STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 000	INITIAL COMMENTS	F 000		

A Complaint Investigation (CI), MS #16350, was initiated 11/4/19 - 11/5/19, and extended from 11/19/19 - 11/21/19, due to an Immediate Jeopardy (IJ), related to Neglect/Supervision. The State Agency (SA) substantiated CI MS #16350 for a resident choking after she was served the wrong diet. During the survey, the facility was found not to be in compliance with the requirement of participation in Medicare and Medicaid, and was cited deficiencies related to CI MS #16350. The SA also investigated CI MS #16416, which was not substantiated for Quality of Care, with no deficiencies cited.

During the investigation, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) existed at:
42 CFR(s): 483.12(a)(1)-Free from Abuse/Neglect (F600);
42 CFR(s): 483.25(d)(1)(2)-Free of Accidents Hazards/Supervision/Devices (F689);

IJ existed at:
42 CFR(s): 483.21(b)(1)-Develop/Implement Comprehensive Care Plan (F656);
42 CFR(s): 483.60(d)(3)-Food in Form to Meet Individual Needs (F805).

The SA identified the IJ and SQC existed on 10/24/19, when Resident #1 was served the incorrect diet consistency and choked. Resident #1 had physician's orders and a Care Plan for a Mechanical Soft Diet with Chopped Meat. On 10/24/19, at the noon meal, the facility served Resident #1 a Regular Diet with whole sliced turkey. Resident #1 choked on the sliced turkey and subsequently suffered a cardiopulmonary

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/18/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 000	Continued From page 1 arrest. The facility staff immediately began Cardiopulmonary Resuscitation (CPR), until the Emergency Management Technicians (EMTs) arrived, took over the CPR, and transported Resident #1 to a local Emergency Room (ER). At the ER, Resident #1 was placed on a ventilator and admitted to the Intensive Care Unit (ICU), where she was treated for Respiratory Failure, due to an obstructed airway. Resident #1 remained in ICU at the local hospital from 10/24/19, until her death on 10/27/19, at approximately 9:15 AM, related to Respiratory Failure. The facility's failure to provide the correct diet for Resident #1, in the texture ordered by the physician, resulted in the choking of the resident and treatment for Respiratory Failure, which resulted in death. This failure placed other residents with a mechanically altered diet in a situation that was likely to cause serious injury, harm, impairment or death. Based on the facility's implementation of corrective actions on 10/25/19, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ removed as of 10/26/19, prior to the SA's first entrance on 11/4/19. The SA notified the Administrator on 11/19/19, at 3:30 PM, of the PNC IJ and SQC. At the time of the extended survey, the facility census was 97, and the facility held a license for 120 beds.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		12/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 2 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure Resident #1 was free from neglect, as evidenced by, staff failed to check the meal ticket and actual diet to ensure correct texture and consistency was provided for one (1) of four (4) residents reviewed, of 39 residents who received mechanically altered diets. The facility staff also acted in a dishonest manner in an attempt to make it appear Resident #1 received the correct diet, by switching meal tickets. An Immediate Jeopardy (IJ) was determined to exist when the facility neglected to serve Resident #1 a Mechanical Soft Diet with Chopped Meats, as ordered. On 10/24/19 at approximately 12:10 PM, Resident #1 was served a Regular Diet with sliced turkey (not chopped) and at approximately 12:15 PM, the resident became choked on the turkey. The facility staff performed the Heimlich maneuver, and began Cardiopulmonary	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 3	F 600		

Resuscitation (CPR), until the resident was transported to a local hospital Emergency Room (ER). Resident #1 was placed in the Intensive Care Unit (ICU) on a ventilator and expired on 10/27/19, as a result of the choking episode and Respiratory Failure.

The facility's failure on 10/24/19, to serve Resident #1 the correct diet consistency/texture of a Mechanical Soft Diet with Chopped Meats, as ordered, caused the resident to choke, and subsequently expire. This placed other residents with mechanically altered diets in a situation that was likely to cause serious harm, injury, impairment or death.

Based on the facility's implementation of corrective actions as of 10/25/19, prior to the State Agency's (SA) entrance on 11/4/19, the SA determined the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to be Past Non-Compliance (PNC) and the IJ was removed as of 10/26/19.

The SA notified the Administrator of the PNC IJ and SQC on 11/19/19 at 3:30 PM.

Findings Include:

Review of the "Suspicion of Abuse, Neglect, Exploitation and/or Injuries of Unknown Origin to Individuals Receiving Services" policy, revised January 2019, revealed: Neglect is the failure to supply an Individual Receiving Services (IRS) with food, shelter, clothing, or other services necessary to maintain physical and mental health. All employees will immediately report witnessing of or discovery of any situation in which suspicion exists that an IRS has been the victim of neglect.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 4	F 600		

Review of Special Food Services Protocol: Therapeutic Programming Snack and Special Event (Protocol 01-01), dated July 2013, revealed: Staff will identify the resident, prior to serving food, by viewing the resident identification bracelet. Staff assisting with meal service will be familiar with special diet considerations, which are part of the Physicians Order List (POL). This includes identification of food consistency required by any listed diet and any special considerations. If the POL is not present in the dining room, then NO food or beverage may be offered until the list is available and checked for reference.

Review of the Food Service Duties: (Quick Reference), dated July 2013, revealed: The Nurse must check the POL with the meal service ticket, and the Certified Nursing Assistant (CNA) must check the identification bracelet. Both the Nurse and CNA must check the basic diet and consistency of food, prior to serving the diet/tray to the resident.

Review of Resident #1's medical record revealed a physician's order, initiated on 6/3/19 for a Mechanical Soft Diet with Chopped Meats, after a choking episode on 6/2/19. Speech Therapy treated Resident #1 for the diagnosis of Dysphagia, Oropharyngeal Phase from 6/3/19, until hospitalized on 8/2/19, related to increased temperature. Resident #1 was readmitted to the facility on 8/7/19, with a continued diagnosis of Dysphagia and Mechanical Soft Diet with Chopped Meats.

Review of the facility's "Investigative Summary Report", dated 10/24/19, revealed Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 5	F 600		

choked after eating a Regular diet tray, which contained a slice of whole turkey. Resident #1 was ordered a Mechanical Soft Diet with Chopped Meat. Abdominal thrusts were performed. Resident #1 became unresponsive and was lowered to the floor. CPR was initiated. Resident #1 was noted to be in respiratory distress from choking. Resident #1 was transferred to the local hospital for further medical treatment. The Investigative Report revealed, CNAs #1, #2, #3 and RN #1, violated established facility Protocol #01-01, which included not checking for proper resident identification and ordered diet. These staff also switched meal tickets between Resident #1 and #2 to make it appear Resident #1 received the right diet. These staff were suspended and terminated for the violations. The report included a section titled, "Accident/Incident Type" which documented, Resident #1's death was a result of staff negligence/procedural violation.

An interview with the Director of Nursing (DON), on 11/4/19 at 10:30 AM, confirmed CNAs #1, #2, #3 and RN #1, had been trained on Diet and Tray Service and Abuse/Neglect, but chose to be dishonest and not follow the protocol, and they knew better. They switched the diet sheets and names off of the meal trays for Resident #1. The DON stated Resident #1's choking incident was recorded via video cameras and uncovered the dishonest acts of the staff.

During an interview on 11/4/19 at 11:00 AM, the Administrator confirmed a photograph of Resident #1's meal tray and ticket, was taken by Speech Therapist #2 on 10/24/19. Review of the photograph, identified what appeared to be a piece of unchopped meat on Resident #1's meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 6	F 600		

tray. In the photograph, Resident #1's meal ticket was sitting beside the tray, which documented: one-half (1/2) cup chopped turkey with gravy. The meal ticket did not match what was identified on the tray for Resident #1's noon meal.

During an interview and review of video footage with the Administrator on 11/4/19 at 11:00 AM and again at 4:30 PM, the Administrator confirmed Resident #1 had been served unchopped turkey at the noon meal on 10/24/19. Resident #1 choked on the unchopped turkey and expired at the local hospital on 10/27/19, as a result of receiving the wrong diet. The Administrator stated he and Licensed Practical Nurse (LPN) #1/Facility Investigator, reviewed the video of the choking incident and discovered four (4) staff, Certified Nursing Assistants (CNAs) #1, #2, #3 and Registered Nurse (RN) #1, failed to verify and serve the appropriate diet to the resident. The video revealed all three (3) CNAs left Resident #1 with the meal tray and the Resident began to cram large amounts of the turkey in her mouth, without swallowing/rests between bites, and she began to choke. The Administrator stated staff attempted to cover up the choking incident, by switching the meal tickets to make it appear Resident #1 received the correct diet and they "knew better."

In an interview on 11/4/19 at 11:15 AM with Licensed Practical Nurse (LPN) #1/Investigator, revealed he had done a complete investigation of all of the events and found that staff members, CNAs (CNA #1, CNA #2, & CNA #3) and Registered Nurse (RN#1), were responsible for the wrong diet being served to Resident #1 on 10/24/19, at the noon meal. LPN #1 stated the four (4) staff had not been truthful about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 7	F 600		

events of the incident on 10/24/19 of Resident #1's choking. CNA #1 and #3 switched the tray tickets to indicate Resident #1 and #2 had received the correct diet. Resident #2 was to have received a Regular Diet, but instead received a Mechanical Soft Diet meant for Resident #1. CNA #1 served Resident #1 the Regular Diet meant for Resident #2. LPN #1 confirmed the four (4) staff involved were negligent on the procedure for following the established Food Service protocol for serving food trays to the residents in the dining room. LPN #1 stated the four (4) staff involved in the choking incident of Resident #1, on 10/24/19, "knew better" and they did not follow the training they had been given.

Interview on 11/5/19 at 11:20 AM, with the Director of the Rehabilitation Department and Speech Therapist (ST) #2, confirmed ST #2 observed Resident #1 choking and she took a photo of the tray Resident #1 had been eating prior to choking on 10/24/19. The Director of the Rehabilitation Department, confirmed Resident #1 was served the wrong diet texture and wrong diet consistency at the noon meal on 10/24/19, that resulted in Resident #1's choking and ultimate death.

During an interview on 11/4/19 at 12:00 PM, the facility's Educator, Registered Nurse (RN) #2, confirmed all staff are trained and were aware of the policies and procedures for Abuse and Neglect and on the "Food Service Duties: (Quick Reference)." RN #2 stated all four (4) staff, (CNA #1, #2, #3 and RN #1), involved in the choking incident of Resident #1, on 10/24/19, had knowledge of the POL, which included Resident #1's diet of Mechanical Soft with Chopped Meat,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 8	F 600		

and failed to follow the policies and procedures. Review of a typed statement, undated, revealed RN #2 documented new employees are educated on how to read a meal ticket, how to pass trays out to residents to verify the correct meal is what is on the plate, and following the Care Guide (Care Plan). She documented failure to follow this process is Abuse/Neglect.

In an interview with the Quality Assurance (QA) Nurse on 11/5/19 at 10:30 AM, revealed the QA Committee met on 10/24/19 at 4:00 PM, and reviewed the choking incident of Resident #1, along with policies and procedures of Abuse/ Neglect, Care Plans, Safe Service of Diets, Accidents Hazards and reporting incidents. The QA Committee determined the failure to follow the established procedures to ensure residents were served the right diet caused Resident #1 to choke and subsequently expire. The dishonest switching of the food tray tickets by the CNAs and the failure to serve the correct diet, was considered a result of staff negligence.

During an interview, on 11/5/19 at 10:50 AM, the Care Plan Nurse Coordinator/Registered Nurse (RN) #5, revealed Resident #1 has been ordered a Mechanical Soft Diet with Chopped Meats, on 6/3/19. RN #5 confirmed the POL dated 10/24/19, did document Mechanical Soft Diet with Chopped Meats for Resident #1. RN #5 confirmed the POL was printed and distributed daily to the dietary department and to each of the nursing stations. RN #5 stated the POL is used to check the food trays against the food tickets for each resident's food tray. RN #5 verified the RN assigned (RN #1) to the dining room was responsible for checking the POLs and the food tickets prior to the CNAs serving the food trays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 9	F 600		

RN #5 stated the order/care plan for Resident #1 was not followed on 10/24/19, which resulted in the choking of Resident #1.

The negligent action by RN #1 of not checking Resident #1's diet, prior to serving, and CNA #1 serving the resident the wrong diet, resulted in the resident's death.

On 11/21/19 at 1:15 PM, an attempt was made to contact CNA #3 by phone without success. Review of a documented statement by CNA #3, dated 10/24/19 at 4:23 PM, revealed Resident #2 was observed eating food from a meal tray with Resident #1's name on the ticket. CNA #3 documented she checked the meal tray, served to Resident #1 by CNA #1, which had dressing, roll and turkey. CNA #3 documented, "give me the ticket."

On 11/21/19 at 1:20 PM, an attempt was made by phone to contact CNA #1 without success. Review of a documented statement by CNA #1, dated 10/24/19 at 2:07 PM, revealed she confirmed Resident #2 ate Resident #1's noon meal tray on 10/24/19, and she gave Resident #1 the meal tray, which belonged to Resident #2. The statement documented, RN #1 opened the lid of Resident #2's tray, stated it was the same food, and instructed CNA #1 to give the meal tray to Resident #1. CNA #1 documented, "I did what I was told and put the tickets with the tray."

In an interview by phone, on 11/21/19 at 2:50 PM, RN #1 confirmed she checked the food tray tickets against the Physician's Order List (POL). RN #1 stated she learned how to check the food tray tickets against the POL by other nurses passing the information to her in reports. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 10	F 600		

stated she had never been trained on the procedure of checking food trays against the POL and/or serving meal trays. RN #1 stated she did pass out trays and did not hand trays to CNAs. RN #1 stated she never told CNA #1 to serve Resident #1 the food tray of Resident #2; she told CNA #1 to give Resident #1 another tray that was the same diet, which was Mechanical Soft with Chopped Meats. RN #1 stated she resigned her position at the facility.

Review of the facility's individual training records and documented in-services revealed, all three (3) CNAs and RN #1 were in-serviced on Abuse/Neglect, New Employee Orientation, Meal and Hydration, Serving Meals in the Dining Room and Armband Checks prior to the choking incident of Resident #1.

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions, prior to the State Agency (SA) entrance on 11/4/19.

In response to the Immediate Jeopardy (IJ) that was cited at 3:30 PM on 11/19/19, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility, to remove the Immediate Jeopardy (IJ):

1. Description Of Incident:
Resident #1 was a 63 year old white female, admitted to the facility, on April 24, 2019. Resident #1 had an admitting diagnosis of Alzheimer's Type Dementia. Resident #1 was admitted on a Regular Diet with No Corn, due to allergies. On June 3, 2019 at 8:45 AM, Resident #1's diet was changed, by the physician, from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 11	F 600		

Regular Diet to a Mechanical Soft with Chopped Meat Diet, due to having a choking episode while eating peaches. On October 24, 2019 at 12:15 PM, Resident #1 choked, while eating lunch in the dining room, due to receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, as ordered by the physician, and the care plan. Resident #1 passed away, on October 27, 2019 at 9:15 AM, at the local hospital, due to Respiratory Failure/Congestive Heart Failure, per local hospital records.

2. The facility's Hospital Director and Nursing Home Administrator were notified of the incident on October 24, 2019 at 12:30 PM, by the facility's Dietary Manager. The Hospital Director gave directives to refer the incident to Investigative Services and the Quality Assurance Department. Investigative Services arrived at the facility and began an investigation of the incident on October 24, 2019 at 12:55 PM.

3. Measures Implemented:
The Quality Assurance (QA) Committee held an Emergency QA Meeting on October 24, 2019 at 4:00 PM, with the following staff: Nursing Home Administrator, Nurse Manager, Medical Nurse Practitioner (Representing the Medical Director), Minimum Data Set (MDS) Coordinator, Contract Rehab Director, Nurse Supervisor, QA Nurse, and Investigator. The QA Committee reviewed the Abuse, Neglect and Exploitation Policy, discussed Accidents and Hazards; the QA Committee did not recommend any changes at this time. The QA Committee also reviewed the Food Service Duties Quick Reference and Resident #1's Care Plan. The QA Committee found that RN #1 and CNAs #1, #2 and #3 failed to follow the Food Service Duties Quick

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 12	F 600		

Reference, which resulted in Resident #1 receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, that was ordered by the physician, and noted on the care plan. The QA Committee recommended to immediately begin training all staff on following the Food Service Duties Quick Reference and following residents diets as care planned, to prevent accidents and hazards. The QA Committee recommended all staff on duty be trained before the next meal was served.

The QA Committee also recommended that RN #1 and CNAs #1, #2, and #3 be placed on Administrative Leave, for serving Resident #1 the wrong diet, and not following policy and procedure. The QA Committee identified 39 of 101 residents, who were on mechanically altered diets, had the potential to be affected, by receiving an incorrect diet. On October 24, 2019 at 5:00 PM, the Quality Assurance Nurse performed chart audits of the 39 residents, who had the potential to be affected, and found that no changes were needed.

4. Training/In-services:
On October 24, 2019 at 4:30 PM, the Nurse Supervisor began in-services on the Food Service Duties Quick Reference procedures for passing out meal trays with all staff. All staff working were trained prior to the next meal being served. The Nurse Supervisor began training for the oncoming night shift employees at 6:30 PM. On October 25, 2019 at 6:30 AM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. On October 25, 2019 at 6:30 PM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. All In-services were completed by October 25, 2019 at 7:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 13	F 600		

Any staff that did not receive this training will be trained immediately upon returning to work. The following In-services covered:

Accidents and Hazards and Supervision - All staff were trained on the Nurse checking the Physician Order List (POL) against the tray ticket, supervision of the resident getting the correct meal tray. If supervision is not carried out it could result in a hazard and/or accident.

Abuse/Neglect - All staff were trained on how to check the diet to ensure the correct diet consistency is on each meal tray for that particular resident per the Physicians Order List (POL).

Diet - All staff were trained on the Nurse checking the Physicians Order List (POL) with the tray ticket for correct diet consistency, and whoever delivers the tray to the resident, must remove the lid from the tray to check the consistency of the food on the tray to the meal ticket.

Care Plan - All staff were trained on each individual resident's diet consistency that is listed on the Physicians Order List (POL), which reflects the resident's Plan of Care.

5. All staff, including new hires, will receive training on food service prior to being able to work.

6. Disciplinary Actions:
On October 24, 2019, after the investigation was initiated, it was determined there was enough evidence to place CNAs #1, #2, #3 and RN #1 on administrative leave pending completion of the investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 14	F 600		

RN #1 resigned from employment on October 25, 2019.
CNA #1 was terminated from employment effective October 31, 2019.
CNA #2 was terminated from employment effective October 30, 2019.
CNA #3 was terminated from employment effective October 30, 2019.

7. Notification of State Agencies:
On October 24, 2019 at 4:52 PM, the facility's Investigator notified the Mississippi State Department of Health (MSDH) by telephone.

On October 25, 2019 at 9:20 AM, the facility's Investigator notified The Mississippi Attorney General's Office in writing of the incident.

8. Removal of Immediate Jeopardy:
All activities to remove the Immediate Jeopardy were accomplished on October 25, 2019, and the facility alleges that the removal of the Immediate Jeopardy was effective as of October 26, 2019.

The State Agency (SA) validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, interview, and facility record review.

1. The SA validated through record review, staff interview, and video tape review of the incident, on 10/24/19, of Resident #1 choking in the dining room during the noon meal. The SA surveyor watched the video along with the facility Administrator. The SA validated Resident #1 had an order for a Mechanical Soft Diet with Chopped Meat and was served a Regular Diet with Whole Sliced Turkey on 10/24/19. Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 15	F 600		

transferred to the hospital after a choking episode from the incorrect diet. Resident #1 expired on 10/27/19, related to the incident.

2. The SA validated the facility began an investigation of the choking incident on 10/24/19, after notification to the Administrator.

3. The SA validated the Quality Assurance (QA) signature sheets and documentation of the QA meeting, that was held on 10/24/19. Interviews with the facility Administrator and QA Nurse/RN #4, validated the QA meeting of 10/24/19. Interviews with the Director of Nursing (DON), the Minimum Data Set (MDS) Care Plan Coordinator/RN#5, and the QA Nurse/RN #4 validated that the orders and care plans of the 39 residents who had mechanically altered diets, were audited with no changes. The QA meeting included recommendations for training of staff for following resident's diets, as care planned, to prevent accidents and hazards. The SA interviewed the QA Nurse on 11/05/19, and validated the signature sheets and the topics discussed in the QA meeting. The QA Nurse confirmed some of the topics discussed in the QA meeting were Abuse and Neglect; Care Plans, Residents Diets and Service of Diets, Safety of Residents, and Prevention of Accidents. The QA Nurse stated the QA members made no further recommendations and determined there were four (4) staff members responsible for the noon meal of Resident #1, and on 10/24/19, they made the choice not to follow the established policies and procedures. The QA Nurse stated these four (4) staff neglected to follow the established policies and procedures and their choice caused Resident #1 to choke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 16	F 600		

4. The SA reviewed the signature sheets for the training, which began on 10/24/19 and ended on 10/25/19. The SA validated the in-services contained training on Abuse and Neglect, Safety, Residents Mechanically Altered Diets, Meal Service and Safety, Checking the Physician Order List (POL), Care Plans, and Accidents/Hazards. Interviews and record reviews validated all staff had been in-serviced on their duty to monitor the dining room, provide the ordered diet, supervision of residents, abuse/neglect and care plans. During the survey, licensed nurses were observed in the dining room monitoring the meals of the residents, per policy and protocol. The facility provided documentation of training topics given to all staff on 10/24/19 and 10/25/19. Copies of the training and the signature sheets were provided to the SA for validation. Interviews with licensed nursing staff, Food Service staff, Administrative staff, and Certified Nursing Assistant (CNA) staff, validated all staff working in the facility had been in-serviced on their duty to serve, check, cue, supervise, and monitor the residents for all meals, and knew the facility's policies and procedures for abuse and neglect.

5. The SA validated no staff worked prior to training of the Food Service Protocol and in-services.

6. The SA validated CNA #1, #2, #3 and RN #1 were suspended on 10/24/19, and are no longer employed by the facility.

7. The SA validated all appropriate State agencies were notified of the choking incident for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 600	Continued From page 17 8. The SA accepted the facility's Removal Plan and determined all corrective actions were completed on 10/25/19, and the IJ was removed on 10/26/19, prior to the SA entrance on 11/4/19.	F 600		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		12/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 18 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy and procedure review, the facility failed to ensure an individual care plan was implemented for a Mechanical Soft Diet with Chopped Meats for one (1) of four (4) sampled residents, of 39 residents, with mechanically altered diets, Resident #1. An Immediate Jeopardy (IJ) was determined to exist on 10/24/19, when Resident #1 was served a Regular Diet, and was ordered and care planned to receive a Mechanical Soft Diet with Chopped Meats. On 10/24/19, during the noon meal, Resident #1 choked after eating a diet with the wrong texture and wrong consistency (whole piece of turkey), served by the facility staff. Resident #1 suffered a Cardiopulmonary Arrest on 10/24/19, and died at a local hospital on 10/27/19, as a result of the choking incident. The staff did not follow the established individual care plan of Resident #1, which resulted in the death of Resident #1. The facility's failure to follow the individual comprehensive care plan for Resident #1, resulted in the choking of Resident #1 and ultimately lead to her death and placed other residents, care planned with mechanically altered diets, in a situation that was likely to cause	F 656	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 19	F 656		

serious harm, injury, impairment, or death.

Based on the facility's implementation of the IJ Removal Plan/ Corrective Actions as of 10/25/19, the SA determined the IJ was Past Non-Compliance (PNC) and the IJ was removed as of 10/26/19, prior to the SA entrance on 11/04/19.

The SA notified the Administrator of the PNC IJ and SQC on 11/19/19 at 3:30 PM.

Findings Include:

Review of the facility's "Interdisciplinary Care Plan" policy, revised July 2018, revealed, it is the policy of the facility to develop a written individualized care plan that meets the needs and choices of each resident as well as address the strengths, weaknesses and goals identified by the resident's assessment, reassessment and results of diagnostic testing. The entire health record should be considered the "plan of care." Care will be provided as planned. Appropriate considerations and monitoring of factors that commonly contributes to the health and well-being of residents over the course of treatment, including but not limited to: Nutrition and hydration requirements. A Daily Care Guide to educate the Certified Nurse Assistants (CNAs) regarding necessary interventions will be provided to the CNAs responsible for the resident's care.

Record review of Resident #1's individual Comprehensive Care Plan, revealed Resident #1 had a care plan revised on 6/3/19 to indicate Mechanical Soft diet with chopped meats. No corn products. Staff to cue and assist with meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 20	F 656		

and snacks and monitor for adequate chewing before swallowing. The care plan designated this role to Nursing staff. Further review of the care plan for Resident #1 revealed, a revision was documented on 7/24/19, Mechanical Soft Diet with chopped meats and no fresh corn. Review of a Speech Therapy (ST) evaluation and Care Plan for Resident #1, dated 7/23/19, revealed ST treatments for Dysphagia.

Record review of Resident #1's October 2019 Physician's Orders, revealed a physician's order dated 8/7/19, for a Mechanical Soft with Chopped Meats.

Review of an investigative report, dated 10/28/19, revealed Resident #1 was served a Regular Diet, which included a slice of whole turkey, instead of a Mechanical Soft Diet with Chopped Meats, as care planned. Resident #1 choked, became unresponsive, and Cardiopulmonary Resuscitation (CPR) was initiated. Resident #1 was transferred to the hospital, admitted to the Intensive Care Unit (ICU) on a ventilator, and subsequently expired on 10/27/19, related to the choking incident.

Interview on 11/5/19 at 10:50 AM, with the Care Plan Nurse Coordinator/Registered Nurse (RN) #5, revealed the care plans are coordinated in conjunction with the Minimum Data Set (MDS) and Resident #1 had been care planned on 6/3/19 for Mechanical Soft Diet with Chopped Meats. RN #5 verified the RN assigned to the dining room was responsible for checking the diet orders and the food tickets prior to the CNAs serving the food trays. RN #5 stated the care plan for Resident #1 was not followed, as she did not receive chopped meats, on 10/24/19, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 21	F 656		

resulted in the choking of Resident #1.

During an interview on 11/20/19 at 3:00 PM, the Registered Dietician (RD), confirmed he had been a part of the team that developed Resident #1's care plan. The RD confirmed the care plan for Resident #1 was not followed during the lunch meal on 10/24/19, and resulted in the choking of Resident #1. RD confirmed Resident #1 was to have received a Mechanical Soft Diet with Chopped Meats, and instead she had received a Regular Diet on 10/24/19, during the noon meal.

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions, prior to the State Agency (SA) entrance on 11/4/19.

In response to the Immediate Jeopardy (IJ) that was cited at 3:30 PM on 11/19/19, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility, to remove the Immediate Jeopardy (IJ):

1. Description Of Incident:
Resident #1 was a 63 year old white female, admitted to the facility, on April 24, 2019. Resident #1 had an admitting diagnosis of Alzheimer's Type Dementia. Resident #1 was admitted on a Regular Diet with No Corn, due to allergies. On June 3, 2019 at 8:45 AM, Resident #1's diet was changed, by the physician, from a Regular Diet to a Mechanical Soft with Chopped Meat Diet, due to having a choking episode while eating peaches. On October 24, 2019 at 12:15 PM, Resident #1 choked, while eating lunch in the dining room, due to receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 22	F 656		

Diet, as ordered by the physician, and the care plan. Resident #1 passed away, on October 27, 2019 at 9:15 AM, at the local hospital, due to Respiratory Failure/Congestive Heart Failure, per local hospital records.

2. The facility's Hospital Director and Nursing Home Administrator were notified of the incident on October 24, 2019 at 12:30 PM, by the facility's Dietary Manager. The Hospital Director gave directives to refer the incident to Investigative Services and the Quality Assurance Department. Investigative Services arrived at the facility and began an investigation of the incident on October 24, 2019 at 12:55 PM.

3. Measures Implemented:
The Quality Assurance (QA) Committee held an Emergency QA Meeting on October 24, 2019 at 4:00 PM, with the following staff: Nursing Home Administrator, Nurse Manager, Medical Nurse Practitioner (Representing the Medical Director), Minimum Data Set (MDS) Coordinator, Contract Rehab Director, Nurse Supervisor, QA Nurse, and Investigator. The QA Committee reviewed the Abuse, Neglect and Exploitation Policy, discussed Accidents and Hazards; the QA Committee did not recommend any changes at this time. The QA Committee also reviewed the Food Service Duties Quick Reference and Resident #1's Care Plan. The QA Committee found that RN #1 and CNAs #1, #2 and #3 failed to follow the Food Service Duties Quick Reference, which resulted in Resident #1 receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, that was ordered by the physician, and noted on the care plan. The QA Committee recommended to immediately begin training all staff on following the Food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 23	F 656		

Service Duties Quick Reference and following residents diets as care planned, to prevent accidents and hazards. The QA Committee recommended all staff on duty be trained before the next meal was served.

The QA Committee also recommended that RN #1 and CNAs #1, #2, and #3 be placed on Administrative Leave, for serving Resident #1 the wrong diet, and not following policy and procedure. The QA Committee identified 39 of 101 residents, who were on mechanically altered diets, had the potential to be affected, by receiving an incorrect diet. On October 24, 2019 at 5:00 PM, the Quality Assurance Nurse performed chart audits of the 39 residents, who had the potential to be affected, and found that no changes were needed.

4. Training/In-services:
On October 24, 2019 at 4:30 PM, the Nurse Supervisor began in-services on the Food Service Duties Quick Reference procedures for passing out meal trays with all staff. All staff working were trained prior to the next meal being served. The Nurse Supervisor began training for the oncoming night shift employees at 6:30 PM. On October 25, 2019 at 6:30 AM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. On October 25, 2019 at 6:30 PM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. All In-services were completed by October 25, 2019 at 7:00 PM. Any staff that did not receive this training will be trained immediately upon returning to work. The following In-services covered:

Accidents and Hazards and Supervision - All staff were trained on the Nurse checking the Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 24	F 656		

Order List (POL) against the tray ticket, supervision of the resident getting the correct meal tray. If supervision is not carried out it could result in a hazard and/or accident.

Abuse/Neglect - All staff were trained on how to check the diet to ensure the correct diet consistency is on each meal tray for that particular resident per the Physicians Order List (POL).

Diet - All staff were trained on the Nurse checking the Physicians Order List (POL) with the tray ticket for correct diet consistency, and whoever delivers the tray to the resident, must remove the lid from the tray to check the consistency of the food on the tray to the meal ticket.

Care Plan - All staff were trained on each individual resident's diet consistency that is listed on the Physicians Order List (POL), which reflects the resident's Plan of Care.

5. All staff, including new hires, will receive training on food service prior to being able to work.

6. Disciplinary Actions:
On October 24, 2019, after the investigation was initiated, it was determined there was enough evidence to place CNAs #1, #2, #3 and RN #1 on administrative leave pending completion of the investigation.

RN #1 resigned from employment on October 25, 2019.
CNA #1 was terminated from employment effective October 31, 2019.
CNA #2 was terminated from employment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 25	F 656		

effective October 30, 2019.
CNA #3 was terminated from employment effective October 30, 2019.

7. Notification of State Agencies:
On October 24, 2019 at 4:52 PM, the facility's Investigator notified the Mississippi State Department of Health (MSDH) by telephone.

On October 25, 2019 at 9:20 AM, the facility's Investigator notified The Mississippi Attorney General's Office in writing of the incident.

8. Removal of Immediate Jeopardy:
All activities to remove the Immediate Jeopardy were accomplished on October 25, 2019, and the facility alleges that the removal of the Immediate Jeopardy was effective as of October 26, 2019.

The State Agency (SA) validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, interview, and facility record review.

1. The SA validated through record review, staff interview, and video tape review of the incident, on 10/24/19, of Resident #1 choking in the dining room during the noon meal. The SA surveyor watched the video along with the facility Administrator. The SA validated Resident #1 had an order for a Mechanical Soft Diet with Chopped Meat and was served a Regular Diet with Whole Sliced Turkey on 10/24/19. Resident #1 was transferred to the hospital after a choking episode from the incorrect diet. Resident #1 expired on 10/27/19, related to the incident.

2. The SA validated the facility began an investigation of the choking incident on 10/24/19,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 26	F 656		

after notification to the Administrator.

3. The SA validated the Quality Assurance (QA) signature sheets and documentation of the QA meeting, that was held on 10/24/19. Interviews with the facility Administrator and QA Nurse/RN #4, validated the QA meeting of 10/24/19. Interviews with the Director of Nursing (DON), the Minimum Data Set (MDS) Care Plan Coordinator/RN#5, and the QA Nurse/RN #4 validated that the orders and care plans of the 39 residents who had mechanically altered diets, were audited with no changes. The QA meeting included recommendations for training of staff for following resident's diets, as care planned, to prevent accidents and hazards. The SA interviewed the QA Nurse on 11/05/19, and validated the signature sheets and the topics discussed in the QA meeting. The QA Nurse confirmed some of the topics discussed in the QA meeting were Abuse and Neglect; Care Plans, Residents Diets and Service of Diets, Safety of Residents, and Prevention of Accidents. The QA Nurse stated the QA members made no further recommendations and determined there were four (4) staff members responsible for the noon meal of Resident #1, and on 10/24/19, they made the choice not to follow the established policies and procedures. The QA Nurse stated these four (4) staff neglected to follow the established policies and procedures and their choice caused Resident #1 to choke.

4. The SA reviewed the signature sheets for the training, which began on 10/24/19 and ended on 10/25/19. The SA validated the in-services contained training on Abuse and Neglect, Safety, Residents Mechanically Altered Diets, Meal Service and Safety, Checking the Physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 656	Continued From page 27 Order List (POL), Care Plans, and Accidents/Hazards. Interviews and record reviews validated all staff had been in-serviced on their duty to monitor the dining room, provide the ordered diet, supervision of residents, abuse/neglect and care plans. During the survey, licensed nurses were observed in the dining room monitoring the meals of the residents, per policy and protocol. The facility provided documentation of training topics given to all staff on 10/24/19 and 10/25/19. Copies of the training and the signature sheets were provided to the SA for validation. Interviews with licensed nursing staff, Food Service staff, Administrative staff, and Certified Nursing Assistant (CNA) staff, validated all staff working in the facility had been in-serviced on their duty to serve, check, cue, supervise, and monitor the residents for all meals, and knew the facility's policies and procedures for abuse and neglect. 5. The SA validated no staff worked prior to training of the Food Service Protocol and in-services. 6. The SA validated CNA #1, #2, #3 and RN #1 were suspended on 10/24/19, and are no longer employed by the facility. 7. The SA validated all appropriate State agencies were notified of the choking incident for Resident #1. 8. The SA accepted the facility's Removal Plan and determined all corrective actions were completed on 10/25/19, and the IJ was removed on 10/26/19, prior to the SA entrance on 11/4/19.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		12/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 28 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy and procedure review, the facility failed to provide residents with the supervision, required and needed, to prevent accidents, hazards, choking, injury, and death, during meal consumption, for one (1) of four (4) sampled residents, of 39 residents, with physician orders for a mechanically altered diet, Resident #1. Resident #1 had a Physician's Order to receive a Mechanical Soft Diet with Chopped Meats. On 10/24/19, during the noon meal, Certified Nursing Assistant (CNA) #1 served Resident #1 a whole piece of sliced turkey, instead of chopped turkey, and the resident choked on the meat. Resident #1 was sent to the hospital, placed on a ventilator, and expired on 10/27/19, related to the incident. Registered Nurse (RN) #1 was assigned to the dining room, and failed to supervise the meal service to ensure staff provided Resident #1 with the correct diet. The facility's failure to provide supervision during meal service, to ensure the correct diet was served, led to Resident #1's death and placed other residents with mechanically altered diets in a situation that was likely to cause serious harm, injury, impairment or death.	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 29	F 689		

Based on the facility's implementation of an Immediate Jeopardy (IJ) Removal Plan and Corrective Actions, as of 10/25/19, prior to the State Agency (SA) entrance on 11/04/19, the SA determined the IJ and the Substandard Quality of Care (SQC) was Past Non-Compliance (PNC) and the IJ was removed as of 10/26/19.

The SA notified the Administrator of the PNC IJ and SQC on 11/19/19 at 3:30 PM.

Findings Include:

Review of the facility's "Special Food Services Protocol: Therapeutic Programming Snack and Special Event" (Protocol 01-01), dated July 2013, revealed the Physicians Order List (POL) will be utilized to verify food consistency. The POL is provided to each nurses and is updated daily. The POL is checked for reference prior to serving any food. Staff assisting with meal service will be familiar with special diet consideration, which includes identification of food consistency, required by any listed diet.

Review of the facility's "Food Service Duties" (Quick Reference)policy and procedure, dated July 2013, revealed: Dining Room (Anytime Food Is Served) 2. NURSE ONLY checks Physician Order List (POL) with Meal Service Ticket. Check 4-5 trays at a time. Check ticket ONLY for basic diet and food/beverages consistency with the POL, if discrepancy, notify the Unit Nurse to check the Physician's Order for verification of correct diet. 3. CNAs or staff assigned to Dining Room Duty that day, will serve trays after the nurse checks the ticket. When the tray is taken to the resident, check the ticket with the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 30	F 689		

identification arm band. If the resident has no arm band, ask the nurse in the dining room area to verify the resident and consistency on the POL, and serve food. Check basic diet and food/beverage consistency on tray ticket with the food on the tray. If there is a discrepancy, notify the kitchen staff the food is not correct.

Record review of the facility's Investigative Summary Report, dated 10/28/19, revealed: "Accident/Incident Type": Resident death (as a result of staff negligence/procedural violation). Resident #1 became choked after being served and eating a Regular Diet with whole meat, instead of the mechanically altered diet with Chopped Meats, during the noon meal on 10/24/19. Abdominal thrusts were performed, resident became unresponsive, and Cardiopulmonary Resuscitation (CPR) was initiated. Resident #1 was transferred by ambulance to the local hospital, where she was admitted to the Intensive Care Unit (ICU) and placed on a ventilator, and subsequently expired on 10/27/19, related to the choking incident. The investigation revealed, Resident #1 was served and was eating a slice of whole turkey, instead of chopped turkey, when she became choked. Resident #1 was served the Regular Diet tray by Certified Nursing Assistant (CNA) #1. The sequence of events involving the wrong diet being served to Resident #1, started when CNA #2 placed Resident #1's correct meal tray on a table unattended (Resident #1 was not present), and Resident #2 ate Resident #1's meal. About the time Resident #2 was finished eating the meal, CNA #1 noticed Resident #2 had consumed Resident #1's meal. Once Resident #1 arrived in the dining room, CNA #1 informed RN #1 of Resident #2 eating Resident #1's meal. CNA #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 31	F 689		

stated the RN opened the lid on a tray (Resident #2's tray), still on the cart, and stated, "It's the same food", and instructed her to give the tray to Resident #1, which was a Regular Diet and contained a slice of whole turkey. CNA #1 and CNA #3 swapped the meal tickets to make it appear Resident #1 received the correct meal tray. The investigation revealed, RN #1 stated her instructions to CNA #1, was to see if Resident #2 was on the same diet as Resident #1, and did not follow up regarding the diets. CNA #1, #2, #3 and RN #1, were placed on administrative leave pending investigation.

Review of a prior Accident and Incident (A&I) Report Form, dated 6/2/19, revealed Resident #1 had a choking incident, which required the Heimlich maneuver to expel food. This resulted in a diet change from a Regular Diet to Mechanical Soft with Chopped Meats.

Review of Resident #1's medical record revealed the October 2019 physician's orders documented an order, dated 8/7/19, for Resident #1 to have a Mechanical Soft Diet with Chopped Meats.

During an interview, on 11/5/19 at 11:20 AM, the Speech Therapist (ST) #1 revealed, she made a recommendation on 6/3/19, for Resident #1 to have a Mechanical Soft Diet with Chopped Meats due to her rate issues with eating foods, which made her a choking risk. The ST confirmed the physician wrote an order for Resident#1 to have a Mechanical Soft Diet with Chopped Meats as a result of her recommendations and evaluations.

Review of the tray ticket, from 10/24/19, for Resident #1, revealed one-half (1/2) cup Chopped Turkey with Gravy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 32	F 689		

Review of a photograph (verified as taken by ST #2), of the meal tray served to Resident #1 on 10/24/19, revealed a partially-eaten slice of whole meat, instead of chopped meats as ordered.

Review of the Physician's Order List (POL), dated 10/24/19, documented Resident #1 was to receive a Mechanical Soft Diet with Chopped Meats.

During an interview with Licensed Practical Nurse (LPN) #1/Facility Investigator, on 11/4/19 at 11:15 AM, confirmed Resident #1 received the wrong diet on 10/24/19, choked, and subsequently expired on 10/27/19. LPN #1 confirmed the four (4) staff, CNA #1, #2, #3 and RN #1, violated Protocol 01-01 (Special Food Services Protocol), when they did not supervise the meal service to ensure the resident received the right diet.

During an interview on 11/4/19 at 12:00 PM, the facility's Educator, Registered Nurse (RN) #2, confirmed all staff are trained extensively on the "Food Service Duties: (Quick Reference)." RN #2 stated all four (4) staff, (CNA #1, #2, #3 and RN #1), involved in the choking incident of Resident #1 on 10/24/19, had knowledge of the POL, which included Resident #1's diet. RN #2 stated the POL is updated daily and given to the nurses and dietary staff each day. RN #2 stated the four (4) staff involved had not followed the policies and procedures for serving residents food trays in the dining room, to ensure the resident received the right diet on 10/24/19. RN #2 stated all staff were trained on Food Service Duties two (2) weeks prior to the incident on 10/24/19, with Resident #1. RN #2 stated the failure to follow the correct process resulted in Resident #1's choking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 33	F 689		

episode and death.

On 11/21/19 at 1:15 PM, an attempt was made to contact CNA #3 by phone without success. Review of a documented statement by CNA #3, dated 10/24/19 at 4:23 PM, revealed she observed Resident #2 eating food from a meal tray with Resident #1's name on the ticket. The statement revealed CNA #3 checked the meal tray, served to Resident #1, which contained dressing, roll and turkey. CNA #3's statement documented, "give me the ticket."

On 11/21/19 at 1:20 PM, an attempt was made by phone to contact CNA #1 without success. Review of a written statement by CNA #1, dated 10/24/19 at 2:07 PM, revealed Resident #2 ate Resident #1's noon meal on 10/24/19, and she had given Resident #1 the meal tray, which belonged to Resident #2. CNA #1's statement documented, RN #1 opened the lid of Resident #2's tray, and stated it was the same food. RN #1 instructed CNA #1 to give the meal tray to Resident #1. CNA #1's statement documented, "I did what I was told and put the tickets with the tray."

During an interview via phone, on 11/21/19 at 2:50 PM, RN #1 stated she did check the POL on 10/24/19. She stated she did not pass out trays or hand trays to the CNAs. RN #1 stated, when made aware Resident #2 had eaten Resident #1's meal, she instructed CNA #1 to give Resident #1 another tray that was like the same diet as ordered for her. RN #1 did not follow up to ensure Resident #1 was served the correct diet.

Review of the facility's individual training records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 34	F 689		

and documented in-services revealed, all three (3) CNAs and RN #1 were in-serviced on New Employee Orientation, Meal and Hydration, Serving Meals in the Dining Room and Armband Checks, prior to the choking incident of Resident #1.

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions, prior to the State Agency (SA) entrance on 11/4/19.

In response to the Immediate Jeopardy (IJ) that was cited at 3:30 PM on 11/19/19, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility, to remove the Immediate Jeopardy (IJ):

1. Description Of Incident:
Resident #1 was a 63 year old white female, admitted to the facility, on April 24, 2019. Resident #1 had an admitting diagnosis of Alzheimer's Type Dementia. Resident #1 was admitted on a Regular Diet with No Corn, due to allergies. On June 3, 2019 at 8:45 AM, Resident #1's diet was changed, by the physician, from a Regular Diet to a Mechanical Soft with Chopped Meat Diet, due to having a choking episode while eating peaches. On October 24, 2019 at 12:15 PM, Resident #1 choked, while eating lunch in the dining room, due to receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, as ordered by the physician, and the care plan. Resident #1 passed away, on October 27, 2019 at 9:15 AM, at the local hospital, due to Respiratory Failure/Congestive Heart Failure, per local hospital records.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 35	F 689		

2. The facility's Hospital Director and Nursing Home Administrator were notified of the incident on October 24, 2019 at 12:30 PM, by the facility's Dietary Manager. The Hospital Director gave directives to refer the incident to Investigative Services and the Quality Assurance Department. Investigative Services arrived at the facility and began an investigation of the incident on October 24, 2019 at 12:55 PM.

3. Measures Implemented:
The Quality Assurance (QA) Committee held an Emergency QA Meeting on October 24, 2019 at 4:00 PM, with the following staff: Nursing Home Administrator, Nurse Manager, Medical Nurse Practitioner (Representing the Medical Director), Minimum Data Set (MDS) Coordinator, Contract Rehab Director, Nurse Supervisor, QA Nurse, and Investigator. The QA Committee reviewed the Abuse, Neglect and Exploitation Policy, discussed Accidents and Hazards; the QA Committee did not recommend any changes at this time. The QA Committee also reviewed the Food Service Duties Quick Reference and Resident #1's Care Plan. The QA Committee found that RN #1 and CNAs #1, #2 and #3 failed to follow the Food Service Duties Quick Reference, which resulted in Resident #1 receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, that was ordered by the physician, and noted on the care plan. The QA Committee recommended to immediately begin training all staff on following the Food Service Duties Quick Reference and following residents diets as care planned, to prevent accidents and hazards. The QA Committee recommended all staff on duty be trained before the next meal was served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 36	F 689		

The QA Committee also recommended that RN #1 and CNAs #1, #2, and #3 be placed on Administrative Leave, for serving Resident #1 the wrong diet, and not following policy and procedure. The QA Committee identified 39 of 101 residents, who were on mechanically altered diets, had the potential to be affected, by receiving an incorrect diet. On October 24, 2019 at 5:00 PM, the Quality Assurance Nurse performed chart audits of the 39 residents, who had the potential to be affected, and found that no changes were needed.

4. Training/In-services:
On October 24, 2019 at 4:30 PM, the Nurse Supervisor began in-services on the Food Service Duties Quick Reference procedures for passing out meal trays with all staff. All staff working were trained prior to the next meal being served. The Nurse Supervisor began training for the oncoming night shift employees at 6:30 PM. On October 25, 2019 at 6:30 AM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. On October 25, 2019 at 6:30 PM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. All In-services were completed by October 25, 2019 at 7:00 PM. Any staff that did not receive this training will be trained immediately upon returning to work. The following In-services covered:

Accidents and Hazards and Supervision - All staff were trained on the Nurse checking the Physician Order List (POL) against the tray ticket, supervision of the resident getting the correct meal tray. If supervision is not carried out it could result in a hazard and/or accident.

Abuse/Neglect - All staff were trained on how to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 37	F 689		

check the diet to ensure the correct diet consistency is on each meal tray for that particular resident per the Physicians Order List (POL).

Diet - All staff were trained on the Nurse checking the Physicians Order List (POL) with the tray ticket for correct diet consistency, and whoever delivers the tray to the resident, must remove the lid from the tray to check the consistency of the food on the tray to the meal ticket.

Care Plan - All staff were trained on each individual resident's diet consistency that is listed on the Physicians Order List (POL), which reflects the resident's Plan of Care.

5. All staff, including new hires, will receive training on food service prior to being able to work.

6. Disciplinary Actions:
On October 24, 2019, after the investigation was initiated, it was determined there was enough evidence to place CNAs #1, #2, #3 and RN #1 on administrative leave pending completion of the investigation.

RN #1 resigned from employment on October 25, 2019.
CNA #1 was terminated from employment effective October 31, 2019.
CNA #2 was terminated from employment effective October 30, 2019.
CNA #3 was terminated from employment effective October 30, 2019.

7. Notification of State Agencies:
On October 24, 2019 at 4:52 PM, the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 38	F 689		

Investigator notified the Mississippi State Department of Health (MSDH) by telephone.

On October 25, 2019 at 9:20 AM, the facility's Investigator notified The Mississippi Attorney General's Office in writing of the incident.

8. Removal of Immediate Jeopardy:
All activities to remove the Immediate Jeopardy were accomplished on October 25, 2019, and the facility alleges that the removal of the Immediate Jeopardy was effective as of October 26, 2019.

The State Agency (SA) validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, interview, and facility record review.

1. The SA validated through record review, staff interview, and video tape review of the incident, on 10/24/19, of Resident #1 choking in the dining room during the noon meal. The SA surveyor watched the video along with the facility Administrator. The SA validated Resident #1 had an order for a Mechanical Soft Diet with Chopped Meat and was served a Regular Diet with Whole Sliced Turkey on 10/24/19. Resident #1 was transferred to the hospital after a choking episode from the incorrect diet. Resident #1 expired on 10/27/19, related to the incident.

2. The SA validated the facility began an investigation of the choking incident on 10/24/19, after notification to the Administrator.

3. The SA validated the Quality Assurance (QA) signature sheets and documentation of the QA meeting, that was held on 10/24/19. Interviews with the facility Administrator and QA Nurse/RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 39	F 689		

#4, validated the QA meeting of 10/24/19. Interviews with the Director of Nursing (DON), the Minimum Data Set (MDS) Care Plan Coordinator/RN#5, and the QA Nurse/RN #4 validated that the orders and care plans of the 39 residents who had mechanically altered diets, were audited with no changes. The QA meeting included recommendations for training of staff for following resident's diets, as care planned, to prevent accidents and hazards. The SA interviewed the QA Nurse on 11/05/19, and validated the signature sheets and the topics discussed in the QA meeting. The QA Nurse confirmed some of the topics discussed in the QA meeting were Abuse and Neglect; Care Plans, Residents Diets and Service of Diets, Safety of Residents, and Prevention of Accidents. The QA Nurse stated the QA members made no further recommendations and determined there were four (4) staff members responsible for the noon meal of Resident #1, and on 10/24/19, they made the choice not to follow the established policies and procedures. The QA Nurse stated these four (4) staff neglected to follow the established policies and procedures and their choice caused Resident #1 to choke.

4. The SA reviewed the signature sheets for the training, which began on 10/24/19 and ended on 10/25/19. The SA validated the in-services contained training on Abuse and Neglect, Safety, Residents Mechanically Altered Diets, Meal Service and Safety, Checking the Physician Order List (POL), Care Plans, and Accidents/Hazards. Interviews and record reviews validated all staff had been in-serviced on their duty to monitor the dining room, provide the ordered diet, supervision of residents, abuse/neglect and care plans. During the survey,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 689	Continued From page 40 licensed nurses were observed in the dining room monitoring the meals of the residents, per policy and protocol. The facility provided documentation of training topics given to all staff on 10/24/19 and 10/25/19. Copies of the training and the signature sheets were provided to the SA for validation. Interviews with licensed nursing staff, Food Service staff, Administrative staff, and Certified Nursing Assistant (CNA) staff, validated all staff working in the facility had been in-serviced on their duty to serve, check, cue, supervise, and monitor the residents for all meals, and knew the facility's policies and procedures for abuse and neglect. 5. The SA validated no staff worked prior to training of the Food Service Protocol and in-services. 6. The SA validated CNA #1, #2, #3 and RN #1 were suspended on 10/24/19, and are no longer employed by the facility. 7. The SA validated all appropriate State agencies were notified of the choking incident for Resident #1. 8. The SA accepted the facility's Removal Plan and determined all corrective actions were completed on 10/25/19, and the IJ was removed on 10/26/19, prior to the SA entrance on 11/4/19.	F 689		
F 805 SS=J	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed	F 805		12/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 41 to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to serve food to residents in accordance with the physician's order, for one (1) of four (4) residents, of 39 residents, with orders for Mechanically Altered Diets, Resident #1. An Immediate Jeopardy (IJ) existed on 10/24/19, when Resident #1 was served a Regular Diet with a piece of whole sliced turkey, instead of a Mechanical Soft Diet with Chopped Meats. Resident #1 choked on the whole sliced turkey, suffered cardiopulmonary arrest, was transferred to the hospital and placed on a ventilator. Resident #1 expired on 10/27/19, related to the choking incident, when she received the wrong diet. The facility's failure to serve Resident #1's food in accordance with the physician's order, resulted in the choking and subsequent death of Resident #1. This failure also placed other residents, with a mechanically altered diet, in a situation that was likely to cause serious harm, injury, impairment, or death. Based on the facility's IJ Removal Plan and corrective actions, completed on 10/25/19, prior to the State Agency (SA) entrance on 11/4/19, the SA determined the IJ was Past Non-Compliance (PNC) and the IJ removed as of 10/26/19. The SA notified the Administrator of the PNC IJ and SQC on 11/19/19 at 3:30 PM. Findings Include: Review of the facility's "Special Food Services	F 805	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 42	F 805		

Protocol: Therapeutic Programming Snack & Special Event" (Protocol 01-01) policy, dated July 2013, revealed the Physicians Orders List (POL) will be utilized to verify food consistency. The POL will be updated daily Monday - Friday by the Minimum Data Set (MDS) staff and a copy of the POL will be provided to the Nurse's Station on both halls. Staff assisting with meal service will be familiar with special diet considerations which are part of the Physicians Orders List. This includes identification of food consistency required by any listed diet and any special considerations including allergies. Meal Food Service Meal Tickets will be provided. If any discrepancy is noted between the Food Service Meal Ticket and the POL, a nurse will consult the Physician's Order in the Medical Record for clarifications. If the POL is not present in the dining room, or at the location where food or beverage is served, then NO food or beverage may be offered until the list is available and checked for reference.

Review of the facility's "Food Service Duties" (Quick Reference)policy and procedure, dated July 2013, revealed: Dining Room (Anytime Food Is Served) 2. NURSE ONLY checks Physician Order List (POL) with Meal Service Ticket. Check ticket ONLY for basic diet and food/beverages consistency with the POL, if discrepancy noted, notify the Unit Nurse to check the Physician's Order for verification of correct diet. 3. CNAs or staff assigned to Dining Room Duty that day, will serve meal trays after the nurse has checked the ticket. When the tray is taken to the resident, meal ticket is checked with the resident's identification arm band. If the resident has no arm band, ask the nurse in the dining room area to verify the resident's identity and consistency on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 43	F 805		

the POL, and serve food. Check basic diet and food/beverage consistency on tray ticket with the food on the tray. If there is a discrepancy, notify the kitchen staff the food is not correct.

Review of the facility's Mechanical Soft/Chopped Entree definition, from a Modified Diets In-service Form, undated, revealed the definition: A near regular diet with the exception all meats must be chopped into small pea sized or less pieces.

Review of Resident #1's October 2019 Physician Orders revealed an order, initiated on 08/07/19, for a Mechanical Soft With Chopped Meats.

Review of an evaluation from Speech Therapy, dated 6/3/19, revealed Resident #1 had a diagnosis of Dysphagia.

Record Review of the daily Physician Orders List (POL) dated 10/24/19 revealed a diet order for Resident #1, dated 08/07/19, Meals QD (every day) Mechanical Soft with Chopped Meats.

Record review of Resident #1's food tray ticket, dated 10/24/19, revealed resident was to be served one-half (1/2) cup Chopped Turkey with Gravy.

Review of an "Investigative Summary Report", dated 10/24/19, for Resident #1, revealed, Resident #1 became choked while eating a Regular Diet instead of the ordered diet of Mechanical Soft with Chopped Meats, served by Certified Nursing Assistant (CNA) #1. Staff initiated abdominal thrusts and Cardio-pulmonary Resuscitation (CPR). Resident #1 was transferred via ambulance to the Emergency Room (ER) for further medical treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 44	F 805		

Resident #1 was placed on a ventilator, then expired on 10/27/19, as a result of the choking incident. The investigation revealed, nursing staff violated facility Protocol 01-01, by failure to verify and ensure the correct diet was served to Resident #1.

Review of a "Medical Nutrition Therapy Long Term Care (LTC) Assessment", dated 10/17/19, revealed Resident #1 required a Mechanical Soft Diet with Chopped Meats.

During an interview, on 11/4/19 at 11:15 AM, the facility's Investigator, Licensed Practical Nurse (LPN) #1, confirmed through his investigation, Resident #1 choked and ultimately died because she was served the wrong diet by facility staff on 10/24/19.

During an interview, on 11/5/19 at 11:20 AM, Speech Therapist (ST) #1 revealed, Speech Therapy recommended the Mechanical Soft Diet with Chopped Meats for Resident #1 related to "rate" issues and risk of choking.

During an interview, on 11/5/19 at 12:10 PM, the Dietary Manager (DM) stated the dietary department receives a new up-dated POL daily, prepares the food, and fills the food trays in accordance with the POL. The Nurse assigned to the dining room gets an updated POL and it is her responsibility to check the food tickets against the daily POL. Once the nurse checks the POL against the food tray tickets, then the CNAs take the tray, and distributes to the residents after they check the resident's arm bands for identity.

During an interview, on 11/04/19 at 12:00 PM, and again on 11/19/19 at 12:15 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 45	F 805		

Educator/Staff Development Registered Nurse (RN) #2 confirmed all nursing staff and Certified Nursing Assistants (CNA's) are trained on a regular basis about serving correct diets. RN #2 confirmed all four (4) staff, (CNA #1, #2, #3 and RN #1), involved in the incident with Resident #1 on 10/24/19, at the noon meal, were well trained. She stated they knew what the processes were, and made the choice not to follow the facility's policies and procedures for dietary services to ensure Resident #1 received the right diet.

During an interview, on 11/4/19 at 3:35 PM, CNA #4 stated she was in the dining room on 10/24/19 when Resident #1 had the choking incident. CNA #4 confirmed staff had been trained on diets and tray service approximately one (1) to two (2) weeks prior to this incident. CNA #4 confirmed they were never to leave a tray on the table unattended.

Interview on 11/20/19 at 3:00 PM, with the Registered Dietician (RD), revealed he teaches and in-services all staff in the facility on dietary services and the policies and procedures of food services "Quick References." He stated he trains the staff on cueing the residents during meals and assisting and monitoring residents during meals. The RD stated he trains staff about "therapeutic" diets and he teaches the staff how to set-up food trays for serving, and to make sure the tray ticket matches what is on the tray. The RD stated all staff had been aware Resident #1 required a Mechanical Soft Diet with Chopped Meats.

On 11/21/19 at 1:15 PM, an attempt was made to contact CNA #3 by phone without success. Review of a documented statement by CNA #3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 46	F 805		

dated 10/24/19 at 4:23 PM, revealed she observed Resident #2 eating food from a meal tray with Resident #1's name on the ticket. There was no meat on the tray Resident #2 was eating. CNA #3 documented she checked the meal tray, served to Resident #1 by CNA #1, which had the same items with the addition of turkey. CNA #3 documented, "give me the ticket."

On 11/21/19 at 1:20 PM, an attempt was made by phone to contact CNA #1 without success. Review of a written statement by CNA #1, dated 10/24/19 at 2:07 PM, revealed Resident #2 ate Resident #1's noon meal tray on 10/24/19, and she gave Resident #1 the meal tray, which belonged to Resident #2. The written statement documented, RN #1 opened the lid of Resident #2's tray, stated it was the same food, and instructed CNA #1 to serve the meal tray to Resident #1. CNA #1 documented, "I did what I was told and put the tickets with the tray."

In an interview by phone, on 11/21/19 at 2:50 PM, RN #1 confirmed she checked the food tray tickets against the Physician's Order List (POL). RN #1 stated she learned how to check the food tray tickets against the POL by other nurses passing the information to her in reports. She stated she had never been trained on the procedure of checking food trays against the POL and/or serving meal trays. RN #1 stated she did pass out trays and did not hand trays to CNAs. RN #1 stated she never told CNA #1 to serve Resident #1 the food tray of Resident #2; she told CNA #1 to give Resident #1 another tray that was the same diet, which was Mechanical Soft with Chopped Meats. RN #1 stated she resigned her position at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 47	F 805		

Review of the facility's individual training records and documented in-services revealed, CNA #1 was trained on 10/9/19, on the POL Protocol. CNA #1 was trained on Special Diets, Serving Meals, and the POL on 8/22/19.

Review of the facility's individual training records and in-services for CNA #2, revealed she was trained on the POL on 10/9/19. CNA #2 was trained on Special Diets and the POL on 11/7/18. On 5/30/19, and 6/6/19, CNA #2 was trained on the POL Protocol, as well as checking the armbands to make sure the right resident is getting the right meal on 4/11/19.

Review of the individual facility's training records and in-services for CNA #3, revealed she was trained on the POL Protocol on 5/30/19, and 6/6/19. On 4/11/19, CNA #3 was trained on checking the armbands to ensure the right resident is getting the right meal. CNA #3 was trained on 3/7/18, on the POL and Serving Meals.

Review of the facility's training record and in-services revealed, RN #1 was trained on the POL Protocol on 10/9/19. RN #1 was trained on Special Diets/Serving on 4/26/19.

The facility implemented the following Immediate Jeopardy (IJ) Removal Plan/Corrective Actions, prior to the State Agency (SA) entrance on 11/4/19.

In response to the Immediate Jeopardy (IJ) that was cited at 3:30 PM on 11/19/19, the facility submitted a brief summary of the event, including an IJ Removal Plan and Corrective Actions, taken by the facility, to remove the Immediate Jeopardy (IJ):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 48	F 805		

1. Description Of Incident:
Resident #1 was a 63 year old white female, admitted to the facility, on April 24, 2019. Resident #1 had an admitting diagnosis of Alzheimer's Type Dementia. Resident #1 was admitted on a Regular Diet with No Corn, due to allergies. On June 3, 2019 at 8:45 AM, Resident #1's diet was changed, by the physician, from a Regular Diet to a Mechanical Soft with Chopped Meat Diet, due to having a choking episode while eating peaches. On October 24, 2019 at 12:15 PM, Resident #1 choked, while eating lunch in the dining room, due to receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, as ordered by the physician, and the care plan. Resident #1 passed away, on October 27, 2019 at 9:15 AM, at the local hospital, due to Respiratory Failure/Congestive Heart Failure, per local hospital records.

2. The facility's Hospital Director and Nursing Home Administrator were notified of the incident on October 24, 2019 at 12:30 PM, by the facility's Dietary Manager. The Hospital Director gave directives to refer the incident to Investigative Services and the Quality Assurance Department. Investigative Services arrived at the facility and began an investigation of the incident on October 24, 2019 at 12:55 PM.

3. Measures Implemented:
The Quality Assurance (QA) Committee held an Emergency QA Meeting on October 24, 2019 at 4:00 PM, with the following staff: Nursing Home Administrator, Nurse Manager, Medical Nurse Practitioner (Representing the Medical Director), Minimum Data Set (MDS) Coordinator, Contract Rehab Director, Nurse Supervisor, QA Nurse,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 49	F 805		

and Investigator. The QA Committee reviewed the Abuse, Neglect and Exploitation Policy, discussed Accidents and Hazards; the QA Committee did not recommend any changes at this time. The QA Committee also reviewed the Food Service Duties Quick Reference and Resident #1's Care Plan. The QA Committee found that RN #1 and CNAs #1, #2 and #3 failed to follow the Food Service Duties Quick Reference, which resulted in Resident #1 receiving a Regular Diet, instead of a Mechanical Soft with Chopped Meat Diet, that was ordered by the physician, and noted on the care plan. The QA Committee recommended to immediately begin training all staff on following the Food Service Duties Quick Reference and following residents diets as care planned, to prevent accidents and hazards. The QA Committee recommended all staff on duty be trained before the next meal was served.

The QA Committee also recommended that RN #1 and CNAs #1, #2, and #3 be placed on Administrative Leave, for serving Resident #1 the wrong diet, and not following policy and procedure. The QA Committee identified 39 of 101 residents, who were on mechanically altered diets, had the potential to be affected, by receiving an incorrect diet. On October 24, 2019 at 5:00 PM, the Quality Assurance Nurse performed chart audits of the 39 residents, who had the potential to be affected, and found that no changes were needed.

4. Training/In-services:
On October 24, 2019 at 4:30 PM, the Nurse Supervisor began in-services on the Food Service Duties Quick Reference procedures for passing out meal trays with all staff. All staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 50	F 805		

working were trained prior to the next meal being served. The Nurse Supervisor began training for the oncoming night shift employees at 6:30 PM. On October 25, 2019 at 6:30 AM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. On October 25, 2019 at 6:30 PM, all oncoming staff were trained by the Nurse Supervisor before starting the shift. All In-services were completed by October 25, 2019 at 7:00 PM. Any staff that did not receive this training will be trained immediately upon returning to work. The following In-services covered:

Accidents and Hazards and Supervision - All staff were trained on the Nurse checking the Physician Order List (POL) against the tray ticket, supervision of the resident getting the correct meal tray. If supervision is not carried out it could result in a hazard and/or accident.

Abuse/Neglect - All staff were trained on how to check the diet to ensure the correct diet consistency is on each meal tray for that particular resident per the Physicians Order List (POL).

Diet - All staff were trained on the Nurse checking the Physicians Order List (POL) with the tray ticket for correct diet consistency, and whoever delivers the tray to the resident, must remove the lid from the tray to check the consistency of the food on the tray to the meal ticket.

Care Plan - All staff were trained on each individual resident's diet consistency that is listed on the Physicians Order List (POL), which reflects the resident's Plan of Care.

5. All staff, including new hires, will receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 51	F 805		

training on food service prior to being able to work.

6. Disciplinary Actions:
On October 24, 2019, after the investigation was initiated, it was determined there was enough evidence to place CNAs #1, #2, #3 and RN #1 on administrative leave pending completion of the investigation.

RN #1 resigned from employment on October 25, 2019.
CNA #1 was terminated from employment effective October 31, 2019.
CNA #2 was terminated from employment effective October 30, 2019.
CNA #3 was terminated from employment effective October 30, 2019.

7. Notification of State Agencies:
On October 24, 2019 at 4:52 PM, the facility's Investigator notified the Mississippi State Department of Health (MSDH) by telephone.

On October 25, 2019 at 9:20 AM, the facility's Investigator notified The Mississippi Attorney General's Office in writing of the incident.

8. Removal of Immediate Jeopardy:
All activities to remove the Immediate Jeopardy were accomplished on October 25, 2019, and the facility alleges that the removal of the Immediate Jeopardy was effective as of October 26, 2019.

The State Agency (SA) validated the facility's investigation of the incident and implementation of the IJ Removal Plan/Corrective Action through observation, interview, and facility record review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 52	F 805		

1. The SA validated through record review, staff interview, and video tape review of the incident, on 10/24/19, of Resident #1 choking in the dining room during the noon meal. The SA surveyor watched the video along with the facility Administrator. The SA validated Resident #1 had an order for a Mechanical Soft Diet with Chopped Meat and was served a Regular Diet with Whole Sliced Turkey on 10/24/19. Resident #1 was transferred to the hospital after a choking episode from the incorrect diet. Resident #1 expired on 10/27/19, related to the incident.

2. The SA validated the facility began an investigation of the choking incident on 10/24/19, after notification to the Administrator.

3. The SA validated the Quality Assurance (QA) signature sheets and documentation of the QA meeting, that was held on 10/24/19. Interviews with the facility Administrator and QA Nurse/RN #4, validated the QA meeting of 10/24/19. Interviews with the Director of Nursing (DON), the Minimum Data Set (MDS) Care Plan Coordinator/RN#5, and the QA Nurse/RN #4 validated that the orders and care plans of the 39 residents who had mechanically altered diets, were audited with no changes. The QA meeting included recommendations for training of staff for following resident's diets, as care planned, to prevent accidents and hazards. The SA interviewed the QA Nurse on 11/05/19, and validated the signature sheets and the topics discussed in the QA meeting. The QA Nurse confirmed some of the topics discussed in the QA meeting were Abuse and Neglect; Care Plans, Residents Diets and Service of Diets, Safety of Residents, and Prevention of Accidents. The QA Nurse stated the QA members made no further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 53	F 805		

recommendations and determined there were four (4) staff members responsible for the noon meal of Resident #1, and on 10/24/19, they made the choice not to follow the established policies and procedures. The QA Nurse stated these four (4) staff neglected to follow the established policies and procedures and their choice caused Resident #1 to choke.

4. The SA reviewed the signature sheets for the training, which began on 10/24/19 and ended on 10/25/19. The SA validated the in-services contained training on Abuse and Neglect, Safety, Residents Mechanically Altered Diets, Meal Service and Safety, Checking the Physician Order List (POL), Care Plans, and Accidents/Hazards. Interviews and record reviews validated all staff had been in-serviced on their duty to monitor the dining room, provide the ordered diet, supervision of residents, abuse/neglect and care plans. During the survey, licensed nurses were observed in the dining room monitoring the meals of the residents, per policy and protocol. The facility provided documentation of training topics given to all staff on 10/24/19 and 10/25/19. Copies of the training and the signature sheets were provided to the SA for validation. Interviews with licensed nursing staff, Food Service staff, Administrative staff, and Certified Nursing Assistant (CNA) staff, validated all staff working in the facility had been in-serviced on their duty to serve, check, cue, supervise, and monitor the residents for all meals, and knew the facility's policies and procedures for abuse and neglect.

5. The SA validated no staff worked prior to training of the Food Service Protocol and in-services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A418	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES T CHAMPION	1455 NORTH LAKELAND DRIVE MERIDIAN, MS 39307

(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 805	Continued From page 54 6. The SA validated CNA #1, #2, #3 and RN #1 were suspended on 10/24/19, and are no longer employed by the facility. 7. The SA validated all appropriate State agencies were notified of the choking incident for Resident #1. 8. The SA accepted the facility's Removal Plan and determined all corrective actions were completed on 10/25/19, and the IJ was removed on 10/26/19, prior to the SA entrance on 11/4/19.	F 805		