STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555738	A. Building B. Wing	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Terrace Health Care	7447 Sepulveda Blvd Van Nuys, CA 91405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39739 Based on interview and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) and Dietary Aid 1 (DA 1) did not act negligently (a situation in which not enough care or attention is provided to someone or something) towards one of five sampled residents (Resident 1), who was prescribed a regular, no salt added, soft and bite-size texture, regular consistency diet (a diet that contains food that is cut into smaller pieces, soft, easy to chew, with lower amounts of salt), and was at risk for aspiration (when something enters your airway or lungs), when: 1. DA 1 prepared a chef ' s salad (a salad of lettuce and other raw [crunchy] vegetables topped with slices of meat, cheese, croutons [bread that is hardened due to being fried or toasted], and hard-boiled eggs) for Resident 1, which contained croutons and raw lettuce, both of which are not allowed based on the resident ' s dietary restrictions. 2. CNA 1 failed to first verify with a licensed nurse, that the prepared chef ' s salad was within Resident 1 dietary restrictions, prior to serving the salad to Resident 1. These deficient practices resulted in Resident 1 choking (to stop breathing because something is blocking your throat) while eating the provided chef ' s salad that did not adhere to his dietary restrictions on [DATE]. Resident 1 required abdominal thrusts (a technique in first aid to dislodge a foreign body in a person's airway by applying sudden upward pressure on the upper abdomen) and cardiopulmonary resuscitation (CPR- an emergency life-saving procedure that is done when someone's breathing, or heartbeat has stopped). Resident 1 was revived (regained life) and transferred to the General Acute Care Hospital (GACH). While at the GACH, the resident coded (abrupt loss of heart function) multiple times, required intubation (placement of a flexible plastic tube into the trachea [a tube structure in the body that carries air] to maintain an open airway), and then expired (died) on [DATE]. On [DATE] at 5:58 p.m., the State Survey Agency called an Immediate Jeopardy (IJ-a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure a resident was kept free from neglect when facility staff provided food to Resident 1 that was contraindicated to the resident ' s prescribed diet. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:43 p.m., the ADM provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], The facility began an investigation into the choking incident involving Resident 1, including interviews, record review, and follow up with the hospital and responsible party (RP). 2. DA 1 was suspended pending investigation on [DATE]. DA 1 was scheduled to be terminated on [DATE], however voluntarily resigned from her position on [DATE]. 3. CNA 1 was verbally counseled on [DATE] and received final written warning on [DATE] for failure to ensure that the food he obtained for Resident 1 was first checked by a licensed nurse to ensure it was within the residents ' dietary restrictions prior to serving it to the resident. 4. In-service was initiated by ADM/ Registered Dietician (RD)/Dietary Manager (DM) on [DATE] for dietary staff regarding resident diets, textures and what is allowed for each; as well as the process to follow, to validate diet orders prior to providing any food requests or substitutions requested by residents or staff to ensure that residents receive the correct texture diet. 5. In-service was initiated for facility staff by Director of Staff Development (DSD)/designee on [DATE] regarding the process to request food substitutes for residents and that all food must be checked by licensed nurses to confirm diet order and tray accuracy prior to serving it to residents. 6. In-service was initiated on [DATE] for facility staff by RD/DON/designee on the different food textures and the potential consequences of providing the wrong texture to residents. 7. Notifications were made by ADM on [DATE] to facility staff regarding the facility ' s system changes with regards to dietary restrictions and verification of prescribed diet to supplement the in-person in-services. 8. In-service was initiated for facility staff by DSD/designee on [DATE] regarding the choking and code status of residents. 9. Quality Assurance and Performance Improvement (QAPI- data driven approach to quality improvement) meeting was held on [DATE] to review incident and review/revise action plan (plan containing actions to achieve a goal). 10. The facility conducted audits of meal services on [DATE] and [DATE] to ensure that appropriate meals have been provided according to each resident's physician ordered diet. No additional concerns have been identified at this time. 11. Direct care staff was surveyed by DON/designee on [DATE] to determine if any residents receiving modified diets are known to request foods that may be inconsistent with their diet order or texture. Four (4) residents were identified. Interdisciplinary Team (IDT - a group of members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) meetings were held with these four (4) residents on [DATE] to determine residents' specific requests and concerns regarding their diets, inform primary physician and develop a resident-specific plan of care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. Review of physician diet orders, tray tickets and resident care plans was initiated on [DATE] to validate that all are accurate and consistent related to diet textures. 13. Documentation log for alternates and food request was initiated on [DATE] to ensure that food substitutes/meals have food provided that is consistent with each resident's physician orders and that physician's ordered diets are reconciled (checked to ensure the order is the same as what is being provided to the resident) with the meals and food served to the residents. Any food requested that is not consistent with diet order will be referred to RD to meet with resident, provide education to resident about ordered diet, initiate IDT meeting, referral to speech therapy, and follow up with primary physician if needed and ensure care plan is updated to reflect any changes made. 14. ADM initiated in-service on [DATE] for RD and IDT regarding the process to be followed if residents are identified as requesting food not consistent with diet order. 15. DON/ Designee will continue in-service of staff regarding the proper process for providing meals including the process of providing alternative substitute menu options. 16. Meal Tray Accuracy log initiated on [DATE] to ensure that meals provided the nursing units are checked against the diet orders to ensure appropriate food items are served. Log will be completed in kitchen as trays are being prepared and then again by licensed nurses prior to food being served to residents on the unit. In-service was initiated on [DATE] for dietary staff and licensed nurses regarding use of the Meal Tray Accuracy log form. 17. DON/ Designee will continue in-service for the licensed nurses and Certified Nursing Assistant s (CNAs)that food items provided to the residents will be checked by the licensed nurse prior to providing to the residents. 18. On [DATE], DON/designee initiated in-service for facility staff regarding the importance of the resident environment remaining as free of accident hazards as is possible; that each resident receives adequate supervision and assistance devices to prevent accidents, and a review of how this standard was not met with regards to the choking incident of Resident 1. 19. QAPI meeting with Governing Board (oversees the operations of the facility) scheduled for [DATE] to review action plan and root cause analysis. 20. Meal Tray Accuracy log will be completed by dietary staff and licensed nurses to ensure that meals provided to the nursing units are checked against the diet orders to ensure appropriate food items are served. Administrator/designee will review these logs weekly for three months to ensure that compliance is consistently met and review for any trends. 21. Documentation log for alternates and food request will be completed by dietary staff to ensure that food substitutes/meals have food provided that is consistent with each resident's physician orders and that physician's ordered diets are reconciled with the meals and food served to the residents. Administrator/designee will review these logs weekly for three months to ensure that compliance is consistently met and that any requests made that is not consistent with diet order have been referred to RD for appropriate follow up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	22. Audit will be done weekly for three months by DM/designee of physician diet orders, tray tickets for current residents, and for 10 random resident care plans to validate that they are accurate and consistently related to diet textures. Immediate correction will be made as needed and reported to ADM. 23. Audit findings will be reported to the QAPI Committee. During the monthly QAPI meetings, the QAPI Committee will review any issues or concerns identified to determine the effectiveness of facility efforts and to provide feedback and program modification if needed for three months or until compliant. 24. An action plan with the above stated action items, education, and audits will be submitted to the Quality Assurance (QA) Committee for continued monitoring to ensure that the facility remains in compliance with the requirements for residents' right to be free from abuse, neglect, and misappropriation of resident property. On [DATE] at 2:23 p.m., while onsite and after verifying the facility ' s full implementation of the IJ removal plan, the State Survey Agency accepted the IJ Removal Plan and removed the Immediate Jeopardy in the presence of the ADM and the DON. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs, making it hard to breathe), and type 2 diabetes mellitus (the body ' s inability to regulate sugar levels in the blood). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE] indicated Resident 1 had moderately impaired cognition (ability to think and make decisions). The MDS also indicated Resident 1 was on a mechanically altered diet (a type of diet where the texture is modified to help people who have difficulty with chewing and swallowing). A review of Resident 1 ' s Physician ' s Order Summary Report indicated a physician ' s order dated [DATE] for a regular, no salt added, soft and bite-size texture, regular consistency diet. A review of Resident 1 ' s Tray Card for [DATE] - Lunch, indicated Resident 1 was on a no added salt diet, soft and bite-sized texture, and thin liquids. A review of Resident 1 ' s Change in Condition Evaluation dated [DATE] indicated Resident 1 was eating his lunch and then choked (to stop breathing because something is blocking your throat). Resident 1 ' s Change in Condition Evaluation further indicated the resident became cyanotic (a bluish coloration of the skin caused by lack of oxygen), Heimlich maneuver (an emergency rescue procedure for application to someone choking on a foreign object) and suctioning (the use of suction to remove debris or body fluids from an airway) was initiated, 911(the number that you call to contact the emergency services) was called, and Resident 1 was taken to the GACH. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility ' s Employee Corrective Action Notice for DA 1, dated [DATE], indicated that DA 1 reviewed Resident 1 ' s diet tray card and noted that the resident was on a soft and bite-sized diet. The Employee Corrective Action Notice indicated that despite reading Resident 1 ' s tray card for their dietary restrictions, DA 1 still provided a chef ' s salad for the resident. The Employee Corrective Action Notice further indicated that the chef ' s salad contained raw vegetables and croutons, both of which are not allowed on Resident 1 ' s soft and bite sized diet. A review of the facility ' s Employee Corrective Action Notice for CNA 1 dated [DATE], indicated CNA 1 obtained a salad for Resident 1 per the resident ' s request but failed to follow the facility process of having a licensed nurse check the food before serving it to the resident. The Employee Corrective Action Notice further indicated that the salad served to Resident 1 did not follow the resident ' s physician ordered diet restrictions that included that need for soft, bite-sized food. During an interview with the DON on [DATE] at 2:25 p.m., the DON stated on [DATE], Resident 1 was served food that was not part of his prescribed diet . The DON stated Resident 1 was on a prescribed diet that required soft, bite-sized food, but was served a chef ' s salad that had raw vegetables and dry croutons. The DON stated Resident 1 had requested for CNA 1 to get him a salad. DON stated that DA 1 provided a chef ' s salad to CNA 1, who then served it to Resident 1. DON stated that as a result of being served a chef ' s salad that included raw vegetables and dry croutons, Resident 1 ended up choking. During an interview with Certified Nursing Assistant 2 (CNA 2) on [DATE] at 2:58 p.m., CNA 2 stated she was in the dining room during lunch time on [DATE]. CNA 2 stated that around 12:30 p.m., when she was walking around the dining room checking on the residents, she saw Resident 1 coughing, gasping for air, with his hands around his neck, indicating he was choking. CNA 2 stated she proceeded to perform abdominal thrusts on Resident 1 while screaming for help. CNA 2 stated Licensed Vocational Nurse 1 (LVN 1) came into the dining room and took over with the abdominal thrusts and asked CNA 2 to get a suction machine (medical device that is primarily used for removing obstructions). CNA 2 stated on her way to get the suction machine, she asked the receptionist to call 911. CNA 2 stated that by the time she went back to the dining room, Resident 1 was on the floor with staff performing CPR on him. During an interview with DM on [DATE] at 3:40 p.m., the DM stated that when she interviewed DA 1 after Resident 1 ' s choking incident on [DATE] and DA 1 admitted that she gave CNA 1 a chef ' s salad even though she saw that Resident 1 ' s tray card indicated that he was on a soft, bite-sized diet. The DM stated a chef ' s salad consisted of raw lettuce, raw tomatoes, shredded cheese, pieces of ham, slices of boiled egg and croutons. The DM stated that DA 1 should have known a chef ' s salad was not allowed for a resident on a soft, bite-sized diet since it had hard, crunchy ingredients like the raw lettuce and croutons. DM stated that the raw lettuce and croutons were not safe for a resident on a soft, bite-sized diet. The DM stated if DA 1 had any questions, she should have asked the DM prior to giving the salad to CNA 1. The DM stated that serving Resident 1 food items not allowed on his prescribed diet put him at risk for choking. The DM stated that DA 1 had many years of experience as a Dietary Aide and should have known that the salad was not part of a soft, bite-sized diet. The DM stated that DA 1 prepared a chef ' s salad for Resident 1, knowing that it was not part of his prescribed diet was very neglectful. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA 1 on [DATE] at 4:10 p.m., CNA 1 stated that during lunch time on [DATE], Resident 1 informed him that he didn ' t like his food and requested for a salad from the kitchen. CNA 1 stated he took Resident 1 ' s tray card to the kitchen, presented it to DA 1, and informed DA 1 that Resident 1 was requesting a salad. CNA 1 stated that DA 1 looked at the tray card and then handed him a chef ' s salad. CNA 1 stated he brought the salad back to the dining room and served it to Resident 1 without having a licensed nurse check the food to verify that the salad prepared was within the resident ' s dietary restrictions. CNA 1 stated he did not verify the salad with a licensed nurse because there were no licensed nurses in or around the dining room at the time, and it was already the end of lunch. CNA 1 stated he understands that he bypassed a safety check, but he was just trying to get Resident 1 the food that he wanted so that the resident could eat. CNA 1 stated that he thought the salad would be okay to serve to Resident 1 because he trusted that DA 1 looked at the tray card to make sure the food given was part of Resident 1 ' s diet. During an interview with the DON on [DATE] at 4:21 p.m., the DON stated that the facility has numerous safety protocols in place to ensure residents are served only food that is part of their physician prescribed diet. The DON stated DA 1 should have checked the tray card carefully and only provide food that is within Resident 1 ' s dietary restrictions. The DON then stated that CNA 1 should have ensured a licensed nurse checked the food before serving it to Resident 1. The DON stated that unfortunately DA 1 and CNA 1 bypassed the facility ' s safety protocols which is neglectful. DON stated that Resident 1 choked as a result of DA1 and CNA 1 bypassing safety protocols. A review of the GACH ' s Discharge Summary Report dated [DATE] indicated that Resident 1 was brought in to the GACH for respiratory distress (trouble breathing) after being found hypoxic (low levels of oxygen in the body). The form further indicated that Resident 1 had pulmonary (relating to the lungs) findings suspicious for pneumonia (severe inflammation of the lungs). Resident 1 decompensated (decline in health) after arrival to GACH and coded three times before being transferred to Intensive Care Unit (ICU- a part of a hospital where patients who are extremely ill or very badly injured are looked after constantly). The discharge summary further indicated that Resident 1 suffered cardiac arrest but did survive. The report went on to state that Resident 1 did want further escalation of care and ultimately expired. A review of the facility ' s policy and procedure titled, Abuse Prohibition and Prevention, revised [DATE], indicated the facility prohibits and prevents abuse, neglect, exploitation, misappropriation of property and mistreatment.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 42040 Based on interview and record review, the facility failed to ensure they did not hire an employee who was found guilty of abuse by a court of law for one of seven facility staff members [Certified Nursing Assistant (CNA 1)]. This deficient practice had the potential to place the residents in the facility at risk for abuse. Findings: During an interview and concurrent record review on 12/9/2022 at 5:00 p.m. with the facility ' s Administrator (ADM), she provided a copy of CNA 1 ' s background check report. During a record review on 12/10/2022 at 9:40 a.m., CNA 1 ' s background check report with completed date of 6/1/2022, indicated the following: Name and date of birth matching CNA 1 Charge type: Misdemeanor (a type of offense punishable under criminal law) Charge: Corporal injury inflicted upon spouse (willfully inflicting a physical injury resulting in a traumatic condition on an intimate partner) Disposition (Outcome of an arrest or prosecution): Guilty Disposition date: 1/16/2020 Sentence (punishment for a crime): Jail 364 days During an interview and concurrent record review on 12/10/2022 at 10:00 a.m., the ADM stated that during the pre-employment background checks process, the applicant will be sent a link through email to submit their information to run through the background check system. Once this has been completed, the results of the background check report are sent to the staff who sent the applicant the online link to submit their information. The ADM stated that this process is usually done by the Director of Staff Development (DSD) and does not recall why she sent him the link instead of the DSD. The ADM further stated that she sent CNA 1 the link for the background check, so she was the one who received the results of his background check report. ADM stated the background checks are done prior to hiring to review and make sure everything is clear, and if there are any concerns then the regional Human Resources will further review prior to making any decisions to employ the applicant. The ADM stated she does not recall discussing his criminal background information indicated on his background check report. The ADM stated she must have missed reviewing the information. The ADM stated she may have sent the information to the Human Resources to review and the decision to hire CNA 1 may have been cleared and approved by them. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/12/2022 at 11:55 a.m., the ADM stated she could not locate any documentation or correspondence between her and the Human Resources to indicate that the background information for CNA 1 was reviewed and approved for employment. The ADM stated that if she saw this information on his background prior to his employment she would not have hired him to work at the facility. ADM stated that she should have reviewed the information more thoroughly and that CNA 1 should not have been employed. A review of the facility ' s policies and procedures titled, Abuse Prohibition and Prevention and Policy and Procedure, dated 8/2022, indicated that facility will not employ or otherwise engage individuals who have been found guilty of abuse by a court of law.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39739 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1), who was prescribed a regular, no salt added, soft and bite-size texture, regular consistency diet (a diet that contains food that is cut into smaller pieces, soft, easy to chew, with lower amounts of salt), and was at risk for aspiration (when something enters your airway or lungs), was provided with appropriate supervision to keep the resident free from accidents and hazards by failing to ensure Certified Nursing Assistant 1 (CNA 1) first verified with a licensed nurse, that the chef ' s salad (a salad of lettuce and other raw [crunchy] vegetables topped with slices of meat, cheese, croutons [bread that is hardened due to being fried or toasted], and hard-boiled eggs) prepared by Dietary Aide 1 (DA 1) was within Resident 1 ' s dietary restrictions, prior to serving the salad to Resident 1. The salad contained croutons and raw lettuce, both of which are not allowed based on the resident ' s dietary restrictions. This deficient practice resulted in Resident 1 choking (to stop breathing because something is blocking your throat) while eating the provided chef ' s salad that did not adhere to his dietary restrictions on [DATE]. Resident 1 required abdominal thrusts (a technique in first aid to dislodge a foreign body in a person's airway by applying sudden upward pressure on the upper abdomen) and cardiopulmonary resuscitation (CPR- an emergency life-saving procedure that is done when someone's breathing, or heartbeat has stopped). Resident 1 was revived (regained life) and transferred to the General Acute Care Hospital (GACH). While at the GACH, the resident coded (abrupt loss of heart function) multiple times, required intubation (placement of a flexible plastic tube into the trachea [a tube structure in the body that carries air to maintain an open airway), and then expired (died) on [DATE]. On [DATE] at 5:58 p.m., the State Survey Agency called an Immediate Jeopardy (IJ-a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure a resident was kept free from hazard when facility staff provided food to Resident 1 that was contraindicated to the resident ' s prescribed diet. On [DATE] at 4:43 p.m., the ADM provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], the facility began an investigation into the choking incident involving Resident 1, including interviews, record review, and follow up with the hospital and responsible party (RP). 2. DA 1 was suspended pending investigation on [DATE]. DA 1 was scheduled to be terminated on [DATE], however voluntarily resigned from her position on [DATE]. 3. CNA 1 was verbally counseled on [DATE] and received final written warning on [DATE] for failure to ensure that the food he obtained for Resident 1 was first checked by a licensed nurse to ensure it was within the residents ' dietary restrictions prior to serving it to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. In-service was initiated by ADM/ Registered Dietician (RD)/Dietary Manager (DM) on [DATE] for dietary staff regarding resident diets, textures and what is allowed for each; as well as the process to follow, to validate diet orders prior to providing any food requests or substitutions requested by residents or staff to ensure that residents receive the correct texture diet. 5. In-service was initiated for facility staff by Director of Staff Development (DSD)/designee on [DATE] regarding the process to request food substitutes for residents and that all food must be checked by licensed nurses to confirm diet order and tray accuracy prior to serving it to residents. 6. In-service was initiated on [DATE] for facility staff by RD/DON/designee on the different food textures and the potential consequences of providing the wrong texture to residents. 7. Notifications were made by ADM on [DATE] to facility staff regarding the facility ' s system changes with regards to dietary restrictions and verification of prescribed diet to supplement the in-person in-services. 8. In-service was initiated for facility staff by DSD/designee on [DATE] regarding the choking and code status of residents. 9. Quality Assurance and Performance Improvement (QAPI- data driven approach to quality improvement) meeting was held on [DATE] to review incident and review/revise action plan (plan containing actions to achieve a goal). 10. The facility conducted audits of meal services on [DATE] and [DATE] to ensure that appropriate meals have been provided according to each resident's physician ordered diet. No additional concerns have been identified at this time. 11. Direct care staff was surveyed by DON/designee on [DATE] to determine if any residents receiving modified diets are known to request foods that may be inconsistent with their diet order or texture. Four (4) residents were identified. Interdisciplinary Team (IDT - a group of members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities) meetings were held with these four (4) residents on [DATE] to determine residents' specific requests and concerns regarding their diets, inform primary physician and develop a resident-specific plan of care. 12. Review of physician diet orders, tray tickets and resident care plans was initiated on [DATE] to validate that all are accurate and consistent related to diet textures. 13. Documentation log for alternates and food request was initiated on [DATE] to ensure that food substitutes/meals have food provided that is consistent with each resident's physician orders and that physician's ordered diets are reconciled (checked to ensure the order is the same as what is being provided to the resident) with the meals and food served to the residents. Any food requested that is not consistent with diet order will be referred to RD to meet with resident, provide education to resident about ordered diet, initiate IDT meeting, referral to speech therapy, and follow up with primary physician if needed and ensure care plan is updated to reflect any changes made. 14. ADM initiated in-service on [DATE] for RD and IDT regarding the process to be followed if residents are identified as requesting food not consistent with diet order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. DON/designee will continue in-service of staff regarding the proper process for providing meals including the process of providing alternative substitute menu options. 16. Meal Tray Accuracy log initiated on [DATE] to ensure that meals provided the nursing units are checked against the diet orders to ensure appropriate food items are served. Log will be completed in kitchen as trays are being prepared and then again by licensed nurses prior to food being served to residents on the unit. In-service was initiated on [DATE] for dietary staff and licensed nurses regarding use of the Meal Tray Accuracy log form. 17. DON/designee will continue in-service for the licensed nurses and Certified Nursing Assistant ' s (CNAs) that food items provided to the residents will be checked by the licensed nurse prior to providing to the residents. 18. On [DATE], DON/designee initiated in-service for facility staff regarding the importance of the resident environment remaining as free of accident hazards as is possible; that each resident receives adequate supervision and assistance devices to prevent accidents, and a review of how this standard was not met with regards to the choking incident of Resident 1. 19. QAPI meeting with Governing Board (oversees the operations of the facility) scheduled for [DATE] to review action plan and root cause analysis. 20. Meal Tray Accuracy log will be completed by dietary staff and licensed nurses to ensure that meals provided to the nursing units are checked against the diet orders to ensure appropriate food items are served. Administrator/designee will review these logs weekly for three months to ensure that compliance is consistently met and review for any trends. 21. Documentation log for alternates and food request will be completed by dietary staff to ensure that food substitutes/meals have food provided that is consistent with each resident's physician orders and that physician's ordered diets are reconciled with the meals and food served to the residents. Administrator/designee will review these logs weekly for three months to ensure that compliance is consistently met and that any requests made that is not consistent with diet order have been referred to RD for appropriate follow up. 22. Audit will be done weekly for three months by DM/designee of physician diet orders, tray tickets for current residents, and for 10 random resident care plans to validate that they are accurate and consistently related to diet textures. Immediate correction will be made as needed and reported to ADM. 23. Audit findings will be reported to the QAPI Committee. During the monthly QAPI meetings, the QAPI Committee will review any issues or concerns identified to determine the effectiveness of facility efforts and to provide feedback and program modification if needed for three months or until compliant. 24. An action plan with the above stated action items, education, and audits will be submitted to the Quality Assurance (QA) Committee for continue monitoring to ensure that the facility remains in compliance with the requirements for resident environment to remain as free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:23 p.m., while onsite and after verifying the facility ' s full implementation of the IJ removal plan, the State Survey Agency accepted the IJ Removal Plan and removed the Immediate Jeopardy in the presence of the ADM and the DON. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs, making it hard to breathe), and type 2 diabetes mellitus (the body ' s inability to regulate sugar levels in the blood). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE] indicated Resident 1 had moderately impaired cognition (ability to think and make decisions). The MDS also indicated Resident 1 was on a mechanically altered diet (a type of diet where the texture is modified to help people who have difficulty with chewing and swallowing). A review of Resident 1 ' s Physician ' s Order Summary Report indicated a physician ' s order dated [DATE] for a regular, no salt added, soft and bite-size texture, regular consistency diet. A review of Resident 1 ' s Tray Card for [DATE] - Lunch, indicated Resident 1 was on a no added salt diet, soft and bite-sized texture, and thin liquids. A review of Resident 1 ' s Change in Condition Evaluation dated [DATE] indicated Resident 1 was eating his lunch and then choked. Resident 1 ' s Change in Condition Evaluation further indicated the resident became cyanotic (a bluish coloration of the skin caused by lack of oxygen), Heimlich maneuver (an emergency rescue procedure for application to someone choking on a foreign object) and suctioning (the use of suction to remove debris or body fluids from an airway) was initiated, 911(the number that you call to contact the emergency services) was called, and Resident 1 was taken to the GACH. A review of the facility ' s Employee Corrective Action Notice for DA 1, dated [DATE], indicated that DA 1 reviewed Resident 1 ' s diet tray card and noted that the resident was on a soft and bite-sized diet. The Employee Corrective Action Notice went on to state that despite reading Resident 1 ' s tray card for their dietary restrictions, DA 1 still provided a chef ' s salad for the resident. The Employee Corrective Action Notice further indicated that the chef ' s salad contained raw vegetables and croutons, both of which are not allowed on Resident 1 ' s soft and bite sized diet. A review of the facility ' s Employee Corrective Action Notice for CNA 1 dated [DATE], indicated CNA 1 obtained a salad for Resident 1 per the resident ' s request but failed to follow the facility process of having a licensed nurse check the food before serving it to the resident. The Employee Corrective Action Notice further indicated that the salad served to Resident 1 did not follow the resident ' s physician ordered diet restrictions that included the need for soft, bite-sized food. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 2:25 p.m., the DON stated on [DATE], Resident 1 was served food that was not part of his prescribed diet. The DON stated Resident 1 was on a prescribed diet that required soft, bite-sized food, but was served a chef ' s salad that had raw vegetables and dry croutons. The DON stated Resident 1 had requested for CNA 1 to get him a salad. DON stated that DA 1 provided a chef ' s salad to CNA 1, who then served it to Resident 1. DON stated that as a result of being served a chef ' s salad that included raw vegetables and dry croutons, Resident 1 ended up choking. During an interview with Certified Nursing Assistant 2 (CNA 2) on [DATE] at 2:58 p.m., CNA 2 stated she was in the dining room during lunch time on [DATE]. CNA 2 stated that around 12:30 p.m., when she was walking around the dining room checking on the residents, she saw Resident 1 coughing, gasping for air, with his hands around his neck, indicating he was choking. CNA 2 stated she proceeded to perform abdominal thrusts on Resident 1 while screaming for help. CNA 2 stated Licensed Vocational Nurse 1 (LVN 1) came into the dining room and took over with the abdominal thrusts and asked CNA 2 to get a suction machine (medical device that is primarily used for removing obstructions). CNA 2 stated on her way to get the suction machine, she asked the receptionist to call 911. CNA 2 stated that by the time she went back to the dining room, Resident 1 was on the floor with staff performing CPR on him. During an interview with DM on [DATE] at 3:40 p.m., the DM stated that when she interviewed DA 1 after Resident 1 ' s choking incident on [DATE] and DA 1 admitted that she gave CNA 1 a chef ' s salad even though she saw that Resident 1 ' s tray card indicated that he was on a soft, bite-sized diet. The DM stated a chef ' s salad consisted of raw lettuce, raw tomatoes, shredded cheese, pieces of ham, slices of boiled egg and croutons. The DM stated that DA 1 should have known a chef ' s salad was not allowed for a resident on a soft, bite-sized diet as it contained hard , crunchy ingredients like the raw lettuce and croutons. DM stated that the raw lettuce and croutons were not safe for a resident on a soft, bite-sized diet. The DM stated if DA 1 had any questions, she should have asked the DM prior to giving the salad to CNA 1. The DM stated that serving Resident 1 food items not allowed on his prescribed diet put him at risk for choking. The DM stated that DA 1 had many years of experience as a Dietary Aide and should have known that the salad was not part of a soft, bite-sized diet. During an interview with CNA 1 on [DATE] at 4:10 p.m., CNA 1 stated that during lunch time on [DATE], Resident 1 informed him that he did not like his food and requested for a salad from the kitchen. CNA 1 stated he took Resident 1 ' s tray card to the kitchen, presented it to DA 1, and informed DA 1 that Resident 1 was requesting a salad. CNA 1 stated that DA 1 looked at the tray card and then handed him a chef ' s salad. CNA 1 stated he brought the salad back to the dining room and served it to Resident 1 without having a licensed nurse check the food to verify that the salad prepared was within the resident ' s dietary restrictions. CNA 1 stated he did not verify the salad with a licensed nurse because there were no licensed nurses in or around the dining room at the time, and it was already the end of lunch. CNA 1 stated he understands that he bypassed a safety check, but he was just trying to get Resident 1 the food that he wanted so that the resident could eat. CNA 1 stated that he thought the salad would be okay to serve to Resident 1 because he trusted that DA 1 looked at the tray card to make sure the food given was part of Resident 1 ' s diet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on [DATE] at 4:21 p.m., the DON stated that the facility has numerous safety protocols in place to ensure residents are served only food that is part of their physician prescribed diet. The DON stated DA 1 should have checked the tray card carefully and only provide food that is within Resident 1 ' s dietary restrictions. The DON then stated that CNA 1 should have ensured a licensed nurse checked the food before serving it to Resident 1. The DON stated that unfortunately DA 1 and CNA 1 bypassed the facility ' s safety protocols. DON stated that Resident 1 choked as a result of DA1 and CNA 1 bypassing safety protocols. A review of the GACH ' s Discharge Summary Report dated [DATE] indicated that Resident 1 was brought in to the GACH for respiratory distress (trouble breathing) after being found hypoxic (low levels of oxygen in the body). The form further indicated that Resident 1 had pulmonary (relating to the lungs) findings suspicious for pneumonia (severe inflammation of the lungs). Resident 1 decompensated (decline in health) after arrival to GACH and coded three times before being transferred to Intensive Care Unit (ICU- a part of a hospital where patients who are extremely ill or very badly injured are looked after constantly). The discharged summary further indicated that Resident 1 suffered cardiac arrest. The report went on to state that Resident 1 did want further escalation of care and ultimately expired. A review of the facility ' s policy and procedure titled, Nutrition Services for All Residents, revised on [DATE] indicated that the resident ' s nutritional status and their nutritional needs will be assessed. A nutritional program specific to their needs will be planned and implanted. A review of the facility ' s policy and procedure titled, Diet Tray Card, revised [DATE], indicated the diet card ' s primary purpose is to inform the dietary staff how to assemble the resident ' s meal tray and provide caregivers with mealtime information. The policy and procedure further indicate that the facility is to ensure that food items served are consistent with tray card information.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42040 Based on interview and record review, the facility failed to follow their policies and procedures to ensure an annual competency check (a method to measure the employee ' s performance based on objective data) was done for one of six facility staff members [Dietary Aide 1 (DA 1)]. This deficient practice had the potential to place residents at risk for not receiving adequate dietary aide services. Findings: A review of DA 1's personnel file indicated DA 1 was hired as a dietary aide by the facility on 1/7/2009. During an interview on 12/10/2022 at 11:55 a.m., the Dietary Manager (DM 1) stated that it is the task and role of the dietary manager to do the annual assessment of the roles of her staff. DM 1 stated that she is responsible to ensure that dietary aides are competent to do their jobs. DM 1 stated that she did not know that DA 1 did not have a competency check done after 2019 and that she should have reviewed DA 1 ' s records to ensure this was done. During an interview on 12/12/2022 at 11:55 a.m., the Administrator (ADM) verified that DA 1 ' s latest competency check done was dated 8/30/2019. The ADM stated she could not find any competency checks that were done for years 2020, 2021, and 2022. The ADM stated that DA 1 should have had competency checks annually to ensure they had the skills and abilities to do their jobs. ADM stated the dietary manager is responsible for performing competency checks. The ADM stated it is the policy of the facility to ensure competency checks are done annually for all staff in the facility including dietary aides. A review of the job description titled, Dietary Aide, updated 7/2011, indicated the primary purpose of this position is to provide assistance in all dietary functions as directed and in accordance with established dietary policies and procedures. A review of the facility ' s policies and procedures titled, Knowledge and Skills Competency Evaluation, dated revised 5/2015, indicated that the purpose of the policy is to provide a method to measure the employee ' s performance based on objective data. The knowledge and skill competencies are evaluated upon hire, annually thereafter and as needed.

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F 0803 Level of Harm - Actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39739 Based on interview and record review, the facility failed to ensure the prescribed diet was followed for one of five residents reviewed (Resident 1), when the facility served the resident, who was on a regular, no salt added, soft and bite-size texture, regular consistency diet (a diet that contains food that is cut into smaller pieces, soft, easy to chew, with lower amounts of salt), and was at risk for aspiration (when something enters your airway or lungs), a chef ' s salad (a salad of lettuce and other raw [crunchy] vegetables topped with slices of meat, cheese, croutons [bread that is hardened due to being fried or toasted], and hard-boiled eggs), which contained croutons and raw lettuce, both of which are not allowed based on the resident ' s dietary restrictions. This deficient practice resulted in Resident 1 choking (to stop breathing because something is blocking your throat) while eating the provided chef ' s salad that did not adhere to his dietary restrictions on [DATE]. Resident 1 required abdominal thrusts (a technique in first aid to dislodge a foreign body in a person's airway by applying sudden upward pressure on the upper abdomen) and cardiopulmonary resuscitation (CPR- an emergency life-saving procedure that is done when someone's breathing, or heartbeat has stopped). Resident 1 was revived (regained life) and transferred to the General Acute Care Hospital (GACH). While at the GACH, the resident coded (abrupt loss of heart function) multiple times, required intubation (placement of a flexible plastic tube into the trachea [a tube structure in the body that carries air] to maintain an open airway), and then expired (died) on [DATE]. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was admitted on [DATE] and readmitted on [DATE], with diagnoses that included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs, making it hard to breathe), and type 2 diabetes mellitus (the body ' s inability to regulate sugar levels in the blood). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE] indicated Resident 1 had moderately impaired cognition (ability to think and make decisions). The MDS also indicated Resident 1 was on a mechanically altered diet (a type of diet where the texture is modified to help people who have difficulty with chewing and swallowing). A review of Resident 1 ' s Physician ' s Order Summary Report indicated a physician ' s order dated [DATE] for a regular, no salt added, soft and bite-size texture, regular consistency diet. A review of Resident 1 ' s Tray Card for [DATE] - Lunch, indicated Resident 1 was on a no added salt diet, soft and bite-sized texture, and thin liquids. (continued on next page)

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F 0803 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1 ' s Change in Condition Evaluation dated [DATE] indicated Resident 1 was eating his lunch and then choked. Resident 1 ' s Change in Condition Evaluation further indicated the resident became cyanotic (a bluish coloration of the skin caused by lack of oxygen), Heimlich maneuver (an emergency rescue procedure for application to someone choking on a foreign object) and suctioning (the use of suction to remove debris or body fluids from an airway) was initiated, 911(the number that you call to contact the emergency services) was called, and Resident 1 was taken to the GACH. A review of the facility ' s Employee Corrective Action Notice for DA 1, dated [DATE], indicated that DA 1 reviewed Resident 1 ' s diet tray card and noted that the resident was on a soft and bite-sized diet. The Employee Corrective Action Notice went on to state that despite reading Resident 1 ' s tray card for their dietary restrictions, DA 1 still provided a chef ' s salad for the resident. The Employee Corrective Action Notice further indicated that the chef ' s salad contained raw vegetables and croutons, both of which are not allowed on Resident 1 ' s soft and bite sized diet. A review of the facility ' s Employee Corrective Action Notice for CNA 1 dated [DATE], indicated CNA 1 obtained a salad for Resident 1 per the resident ' s request but failed to follow the facility process of having a licensed nurse check the food before serving it to the resident. The Employee Corrective Action Notice further indicated that the salad served to Resident 1 did not follow the resident ' s physician ordered diet restrictions that included the need for soft, bite-sized food. During an interview with the DON on [DATE] at 2:25 p.m., the DON stated on [DATE], Resident 1 was served food that was not part of his prescribed diet. The DON stated Resident 1 was on a prescribed diet that required soft, bite-sized food, but was served a chef ' s salad that had raw vegetables and dry croutons. The DON stated Resident 1 had requested for CNA 1 to get him a salad. DON stated that DA 1 provided a chef ' s salad to CNA 1, who then served it to Resident 1. DON stated that as a result of being served a chef ' s salad that included raw vegetables and dry croutons, Resident 1 ended up choking. During an interview with Certified Nursing Assistant 2 (CNA 2) on [DATE] at 2:58 p.m., CNA 2 stated she was in the dining room during lunch time on [DATE]. CNA 2 stated that around 12:30 p.m., when she was walking around the dining room checking on the residents, she saw Resident 1 coughing, gasping for air, with his hands around his neck, indicating he was choking. CNA 2 stated she proceeded to perform abdominal thrusts on Resident 1 while screaming for help. CNA 2 stated Licensed Vocational Nurse 1 (LVN 1) came into the dining room and took over with the abdominal thrusts and asked CNA 2 to get a suction machine (medical device that is primarily used for removing obstructions). CNA 2 stated on her way to get the suction machine, she asked the receptionist to call 911. CNA 2 stated that by the time she went back to the dining room, Resident 1 was on the floor with staff performing CPR on him. (continued on next page)

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F 0803 Level of Harm - Actual harm Residents Affected - Few	During an interview with DM on [DATE] at 3:40 p.m., the DM stated that when she interviewed DA 1 after Resident 1 ' s choking incident on [DATE] and DA 1 admitted that she gave CNA 1 a chef ' s salad even though she saw that Resident 1 ' s tray card indicated that he was on a soft, bite-sized diet. The DM stated a chef ' s salad consisted of raw lettuce, raw tomatoes, shredded cheese, pieces of ham, slices of boiled egg and croutons. The DM stated that DA 1 should have known a chef ' s salad was not allowed for a resident on a soft, bite-sized diet because it included hard, crunchy ingredients like the raw lettuce and croutons. DM stated that the raw lettuce and croutons were not safe for a resident on a soft, bite-sized diet. The DM stated if DA 1 had any questions, she should have asked the DM prior to giving the salad to CNA 1. The DM stated that serving Resident 1 food items not allowed on his prescribed diet put him at risk for choking. The DM stated that DA 1 had many years of experience as a Dietary Aide and should have known that the salad was not part of a soft, bite-sized diet. During an interview with CNA 1 on [DATE] at 4:10 p.m., CNA 1 stated that during lunch time on [DATE], Resident 1 informed him that he did not like his food and requested for a salad from the kitchen. CNA 1 stated he took Resident 1 ' s tray card to the kitchen, presented it to DA 1, and informed DA 1 that Resident 1 was requesting a salad. CNA 1 stated that DA 1 looked at the tray card and then handed him a chef ' s salad. CNA 1 stated he brought the salad back to the dining room and served it to Resident 1 without having a licensed nurse check the food to verify that the salad prepared was within the resident ' s dietary restrictions. CNA 1 stated he did not verify the salad with a licensed nurse because there were no licensed nurses in or around the dining room at the time, and it was already the end of lunch. CNA 1 stated he understands that he bypassed a safety check, but he was just trying to get Resident 1 the food that he wanted so that the resident could eat. CNA 1 stated that he thought the salad would be okay to serve to Resident 1 because he trusted that DA 1 looked at the tray card to make sure the food given was part of Resident 1 ' s diet. During an interview with the DON on [DATE] at 4:21 p.m., the DON stated that the facility has numerous safety protocols in place to ensure residents are served only food that is part of their physician prescribed diet. The DON stated DA 1 should have checked the tray card carefully and only provide food that is within Resident 1 ' s dietary restrictions. The DON then stated that CNA 1 should have ensured a licensed nurse checked the food before serving it to Resident 1. The DON stated that unfortunately DA 1 and CNA 1 bypassed the facility ' s safety protocols. DON stated that Resident 1 choked as a result of DA1 and CNA 1 bypassing safety protocols. A review of the GACH ' s Discharge Summary Report dated [DATE] indicated that Resident 1 was brought in to the GACH for respiratory distress (trouble breathing) after being found hypoxic (low levels of oxygen in the body). The form further indicated that Resident 1 had pulmonary (relating to the lungs) findings suspicious for pneumonia (severe inflammation of the lungs). Resident 1 decompensated (decline in health) after arrival to GACH and coded three times before being transferred to Intensive Care Unit (ICU- a part of a hospital where patients who are extremely ill or very badly injured are looked after constantly). The discharged summary further indicated that Resident 1 suffered cardiac arrest. The report went on to state that Resident 1 did want further escalation of care and ultimately expired. A review of the facility ' s policy and procedure titled, Nutrition Services for All Residents, revised on [DATE] indicated that the resident ' s nutritional status and their nutritional needs will be assessed. A nutritional program specific to their needs will be planned and implanted. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled, Diet Tray Card, revised [DATE], indicated the diet card ' s primary purpose is to inform the dietary staff how to assemble the resident ' s meal tray and provide caregivers with mealtime information. The policy and procedure further indicate that the facility is to ensure that food items served are consistent with tray card information.