| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155685 | A. BUILDING _____ B. WING _____ | C 04/27/2023 |

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| BRICKYARD HEALTHCARE - ELKHART CARE CENTER | 1001 W HIVELY AVE ELKHART, IN 46517 |

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| F 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00404852, IN00405551, and IN00407017.<br><br>Complaint IN00404852 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00405551 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00407017 - Deficiencies related to the allegations are cited at F805.<br><br>Survey dates: April 25, 26, and 27, 2023<br><br>Facility number: 000039<br>Provider number: 155685<br>AIM number: 100275130<br><br>Census Bed Type:<br>SNF/NF: 90<br>Total: 90<br><br>Census Payor Type:<br>Medicare: 4<br>Medicaid: 76<br>Other: 10<br>Total: 90<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed 5/9/2023. | F 000 | | |
| F 805 SS=G | Food in Form to Meet Individual Needs<br>CFR(s): 483.60(d)(3)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides- | F 805 | | |

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

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| F 805 | Continued From page 1<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide the appropriate supervision and the appropriate textured diet for 1 of 3 residents reviewed for mechanically altered diets that resulted death. (Resident B)<br><br>Finding includes:<br><br>A record review was completed for Resident B on 4/25/2023 at 4:33 P.M. Diagnoses included, but were not limited to: Parkinson's disease, hemiplegia, dementia, and atrial fibrillation.<br><br>A Quarterly Minimum Data Set (MDS) Assessment, dated 3/29/2023, indicated Resident B had severe cognitive impairment. He was able to be understood and understand others. He required meal set-up with supervision for eating. Resident B received a mechanically altered diet.<br><br>A Physician's Order, dated 6/29/2022, indicated, " ...Direct supervision for entirety consumption of food and liquids ...."<br><br>On 7/13/2022, a Physician's Order indicated, " ...Resident has exhibited coughing or choking during meals or when swallowing medications ...."<br><br>A Care Plan, initiated on 7/22/2022, and resolved on 2/13/2023, indicated Resident B was at risk for coughing and or choking during meals or when swallowing medication. The goal was for Resident B to remain free of adverse effects associated with coughing/choking during meals or | F 805 | Past noncompliance: no plan of correction required. | |

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when swallowing medications.

A Physician's Order dated 1/19/2023, indicated a regular diet, mechanical soft/easy to chew texture diet.

A Nurse's Note, dated 4/20/2023 at 6:32 P.M., indicated Resident B finished eating his dinner, stood up from the table, and placed his hands next to his throat. The Heimlich maneuver was done. Resident B was sitting on the floor with an occasional breath. Resident B's mouth was swept and small pieces of diced fruit was removed from his mouth. Resident B's lips were turning blue and 911 was called. Oxygen was placed and suctioning was attempted with no success.

On 4/20/2023 at 6:39 P.M., a Nurse's Note indicated, 911 arrived and took over care. Cardiopulmonary resuscitation (CPR) was initiated for approximately twenty minutes before the time of death was called.

On 4/26/2023 at 9:27 A.M., the facility provided a folder that contained the investigation information for the incident on 4/20/2023.

A form titled "Alleged Incident Statement", dated 4/20/2023, CNA (certified nursing assistant) 3's statement indicated on 4/20/23 at 6:20 P.M., " ...I was sitting at a table feeding a resident turned around notice the resident [Resident B] was looking like he was choking I called [name of QMA 4] he ran over started the hemlich [Heimlich] maneuver then I preceded to call the nurses. ...Injury? Death ...."

Another "Alleged Incident Statement", dated 4/20/2023, handwritten by QMA (qualified

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medication assistant) 4 indicated " ...Resident [Resident B] was eating and I noticed him grasping for and trying to get our attention, Realizing he was choking I conducted Heimlich maneuver while calling for nurse ...Resident [Resident B] was eating mechanical [ground] hamburger chips and peaches ...Injury? Not certain though it appeared resident was choking ...."

An "Alleged Incident Statement", dated 4/20/23, handwritten by QMA 5 indicated " ...While counting and getting report, got a scream from the dining room from a CNA that a resident is choking. I run and helped to with the Heimlich Maneuver and I put a glove and sweep out his mouth and found in mouth. Then the nurse took over and helped him more and proceeded to call 911 and paperwork and authorities ...Injury? Death ...."

A typed interview, dated 4/20/23, Cook 6 indicated he would know the type of diet a resident should receive, by observing the "ticket". Cook 6 then explained the mechanical soft diet for the evening meal on 4/20/2023 was " ...Chopped hamburger with a slice of cheese on a bun. Spiced apricots that were cut up into small pieces. And Cheetos Cheese Puffs ...." Cook # 6 statement indicated the meals are loaded onto a cart, then delivered to the unit's dining room. The mechanical soft diets were checked by the dietary staff who loads the cart. Cook # 6 indicated the fruit in a mechanical soft diet, would be served cut up, into small pieces.

A document titled, "Interview [LPN 2] for incident on 4/20/23, LPN (licensed practical nurse)" dated 4/24/2023, from an interview with Area Vice

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President, indicated, " ...The nurse was as giving report to oncoming QMA at approx. [approximately] 6:20 P.M. We heard yelling. The CNA started yelling for the nurse, Nurse went immediately to the dining room. The nurse states that CNA reports to her that they observed the resident standing up with his hand on his chest and lower throat area. The nurse observed upon arrival was resident in sitting position on the floor. Resident appeared to have taken a few deep breaths every few seconds. CNA assisted Nurse with putting resident in the chair. Directive was given to staff to call 911. The crash cart was grabbed by a staff member. O2 [oxygen] was placed on the resident. O2 stat machine was showing a pulse, but the machine was not reading a number. Lips were starting to turn a light blue. Nurse suctioned resident x 2 [times two]. No particles were coming out of the resident mouth through the suction. The nurse continued with abdominal thrusts and sweep of mouth. Findings from nurse appeared to be small, diced peach-colored particles. EMT's [Emergency Medical Technicians] arrived and laid resident down on floor. EMT's initiated CPR [cardiopulmonary resuscitation] and took over from nurse ...."

A document titled, "Timeline", dated 4/20/2023, indicated the following:
" ...1. Beginning of meal service (exact time unknown)-resident dropped plate on floor.
2. CNA 4 assisted resident from stepping in his dropped plate while another staff member cleaned up the tray on the floor.
3. Resident assisted back to his seat and provided with another tray.
4. Staff resumed their duties of assisting residents with meal service.

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5. Resident appeared to still be hungry.
6. CNA 4 observed this and provided another tray to resident.
7. CNA 4 redirected this resident from taking food from a tablemate's plate. CNA 4 observed this resident take one chip from the tray he set down in front of him.
8. CNA 4 went back to cleaning the dining room. Other CNA assisting residents with finishing meal service.
9. CNA 4 states he was putting a tray in the cart and he walked back toward the tables, he observed resident Rico [sic] standing with his head down, looking unusual.
10. CNA 4 stated he rushed to the resident and called for the other CNA to get the nurse.
11. CNA 4 stated that QMA 5 arrived and abdominal thrusts were immediately started.
12. CNA 4 stated resident was starting to become weak in the legs and limp, he was sat in a chair. The nurse arrived and began abdominal thrusts.
13. 911 was called by CNA.
14. The nurse instructed CNA 4 to get O2 and crash cart. Resident was placed on floor.
15. Nurse reports she did a finger sweep and a small amount of what appeared to be sliced peaches were in resident mouth.
16. Nurse attempted to suction without observing items coming out.
17. EMT's arrived at approx. 18:39 [6:39 P.M.] and continued to suction.
18. Resident passing at approx. [approximately] 16:53 [4:53 P.M.] ...."

The folder contained the self-report incident #549, dated 4/21/2023 at 4:16 P.M., indicated, Resident B was, " ...in dining room at dinner time, noted to be experiencing a change in condition. Nursing staff immediately attended to resident, as he

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appeared to be choking. Nurse performed abdominal thrust. 911 immediately called. Nurse triage continued until EMT arrival. Resident passed away while at facility with EMT's present ...." Actions taken after the incident included audits and education to include checking that diet orders match the meals being served and therapeutic diet have been completed and are ongoing education completed and ongoing prior to the start of their shift ...."

During an interview, on 4/26/2023 at 11:49 A.M., LPN 2, an agency nurse, indicated when she arrived at the dining room no one was doing anything for the resident and was found sitting on the floor. She immediately checked the resident's mouth for debris and got out a few pieces of fruit. She had staff put the resident into a chair so she could provide the Heimlich Maneuver to the resident. Once suction arrived, to the area, she suctioned the resident but did not get anything so went back to do Heimlich Maneuver 2-3 times, then back to check mouth and suction. When Emergency Personnel arrived, they asked for his DNR paperwork, but it was not on the chart, so they started CPR and continued to provide CPR until a staff member provided the DNR paperwork. The resident was pronounced dead at the scene by the Emergency Personnel. LPN 2 indicated the tray she observed, for the resident had a bun, with ground meat in it, cut up fruit and potato chips.

During an interview, on 4/26/2023 at 12:55 P.M., the Dietician indicated that potato chips were not to be provided to a resident on a mechanical soft diet. And she also indicated she did not believe cheese puffs were either. She indicated she would check to see if the resident had a speech

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therapy evaluation and would provide a copy.

On 4/27/2023 at 1:33 P.M., the Vice President of Regulatory Compliance provided the policy titled, "Therapeutic Diet Orders". The policy indicated, " ...The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences ..."Mechanically Altered Diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids ...3. Therapeutic diets are provided only when ordered by the attending physician or a registered or licensed dietician who has been delegated to write diet orders, to the extent allowed by state law ....5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form ...."

The past noncompliance began on 4/20/2023. The tag was removed and the deficient practice corrected by 4/21/2023 after the facility implemented a systemic plan that included the following actions: an investigation of the diet received for Resident B on 4/20/2023, a review of all facility residents' dietary orders and recommendations with emphasis on mechanically altered diets, a review of all dietary department tray tickets for all residents, education provided to nursing staff and dietary staff that regarded appropriate diets were plated and served to residents, applicable facility policies and procedures for diet consistencies, a meal grid was placed in each dining area for easy identification of meal types, substitutions for items

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| F 805 | Continued From page 8<br>on the menu to be logged and approved by the Registered Dietician or clarified if needed, continued supervision for all food preparation and meals provided for three months, and nursing and dietary services to continue audits for the next four months.<br><br>This Federal tag relates to complaint IN00407017.<br><br>1.3-21(a)(3) | F 805 | | |