopardy Removal: 4/26/25 Date of alleged compliance: 4/26/25 On 6/9/2025, the corrective action plan was validated by onsite and offsite verification through facility staff interviews and observations. The interviews revealed all nursing staff, department heads and activity staff received training on the need for Resident #1 supervision to prevent choking after 3/19/2025 episode. Staff were observed during two dining opportunities. Staff checked the meal tickets and the meal tray for diet accuracy. Meal carts were not left unattended at any time during passing out or picking up meal trays. The meal carts were observed on the first and second floors. Meal carts were brought to the nurse's station, and the door faced the wall. The meal carts were returned to the kitchen after the trays were retrieved. Audits that the facility conducted on altered diets and residents who seek food were reviewed. The facility's immediate jeopardy removal date of 4/26/2025 was validated.	F 689		

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