STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	04/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00351093. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00351093 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689 and F803. Survey dates: April 8, 9, 10, 11 and 12, 2021. Facility number: 000081 Provider number: 155162 AIM number: 100289570 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 9 Medicaid: 39 Other: 8 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 15, 2021.	F 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after 4/30/21 . We respectfully request a desk review in lieu of a post survey revisit.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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

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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview the facility failed to ensure a resident with dysphagia and at risk for choking received supervision while eating for 1 of 4 residents at risk for choking. This deficient practice resulted in the resident choking, coded and the emergency services being called and the resident hospitalized. The resident later died on 4/8/2021. (Resident B). The immediate jeopardy began on 4/5/21 when a Dietary Aide served Resident B a tray of food and left the resident with no assistance or supervision. The Administrator and Nurse Consultant were notified of the immediate jeopardy at 1:11 p.m. on April 9, 2021. The immediate jeopardy was removed on 4/11/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Resident B's clinical record was reviewed on 4/8/21 at 9:58 a.m. Diagnoses included, but were not limited to, unspecified intellectual disabilities, other intellectual disabilities, unspecified dementia without behavioral disturbance, age-related cognitive decline, bipolar disorder, gastro-esophageal reflux disease without esophagitis, dysphagia, unspecified note: esophageal and dysphagia, oropharyngeal phase. Her orders included, but were not limited to,	F 0689	**F 689 –Free of Accident Hazards/Supervision/Devices** It is the practice of this provider to ensure the resident environment remains as free of accident hazards as is possible, and each that each resident receives adequate supervision and assistance devices to prevent accidents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** · Any residents who require supervision while eating have the potential to be affected by this finding. · Speech Therapy will screen all residents who are coded as total dependent, extensive assist, limited assist, and supervision for eating and will recommend level of supervision during meals. These screens will be completed on or before 4/11/21.	04/30/2021

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	consistent carbohydrate, mechanical soft, ground meat, special instructions: Kennedy cups (a spill proof cup with lid) and divided plate with meals started on 2/12/21 and speech therapist to treat three times week for eight weeks for oropharyngeal dysphagia treatment will include restorative exercise, compensatory strategy training, and staff/caregiver as indicated started on 01/19/2021. A 5-day admission Minimum Data Set (MDS) assessment, dated 1/21/21, indicated the resident was moderately cognitively impaired. She required extensive assistance of one staff member for eating. She required a therapeutic diet and she had no swallowing disorders. She had no natural teeth or tooth fragment(s) (edentulous). A physician evaluation and management report for a swallow study performed on 1/26/21 indicated the resident was seen due to problems with eating and drinking. The diet recommendations were to give pills, one at a time in puree carrier. The following actions were recommended regarding the patient's feeding: small bites/sips, alternate bites/sips, precautions during mouth feeding: speech language therapist and trained staff only, small bites/sips, cueing for strategies: allow extra time, aspiration precautions: monitor for pulmonary status, reflux precautions: head of bed no lower than 45 degrees all other times, upright at 90 degrees during by mouth and 45 minutes after meals, monitor patient for adequate nutrition and hydration. A 2/3/21 reviewed/revised care plan indicated the resident was at risk for aspiration related to diagnosis of dysphagia. Her goal was that she		· Care plans and resident profiles will be updated to reflect the required need of supervision during resident meals per ST recommendations. These were completed by 4/11/21. · Inservice all staff per Executive Director/Designee by 4/11/21. Inservice to cover ONLY nursing to order resident meal trays from Culinary and required supervision for residents during resident meals. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · Inservice all staff per Executive Director/Designee by 4/11/21. Inservice to cover ONLY nursing to order resident meal trays from Culinary and required supervision for residents during resident meals. · Residents who require supervision for eating will be encouraged to eat each meal in the Assist Dining room. This was initiated on 4/11/21. · Nursing department will be completing a supervision log for each meal that signifies the Nurse or designee provided supervision for meal service through the entirety of the meal. This was initiated on 4/11/21. · Speech Therapy will screen all new admissions/readmissions, and all	

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	would be free from symptoms of aspiration. Interventions included, but not limited to, diet as ordered and observe for symptoms of aspiration, which included choking, frequent cough that occurs before/during or after swallowing, runny nose while eating. A diet order and communication form from Speech Therapist 17, dated 2/8/21, indicated there was a diet change, mechanical soft with thin liquids and needed divided plates and a Kennedy cup. A 2/18/21 reviewed/revised care plan for the resident required assistance with Activity of Daily Living(ADLs) including eating. Interventions included, but were not limited to, may use divided plates and Kennedy cups with meals, assist with eating and drinking as needed, assist with oral care at least two times daily, upper and lower dentures. A diet order and communication form from Speech Therapist 17, dated 3/10/21, indicated a diet order for controlled carbohydrates, a mechanical soft diet and she needed a divided plate and a two handled spout cup. A Speech Therapist progress note, dated 4/1/21, indicated Impact on Burden of Care/Daily Life: the patient continued to require set up assist prior to and supervision during intake. Patient required set up assist for bolus size modifications, large food items to be cut to bite-size due to decreased safety awareness, decreased safety judgement, and poor ability to bite due to edentulous status. Due to impulsivity and poor safety judgement, she required verbal cues to slow rate of intake, finish one bolus prior to initiating another. She continued to require		residents triggering for a diet downgrade to identify the needed supervision during resident meals. · Speech Therapy will complete the Therapy Recommendation log and review with DNS/Designee during daily clinical meeting. Resident care plan and profile will be updated during clinical meeting with identified recommendation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place:** ·Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive Director. ·DNS or designee will document on the "Supervision during meals QAPI Audit Tool" daily for 6 weeks, weekly x 6 months, and monthly thereafter until compliance is achieved. ·If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 4/30/21	

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	modified diet of mechanical soft secondary to poor ability to masticate, poor oral control, poor lingual coordination and Base of Tongue (BOT) strength, poor pharyngeal constriction. She continued to require adaptive equipment i.e. spout cup or Provale cup to facilitate rate of liquid intake. She continued to require handled cup and divided plate to facilitate self-feeding. She continued to require reflux precautions secondary to esophageal reflux and retention. Precautions: Supervise by mouth intake, soft diet, cut foods to bite-size, poor safety awareness, poor recall, high fall risk, weight bearing as tolerated for her left lower extremity. A nurse's note, dated 4/5/21 at 1:45 p.m., indicated the resident was in the dining room eating when a CNA noted the resident choking, the Heimlich was performed at that time, a finger sweep was performed three times and was unsuccessful. The resident was moved to her room at that time Cardiopulmonary Resuscitation (CPR) was initiated and 911 was called. On 4/5/21 at 1:58 p.m., the local fire department was at the facility and CPR continued. On 4/5/21 at 2:17 p.m., the local fire department (Emergency Management Team) EMTs continued with CPR, pulse and respiration was revived. Resident was transported to a local hospital's emergency room. During an interview with Dietary Cook 15, on 4/8/21 at 11:14 a.m., she indicated on 4/5/21 someone had called down to the kitchen and requested a peanut butter and jelly sandwich because the resident didn't like what she had on her tray. She prepared the peanut butter and jelly			

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	sandwich, a banana, an oatmeal creme pie and a chocolate milk and took the tray upstairs, Activity Aide 21 was in the dining room with another CNA and indicated she thought the resident had already ate, Dietary Cook 15 indicated to Activity Aide 21 that the resident didn't like what was on her tray and she placed the tray in front of the resident. During an interview, on 4/8/2021 at 11:28 a.m., QMA 12 indicated she was passing medication and one of the CNAs said the resident was choking, QMA 12 went to the dining room and did the Heimlich maneuver on her while she was in her wheelchair and told the CNA to get the nurse and the DON came to the dining room. The DON did an assessment on the resident and took her to her room, then QMA 12 grabbed some oxygen supplies and other supplies the DON needed. She was unaware if anyone was in the lounge with the resident when she started choking because she was passing down the hall where the DON's office. One of kitchen staff brought the peanut butter and jelly sandwich up to the resident because she didn't care for the food they had that day. During an interview, on 4/8/21 at 11:35 a.m., CNA 29 indicated the CNAs were in and out of the dining room doing weights because Resident B was done eating. She didn't know who called down to the kitchen and asked for the sandwich. Therapy worked with her, the resident could feed herself, they would set her up, get her started and she would do it herself. During an interview, on 4/8/21 at 12:00 p.m., Speech Therapist 17, indicated the resident was on her caseload, she was working with her on rate of intake because she liked to eat quickly and not			

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	finish the bite in her mouth before she took another bite. She needed verbal and tactile cues, she followed verbal cues well. She was also working on taking smaller bites and smaller drinks, she was not cognitively aware of safety and her fine motor skills were not great. She had not worked with her on the day she choked. She had recommended supervision in the resident's progress notes and the swallow study recommended supervision also. She did verbal education with the nursing staff and reviewed the recommendations from the swallow study a couple months ago but there had been a lot of new staff since then and didn't know if it got carried over. She worked with peanut butter and jelly with the resident and would cut it up for her and would cue her, she didn't feel it was safe for her to eat unsupervised. During an interview, on 4/8/21 at 2:01 p.m., Physical Therapist 34, indicated he completed an evaluation at a table in the dining room on third floor around the same area as Resident B had choked. He had glanced over and noticed Resident B started to choke and the CNAs were standing in the hallway behind the resident. He ran to the nurse who was standing at the medication cart and told her the patient was choking and she started doing the Heimlich maneuver on the resident. She was not purple, she was starting to choke. A review of the hospital notes on 4/9/21 at 9:30 a.m. indicated the following: History of Present Illness (HPI) dated 4/5/21 from the local hospital Emergency Room (ER) indicated the resident presented emergency department status post respiratory and subsequent cardiac arrest. She had multiple			

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	medical problems. She was found unresponsive. First responder found her pulseless and started CPR. She had full Advanced Cardiovascular Life Support (ACLS) protocol. She was apparently found in asystole. She had a few rounds of epinephrine and about 20 minutes of chest compressions. She was intubated. She apparently had a large amount of peanut butter sandwich removed from her airway. She regained pulses and transported to the ER. There was no trauma. Medical Decision Making (MDM) dated 4/5/21 from the local hospital ER indicated the resident was hydrated and maintained on a ventilator. Antibiotics were initiated for possible pneumonia and urinary tract infection. She required sedation and had a satisfactory blood pressure and heart rate at that time. She would be transferred to a larger hospital and remained generally unchanged during the emergency department course. A Communication with Primary Treatment Team from the larger hospital, dated 4/8/21, indicated the resident's family was at bedside and poor prognosis, completed hypothermia, Electroencephalogram(EEG) with no epileptic waveform with goals and process of compassionate extubation was discussed. Family planned for compassionate extubation sometime that day. A progress note dated 4/8/21, at 4:17 p.m. indicated the resident was extubated to room air. A hospital progress note, dated 4/8/21 at 6:54 p.m., indicated the resident's respirations had ceased. A hospital progress note, dated 4/8/21 at 8:25			

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	p.m., indicated the event that lead to death was the patient choked on a peanut butter sandwich and then cardiac arrest. Diagnosis was cardiac arrest. Date and time of death was 4/8/21 at 6:54 p.m. During an interview with the Administrator and the Nurse Consultant, on 4/9/21 at 2:34 p.m., the Administrator indicated a housekeeper had called down to the kitchen to order the resident's food. A current facility policy, revised on 2/2015, titled "Deliver and Documentation of Meal Service and Between Meal Nourishments," provided by the Nurse Consultant on 4/8/21 at 3:00 p.m. indicated the following: "...PROCEDURE, Delivery, The Nursing Department with the assistance of the Dietary Department will be responsible for the delivery of meals and nourishments and ensuring that all efforts are made to assist residents during meal and nourishment times. The Licensed Nurse is responsible for the supervision and coordination of CNAs during these daily activities...Specific mealtime responsibilities are: Provide assistance needed for meal set up (i.e. buttering bread, opening condiment packages, opening removing covers on foods and beverages). Assist residents in eating as needed...Review tray identification card...Substitutes for Food Refusals...Substitutes should be offered which are within the parameters of any therapeutic diet order...In the event that a resident consistently will accept only substitutes which are outside the parameters of the diet order, the Dietary Manger or Registered Dietitian will offer diet instruction and the benefits of the special diet to the resident's overall health. This will be documented in the medical record...."			

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	The immediate jeopardy that began on 4/5/21 was removed on 4/11/21 when the facility educated staff regarding supervision during meals including ordering meals for residents, Speech Therapy screened all residents who were coded as total dependent, extensive assist, limited assist and supervision during meals, but the noncompliance remained at no actual harm, but potential for minimal harm because all care plans and profiles had not been updated and education and monitoring had not been completed. This Federal tag relates to complaint IN00351093. 3.1-45(2)			
F 0803 SS=J Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;			

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	§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on record review and interview the facility failed to ensure a resident with dysphagia and at risk for choking received a diet in the correct form for 1 of 4 residents reviewed for a risk of choking. This deficient practice resulted in the resident choking, coding and the emergency services being called and resident hospitalized. The resident later died on 4/8/2021. (Resident B). The immediate jeopardy began on 4/5/21 when a Dietary Aide served Resident B a tray of food that was not in the correct form and left the resident to eat. The Administrator and Nurse Consultant were notified of the immediate jeopardy at 1:11 p.m. on April 9, 2021. The immediate jeopardy was removed on 4/11/21, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Resident B's clinical record was reviewed on 4/8/21 at 9:58 a.m. Diagnoses included, but were not limited to, unspecified intellectual disabilities, other intellectual disabilities, unspecified dementia without behavioral disturbance, age-related cognitive decline, bipolar disorder, gastro-esophageal reflux disease without esophagitis, dysphagia,	F 0803	F803 – Menus meet resident needs/prep in advance/followed: It is the intent of this provider that all residents will receive food in accordance with state and federal guidelines regarding menus, food prep, and nutritional value. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** • Any resident who has an altered diet (i.e pureed, mechanical soft, thickened liquids) has the potential to be affected they the deficient practice. • An in-service for all staff was completed by 4/12/21 per Executive Director/Designee on serving the appropriate meal/proper form per order as well as ordering food for residents.	04/30/2021

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	esophageal and dysphagia, oropharyngeal phase. Her orders included, but were not limited to, consistent carbohydrate, mechanical soft, ground meat, special instructions included to use Kennedy cups (a spill proof cup with lid) and divided plate with meals started on 2/12/21 and the speech therapist was to treat three times week for eight weeks for oropharyngeal dysphagia (the inability to initiate swallowing). The treatment would include restorative exercise, compensatory strategy training, and staff/caregiver as indicated started on 01/19/2021. A 5-day admission Minimum Data Set (MDS) assessment, dated 1/21/21, indicated the resident was moderately cognitively impaired. She required extensive assistance of one staff member for eating. She required a therapeutic diet and she had no swallowing disorders. She had no natural teeth or tooth fragment(s) (edentulous). A physician evaluation and management report for a swallow study performed on 1/26/21 indicated the resident was seen due to problems with eating and drinking. The diet recommendations were to give pills, one at a time in puree carrier. Meat diet was to be mechanical soft (all solids ground) and thin liquids. The following actions were recommended regarding the patient's feeding: a. small bites/sips b. alternate bites/sips Precautions during mouth feeding included: a. speech language therapist and trained staff only b. small bites/sips		• *A facility-wide audit of all resident diet orders and proper form was completed by the CM/designee on 4/10/21. Resident tray cards were updated with any changes noted during the tray card audit on 4/11/21. · Any residents identified with any altered diet will be screened by Speech Therapy to ensure proper form is being served/ordered. This was completed on 4/11/21. · All care plans and resident profiles were updated to reflect the proper form/diet. This was completed on 4/11/21. · * Resident tray cards were updated on 4/11/21 by CM to reflect any changes to a resident's diet to ensure tray card reflected the ordered diet in proper form. There were no resident's whose diet order/form did not match the tray cards. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** · In-service for all staff per Executive Director/Designee was completed on or by 4/12/21 on serving the appropriate meal/proper form per order as well as ordering food for residents.	

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	Cueing strategies included: a. allow extra time A diet order and communication form from the Speech Therapist (ST) 17, dated 2/8/21, indicated there was a diet change, the resident was to have a mechanical soft diet with thin liquids and needed divided plates and a Kennedy cup. A diet order and communication form from Speech Therapist 17, dated 3/10/21, indicated a diet order for controlled carbohydrates, a mechanical soft diet and she needed a divided plate and a two handled spout cup. A nurse's note, dated 3/14/21 at 12:56 a.m., indicated the resident had behaviors that shift and yelled out profanities throughout the shift. Resident had been given two cookies, fresh ice water, a strawberry ensure, and potato chips. An ST progress note, dated 4/1/21, indicated Impact on Burden of Care/Daily Life: the patient continued to require set up assist prior to and supervision during intake. Patient required set up assistance for bolus size modifications, large food items to be cut to bite-size due to decreased safety awareness, decreased safety judgement, and poor ability to bite due to edentulous status. Due to impulsivity and poor safety judgement, she required verbal cues to slow rate of intake, finish one bolus prior to initiating another. She continued to require modified diet of mechanical soft secondary to poor ability to masticate, poor oral control, poor lingual coordination and Base of Tongue (BOT) strength, poor pharyngeal constriction. She continued to require adaptive equipment i.e. spout cup or Provale cup to facilitate rate of		· *Resident's tray cards will be monitored for each meal by Culinary Cook to ensure the proper diet/form is served. * * Resident tray cards will be updated when there is a change of diet/form, and will be audited by the Culinary Manager for each resident in accordance with their scheduled MDS assessment. · Culinary Cooks will keep a log each meal to validate the tray cards were monitored for proper diet/form. · DNS/Designee will round during each meal to ensure the proper diet/form is served. · Speech Therapy will screen all new admissions/readmissions or residents who experience a change in condition related to change in diet to determine the proper food form the resident should receive. · Only Nursing staff will call Culinary to notify them if a resident is requesting something different than what was on the menu. The Culinary Cook will deliver the food to the member of the Nursing team who ordered the food. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place:**	

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	liquid intake. She continued to require handled cup and divided plate to facilitate self-feeding. She continued to require reflux precautions secondary to esophageal reflux and retention. Precautions: Supervise by mouth intake, soft diet, cut foods to bite-size, poor safety awareness, poor recall, high fall risk, weight bearing as tolerated for her left lower extremity. A nurse's note, dated 4/5/21 at 1:45 p.m., indicated the resident was in the dining room eating when a CNA noted the resident choking, the Heimlich was performed at that time, a finger sweep was performed three times and was unsuccessful. The resident was moved to her room at that time CPR was initiated and 911 was called. On 4/5/21 at 1:58 p.m., the local fire department was at the facility and CPR continued. On 4/5/21 at 2:17 p.m., the local fire department Emergency Medical Technicians (EMTs) continued with CPR, pulse and respiration was revived. Resident was transported to a local hospital emergency room. A 4/6/21 reviewed/revised care plan for the resident indicated she utilized a full set of dentures and was at risk for mouth pain/problems due to use of dentures and needed assistance in caring for dentures. Her goal was that she would have clean, properly fitting dentures/bridge or partial, assure that device was fitting properly and assure that device was present before meals. Observe for any chewing. During an interview, on 4/8/21 at 11:10 a.m., the Dietary Manager, indicated the mechanical soft diets were anything that pertained to the meat and		• Ongoing compliance with this corrective action will be monitoring through facility QAPI Program, with meetings being held monthly and overseen by the Executive Director. • The "Proper Diet/Form QAPI Tool" daily x 6 weeks, weekly x 6 months, monthly thereafter until compliance is achieved. • If threshold of 100% is not met, an action plan will be developed. Findings will be submitted to the QAPI committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date = 4/30/21.	

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	vegetables, like salisbury steak would be served with gravy and peas would be pureed due to the pods, the peanut butter and jelly sandwich would probably not be mechanical soft. On 4/5/21 a staff member, not the therapist, called the kitchen and asked for the sandwich. The kitchen staff had taken the sandwich to the third floor. The kitchen staff should have looked at the diet order first before taking to the third floor. During an interview with Dietary Cook 15, on 4/8/21 at 11:14 a.m., she indicated on 4/5/21 the menu was ham and bean soup for lunch and someone had called down to the kitchen and requested a peanut butter and jelly sandwich because the resident didn't like what she had on her tray. She prepared the peanut butter and jelly sandwich, a banana, an oatmeal creme pie and a chocolate milk and took the tray upstairs, Activity Aide 21 was in the dining room with another CNA and indicated she thought the resident had already eaten, Dietary Cook 15 indicated to Activity Aide 21 that the resident didn't like what was on her tray and she placed the tray in front of the resident. Dietary Cook 15 indicated the food was soft and appropriate for the resident's mechanical soft diet. On her ticket it indicated the resident had a mechanical soft diet and a divided plate because she doesn't like her food touching, it did not indicate to cut up her food. It was not uncommon for the staff to call the kitchen and ask for a sandwich and she would deliver what they requested to the resident. During an interview, on 4/8/21 at 11:28 a.m., QMA 12 indicated she was passing medication and one of the CNAs said the resident was choking, QMA 12 went to the dining room and did the Heimlich maneuver on her while she was			

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	in her wheelchair and told the CNA to get the nurse and the DON came to the dining room. The DON did an assessment on the resident and took her to her room, then QMA 12 grabbed some oxygen supplies and other supplies the DON needed. She was unaware if anyone was in the lounge with the resident when she started choking because she was passing medication down the hall where the DON's office was located. One of kitchen staff brought the peanut butter and jelly sandwich up to the resident because she didn't care for the food they had that day. She had seen the dentures in the resident's room before and she thought the resident needed set up assistance for eating. During an interview on 4/8/21 at 11:35 a.m., CNA 29 indicated that on the day Resident B choked, the nurse instructed them to weigh the residents and that they needed to make a few beds. They weighed the residents in a closet in the dining room. CNA 22 and herself were taking turns weighing the residents. Lunch was over, they assisted the residents that needed assistance with eating and picked up all the trays in the dining room and down the halls including Resident B's meal tray. Dietary Cook 15 took the sandwich to Resident B's room and another CNA was making Resident B's roommates' bed and indicated to Dietary Cook 15 that Resident B was in the dining room and she had just finished lunch and that was why everyone was confused because she had already eaten. CNAs were in and out of the dining room doing weights because Resident B was done eating. She didn't know who called down to the kitchen asking for the sandwich. The resident wore dentures and refused them often and she was offered dentures in the morning. CNA 22 did put her dentures in that morning because when she went in to collect linens after			

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	CNA 22 performed morning care, CNA 22 was cleaning the dentures and had put them in her mouth. After the incident she thought they found the residents denture in her room in the denture cup. Therapy worked with her, the resident could feed herself, they would set her up, get her started and she would do it herself. During an interview on 4/8/21 at 12:00 p.m., The Speech Therapist 17, indicated the resident was on her caseload, she was working with her on rate of intake because she liked to eat quickly and not finish the bite in her mouth before she took another bite. She needed verbal and tactile cues, she followed verbal cues well. She was also working on taking smaller bites and smaller drinks, she was not cognitively aware of safety and her fine motor skills were not great. She had not worked with her on the day she choked. She had only known the resident to wear her dentures one time and that was when she first did her evaluation and she had worked with the resident five days a week for the last two months. The resident did not like her denture and they didn't fit due to weight loss. She offered the resident her dentures and she refused and said she didn't like to have them in. She had recommended supervision in the resident's progress notes and the swallow study recommended supervision also. She did verbal education with the nursing staff and reviewed the recommendations from the swallow study a couple months ago but there had been a lot of new staff since then and didn't know if it got carried over. She worked with peanut butter and jelly with the resident and would cut it up for her and cued her, she didn't feel it was safe for her to eat unsupervised. During a telephone interview with the resident's nurse at the hospital, on 4/8/21 at 1:22 p.m., she			

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	indicated the resident was being terminally weaned from the ventilator at 3:00 p.m. During an interview on 4/8/21 at 2:01 p.m., Physical Therapist 34, indicated he completed an evaluation at a table in the dining room on third floor around the same area as Resident B had choked. He had glanced over and noticed Resident B started to choke and the CNAs were standing in the hallway behind the resident. He ran to the nurse who was standing at the medication cart and told her the patient was choking and she started doing the Heimlich maneuver on the resident. A review of the hospital notes on 4/9/21 at 9:30 a.m. indicated the following: a. History of Present Illness (HPI), dated 4/5/21 from the local hospital ER indicated the resident presented emergency department status post respiratory and subsequent cardiac arrest. She had multiple medical problems. She was found unresponsive. First responder found her pulseless and started CPR. She had full ACLS protocol. She was apparently found in asystole. She had a few rounds of epinephrine and about 20 minutes of chest compressions. She was intubated. She apparently had a large amount of peanut butter sandwich removed from her airway. She regained pulses and was transported to the ER. b. Medical Decision Making (MDM), dated 4/5/21 from the local hospital ER indicated the resident was hydrated and maintained on a ventilator. Antibiotics were initiated for possible pneumonia and urinary tract infection. She required sedation and had a satisfactory blood pressure and heart rate at that time. She would be			

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	transferred to a larger hospital and remained generally unchanged during the emergency department course. c. An assessment from the larger hospital, dated 4/5/21, indicated the resident was orally intubated with oral gastric tube and her pupils were pinpoint, deviated upward. She was slightly coarse in her bilateral upper lung fields. She was having facial twitching, noted of mouth around eyes, no response to verbal stimuli. d. A Communication with Primary Treatment Team from the larger hospital, dated 4/8/21, indicated the resident's family was at bedside and poor prognosis, completed hypothermia, EEG with no epileptic waveform with goals and process of compassionate extubation was discussed. Family plans for compassionate extubation sometime that day. e. A palliative care assessment completed on 4/8/21, indicated the resident's palliative performance scale determined she was moribund-fatal processes progressing rapidly. She was intubated, her pupils were not reactive. She had decreased breath sounds and rhonci was present with no wheezing. Bowel sounds were decreased, and she had a urinary foley catheter. She was unresponsive, intubated with no spontaneous or purposeful movement. f. A progress note, dated 4/8/21 at 4:17 p.m. indicated the resident was extubated to room air. g. A hospital progress note, dated 4/8/21 at 6:54 p.m., indicated the resident's respirations had ceased. h. A hospital progress note, dated 4/8/21 at 8:25			

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	p.m., indicated the event that led to death was the patient choked on a peanut butter sandwich and then cardiac arrest. Diagnosis was cardiac arrest. Date and time of death was 4/8/21 at 6:54 p.m. During an interview with CNA 23, on 4/9/21 at 12:03 p.m., she indicated Resident B was on soften mechanical diet. They did not normally feed the resident peanut butter and jelly, therapy would give it to her, cut it up and watch her. The resident did not normally didn't eat alone. Sometimes the kitchen staff would deliver the food directly to the resident. The day the resident choked, she did not order any food and the other two CNAs that were working said they didn't order it, either. CNA 23 was observed during the interview on the kiosk, she indicated to find the diets for the residents, it would be on their profile and on the meal tickets. She clicked on a resident to find the diet and was unable to locate the diet. Then she tried to look up another resident and with much searching she found his diet. Then went back to the other resident to locate her diet. Someone would order food for a resident and kitchen staff would take it directly to the residents. There were normally two or three staff members in the dining room, they were in and out of the dining room weighing residents that day and the therapist was in there but she was not aware the resident had a second tray and was eating. A current facility policy, dated 9/1/13, titled "PROTOCOL FOR ALTERED DIET CONSISTENCY/THICKENED LIQUIDS," provided by the Administrator on 4/8/21 at 1:17 p.m. indicated the following: "Speech therapist determine an altered diet consistency and/or thickened liquids are necessary: 1. Speech Therapist to meet with resident and/or			

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	responsible party to discuss the recommendations to include: Reasons for the altered diet consistency and/or thickened liquids order i.e. chewing/swallowing difficulties, risk for aspiration. Risks associated with not following the recommendation for the altered diet consistency and/or thickened liquids. 2. Speech Therapy to complete Altered Diet Consistency Acknowledgement in Matrix...An altered consistency diet is any diet consistency that is not a regular consistency - Mech Soft, Ground or Chopped Meat, Puree, etc...." A current facility policy, revised on 2/2015, titled "Deliver and Documentation of Meal Service and Between Meal Nourishments," provided by the Nurse Consultant on 4/8/21 at 3:00 p.m. indicated the following: "...PROCEDURE Delivery The Nursing Department with the assistance of the Dietary Department will be responsible for the delivery of meals and nourishments and ensuring that all efforts are made to assist residents during meal and nourishment times. The Licensed Nurse is responsible for the supervision and coordination of CNAs during these daily activities...Specific mealtime responsibilities are: Provide assistance needed for meal set up (i.e. buttering bread, opening condiment packages, opening removing covers on foods and beverages). Assist residents in eating as needed...Review tray identification card...Substitutes for Food Refusals...Substitutes should be offered which are within the parameters of any therapeutic diet order...In the event that a resident consistently will accept only substitutes which are outside the parameters of the diet order, the Dietary Manger or Registered Dietitian will offer diet instruction and the benefits of the special diet to the resident's overall health. This will be documented in the			

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	medical record...." An undated paper titled, "Mechanical or Dental Soft Diet," provided by the Administrator on 4/9/21 at 9:34 p.m. from the Indiana Diet Manual, indicated the following: "Use: The mechanical soft or dental soft diet is for individual who have difficulty chewing regular textured foods, perhaps due to ill fitting dentures or worn teeth. The SLP (Speech Language Pathologist) may evaluate the individual to determine if the diet is appropriate. This diet may not be appropriate for individuals being treated for dysphagia ...Food allowed: Bread/grains: easy to chew breads, toast crackers, graham crackers, cooked pasta or rice, hot cereal, dry cereal moistened with milk ...Foods not allowed: dry tough meats, whole pieces of meat, bacon slices, peanut butter or cheese by itself, hot dogs ...." The Administrator indicated at that time the peanut butter was not allowed but the soft bread was on the allowed list. A document, titled "National Dysphagia Diet Mechanically Altered," provided by the Nurse Consultant on 4/9/21 at 2:34 p.m. and indicated they were following, the document indicated the following: Definition: This diet consists of foods that are mechanically altered by blending, chopping, grinding, or mashing so that they are easy to chew and swallow. Meat pieces are ground or minced and no larger that ¼-inch pieces. Foods are moist and soft textured to easily form a bolus. Foods in large chunks or foods that are too hard to be chewed thoroughly should be avoided. Indications: This diet is appropriate for individuals with dysphagia or chewing/swallowing issues as assessed by a speech-language pathologist. The chart indicated the foods that were recommended were soft			

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	pancakes, breads, sweet rolls, Danish pastries, French toasts well mositened, blended, chopped or ground to less than 1/4-inch thick with syrup or sauce...Smooth nut and seed butters, such as peanut butter, almond butter, and sunflower seed butter as tolerated, and ok if used in tolerated recipes. All seasonings and sweetners, inclluding honey, jams, jellies and perserves...." The immediate jeopardy that began on 4/5/21 was removed on 4/11/21 when the facility educated staff regarding serving the appropriate meal/proper form per order as well as ordering food for residents, an audit of all resident's diet orders and proper form and resident's that identified with any altered diet was screened by the Speech Therapy to ensure proper form was being served/ordered, but the noncompliance remained at at no actual harm, but potential for minimal harm because all care plans and profiles were not updated and education and monitoring had not been completed. This Federal tag relates to complaint IN00351093. 3.1-21(a)(3)			