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M 000	Initial Comments The State Agency (SA) conducted a COVID-19 Focus Infection Control Survey, along with Complaint Investigation (CI) MS #16992 on 09/01/2020 through 09/06/2020. The COVID-19 survey was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices. The facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm related to CI MS #16992, which involved a choking incident which resulted in the death of Resident #1, and was cited state statutes at M500 and M640. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) on 09/02/2020, that began on 05/15/2020, when the facility failed to provide Resident #1, who was a known choking risk, supervision during food consumption which resulted in Resident #1 choking, aspirating, and expiring. The failure to supervise Resident #1 during food consumption, caused the death of Resident #1 and placed other residents, who are at risk for choking, in a situation which could potentially cause serious injury, harm, impairment, and death. On 09/02/2020 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC. The IJ and SQC existed at: Rule 45.17.2 - Resident Rights (M500) Rule 45.21.8 - Accidents (M640) The facility submitted an Acceptable Removal	M 000		

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M 000	Continued From page 1 Plan on 09/05/2020, in which the facility alleged all corrective actions were completed on 09/04/2020, and the IJ removed on 09/05/2020. The SA validated the facility's Removal Plan on 09/06/2020 and determined the IJ was removed on 09/05/2020, prior to exit. Therefore, the scope and severity for M500 - Resident Rights and M640 - Accidents were lowered from a "Level IV" to a scope and severity of a "Level II", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of the survey, the facility had a census of 64, and held a license for 100 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		

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M 500	Continued From page 2 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 3 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

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M 500	Continued From page 4 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 5 This Statute is not met as evidenced by: Level IV Based on observation, facility investigation, record review, staff interview, and facility policy review, the facility failed to ensure a resident was free of neglect and provide the necessary care and services to avoid physical harm, as evidenced by, Resident #1, who had behaviors of shoveling food in his mouth and was a known choking risk, was left unattended in the dining room with food, for one (1) of four (4) residents reviewed for behaviors/choking risk. On 06/01/2020, the State Agency (SA) received a complaint from the local Ombudsman, which revealed, the facility failed to provide one on one supervision with Resident #1 to prevent choking and aspiration. On 05/15/2020 at 6:44 AM, Resident #1 was left unattended with food at the dining room table. Resident #1 shoveled his food, along with another resident's food, in his mouth, which caused Resident #1 to aspirate and die at the facility. The facility's failure to ensure a resident's right to be free from neglect, placed Resident #1 and other residents with behaviors and choking risks, in a situation that would likely cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 05/15/2020, when the facility left Resident #1 unsupervised with food, in the dining room. Resident #1 was known by staff for shoveling food in his mouth and was a choking risk. There was no licensed personnel in the dining room at the time of the	M 500		

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M 500	Continued From page 6 incident. The facility's Administrator was notified of the IJ and SQC on 09/02/2020. The facility submitted an acceptable Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed as of 09/04/2020, and the Immediate Jeopardy was removed on 09/05/2020. The SA validated the Removal Plan and determined the IJ and SQC was removed as of 09/05/2020, prior to exit. Therefore, the scope and severity for the IJ and SQC at 42 CFR(s): 483.12(a)(1) - Freedom from Abuse/Neglect, (F600), was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Abuse, Neglect and Exploitation Policy", dated 11/2018, revealed: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of residential property. "The policy also revealed the definition of neglect as: "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Record review of the facility's Speech Therapy Plan of Care, dated 11/08/2019, revealed, Resident #1 was referred to Speech Therapy	M 500		

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because he exhibited new onsets of decreased safety during oral intake, coughing, choking during oral intake, risk for aspiration, decreased safety awareness, increased behaviors, decreased verbal communication, increased need for assistance from others, decreased ability to use compensatory strategies and cognitive-communicative deficits placing patient at risk for aspiration, weight loss and further decline in functions and falls. The Speech Therapist also indicated Resident #1 was at risk for aspiration, had impulsive tendencies, to restrict the resident's performance in unsupervised tasks, reduce background noise, stand directly in front of the resident and speak in a deep voice when communicating. The Speech Therapist recommended a Mechanical Soft Diet with supervision, and assistance required being determined by the resident's mood and impulsive tendencies at that moment dated 01/02/2020.

A review of Resident #1's Nurses' Notes dated 11/05/2019, revealed, a nurse was called to the Memory Care Unit. The Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The CNA also stated she had to dig the roll out of his mouth. The CNA revealed, the resident choked yesterday on green beans because he eats so fast.

Review of the facility's Nurses' Notes for Resident #1, dated 12/31/2019, revealed, Resident #1 feeds self with cueing and supervision. Resident #1 gulps food unless monitored.

Record review of the Speech Therapy's Plan of Care, dated 05/01/2020, revealed, Resident #1 was referred to Speech Therapy after a new onset of decreased safety during a meal, which was evidenced by Resident #1 severely choking

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during a meal when food was stuck in the resident's throat. As a result, nursing monitored Resident #1 and took Pneumonia precautions with X-ray, after the resident's temperature spiked. The Therapist standardized test, dated 05/01/2020, revealed, Resident #1 was given the bedside dysphagia evaluation, in which Resident #1 was found to have both Oral and Pharyngeal Dysphagia, which put him at risk for aspiration. The test indicated Resident #1 was impulsive and put large spoons/bites in his mouth and sometimes two (2) or more spoons/bites in his mouth causing severe choking episodes. Resident #1 was found to be a candidate for skilled dysphagia therapy to implement training strategies for both Resident and caregivers to decrease choking risk.

A record review of the Speech Therapist's in-service instructions for Resident #1, dated 05/01/2020, revealed, Certified Nursing Assistant (CNA) #1 and CNA #2 was in-serviced on: Purpose of a small spoon, to encourage liquids between swallows during meal time, strategies to recognize impulsive behavior during meal time also have the ability to recognize mood of patient and determine level of assistance needed that day. Implement use of compensatory strategies (i.e. Hand over Hand, diet modifications "not giving roll", removing tray from patient and calming patient down, giving meal tray last, and being one-on-one, handing patient something to drink in between bites and ultimately removing tray from patient and feeding patient) to decrease impulsive behavior and to ensure meal time safety.

Record review of Resident #1's Nurses' Notes, dated 03/18/2020, revealed, Resident #1 was noted to be coughing and choked on some food

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during lunch. Resident #1 was trying to put too much food in his mouth at one time, swallowed it whole, and choked on it. On 04/06/2020, Registered Nurse (RN) #1 documented, "Resident #1 feeds self with tray set up help. Resident #1 over stuffs mouth with food. Resident #1 is encouraged to slow down and take his time eating. Resident #1 is offered fluids with meals." On 04/29/2020, Resident #1 choked on food due to him shoveling food in his mouth.

A record review of the facility's nurses' note for Resident #1, dated 05/15/20, revealed, RN #1 was called to the Memory Care Unit where she observed Resident #1 standing up with a bluish-gray pale tint to his face and around his lips. Resident #1 appeared to be choking. The resident was unable to cough to clear his airway. The Heimlich maneuver was performed. Resident #1 became weak and collapsed to the floor. Mouth sweeps were performed with food particles removed. Resident #1 was placed in a wheelchair and taken to his room. The Medical Doctor (MD) was at bedside. Oxygen was administered, as well as suctioning. Food particles were removed from Resident #1's airway. The staff was unable to clear airway. The MD pronounced Resident #1 at 7:28 AM.

Record review of the Physicians Notes for Resident #1, dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, and aspirated with collapse. The Heimlich and mouth sweeps were performed by the nursing code team. Large chunks of scrambled eggs were removed from Resident #1's airway before he arrived from down the hall. Resident #1 was awake, eyes opened, sitting up, no coughing, but spontaneous respirations. Within a minute, Resident #1 collapsed again,

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was transferred to the bed, and suctioned with more food debris. Resident #1 noted to be a Do Not Resuscitate (DNR), no spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

A review of Resident #1's Death Certificate, dated 05/27/2020, revealed the cause of death was hypoxia due to airway obstruction and aspiration of food.

Record review of the Physician Orders for Resident #1, dated 09/01/2020, revealed, Resident #1 was ordered a Mechanical Soft Diet with chopped meat texture consistency. Chopped meats in gravy. Resident #1 would receive a small spoon with all meals to lower risk of choking due to impulsive and big spoons of food during oral consumption.

On 06/01/2020, the State Agency (SA) received a complaint from the local Ombudsmen stating the facility failed to provide one on one care with Resident #1, causing him to choke, aspiration and die.

During an interview with the local Ombudsman on 08/31/2020, she revealed, Resident #1's family called and stated the facility gave Resident #1 the wrong diet, which caused him to aspirate and die. The family said this incident happened on 05/15/2020.

An interview via phone, on 09/03/2020 at 9:30 AM, with Resident #1's daughter, revealed, she called the local Ombudsman and stated Resident #1 had behaviors and was in the Memory Care

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M 500	Continued From page 11 Unit at the facility. Resident #1's daughter stated the facility gave Resident #1 the wrong diet which caused him to aspirate and die. The daughter also stated two (2) weeks prior to Resident #1's death, the facility called her mother and said Resident #1 had choked on a roll and aspirated. Resident #1 was placed on an antibiotic for aspiration and bronchitis. Resident #1's daughter stated two (2) weeks later, the facility called and stated Resident #1 had choked and died. The family asked for a copy of Resident #1's medical records. She stated the facility did not return their calls. During an interview, on 09/03/2020 at 10:15 AM, Certified Nursing Assistant (CNA) #2 revealed, she worked the Memory Care Unit on 05/15/2020. CNA #2 stated Resident #1 came out of the dining room, with CNA #1 patting him on his back, because he had stuffed food in his mouth. She stated Resident #1 fell to the floor. CNA #1 was trying to get food out of his mouth. She revealed the nurse was not in the dining room. CNA #2 stated the nurse made rounds on the unit periodically. CNA #2 stated she called for help and Registered Nurse (RN) #1 came on the unit and pulled eggs out of Resident #1's mouth. CNA #2 stated Resident #1 would hoard food and pocket food in his mouth. CNA #2 stated the Speech Therapist in-serviced all the CNAs on the Memory Care Unit indicating Resident #1 should eat last, should drink in between bites and should be supervised during meals because he has a history of choking by shoveling large amounts of food down his throat. CNA #2 stated Resident #1 had several behaviors that required one on one supervision. An observation of the lunch meal, on the Memory Care Unit, on 09/03/2020 at 11:45 AM, revealed,	M 500		

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two (2) CNAs assisting residents with lunch. The residents were spread out around the dining room. There were no licensed nurses in the dining room during the meal. The CNAs uncovered the residents' lunch trays, and they fed themselves without difficulty.

During an interview, on 09/03/2020 at 12:30 PM, CNA #1 stated she was assisting Resident #1 with his breakfast on 05/15/2020, when another resident came into the dining room. CNA #1 confirmed she left Resident #1 at the table to assist the other resident with unwrapping her food and setting up her tray. CNA #1 stated when she turned around to check on Resident #1, she noticed Resident #1 stuffing food in his mouth from his tray and another resident's tray. She stated Resident #1 was turning gray and that she tried to get him to open his mouth. She stated Resident #1 clenched his teeth together. CNA #1 revealed she tried to assist Resident #1 to the bathroom to clean his mouth, but he started turning blue and fell to the ground in the day area by the nurses' station. CNA #2 stated she tried to take the food out of Resident #1 mouth. She revealed that CNA #2 called for a nurse, because there were no nurses on the unit. CNA #1 stated the nurses were not on the unit during meals. CNA #1 stated she was in-serviced by the Speech Therapist to give Resident #1 his meals last and to assist him with his meals, because he stuffed food in his mouth that would choke him. CNA #1 stated she should have asked CNA #2 to assist with the other resident's breakfast. CNA #1 confirmed Resident #1 should not have been left unattended because he was impulsive and had a history of shoving food in his mouth.

During an interview, on 09/03/2020 at 1:00 PM, RN #1 revealed, she was called into the Memory

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(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) COMPLETE DATE
M 500	Continued From page 13 Care Unit by CNA #1. RN #1 stated she was the supervisor on the day of the choking incident. RN #1 stated Resident #1 was blue when she entered the unit and was laying on the floor. RN #1 stated she performed the Heimlich maneuver, but was not successful. RN #1 revealed Resident #1 was taken to his room and suction was initiated. She stated a large amount of scrambled eggs was removed from Resident #1's mouth. RN #1 also stated Resident #1 had a history of choking on his food because he puts large amounts of food in his mouth at one time. RN #1 confirmed Resident #1 needed one on one supervision with meals. During an interview, on 09/03/2020 at 1:30 PM, the Speech Therapist (ST) revealed, Resident #1 had a history of choking and aspirating. She stated Resident #1 was impulsive and shoveled food into his mouth. The ST stated she had put several things in place for Resident #1's behavior medication and safety, such as: Resident #1 should receive his tray last, one on one supervision with meals, ordered a small spoon and receive sips of water between each bite. The ST said she in-serviced the CNAs on May 1, 2020 on Resident #1's feeding instructions. The ST also stated she talked to the Director of Nursing (DON) about Resident #1's behavior modification and safety. The Speech Therapist revealed, she recommended the facility have a nurse in all the dining rooms to promote patient safety. The ST further stated, the Assistant Director of Nursing (ADON) told her that Resident #1 swallowed a whole roll and coughed the roll up. The Speech Therapist stated Resident #1 was re-evaluated on 05/01/2020. The Speech Therapist revealed, she in-serviced the CNAs with instructions on how to provide behavior modifications to keep the resident from choking. The ST stated she	M 500		

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in-serviced the CNAs because they were the ones taking care of the resident. The Speech Therapist stated she placed instructions in her notes. The ST stated the facility had a communication issue between Nursing and Therapy.

During an interview, on 09/04/2020 at 9:30 AM, RN #3/Nursing Supervisor, revealed, she observed Resident #1 lying on his right side on the floor. She stated Resident #1 was gray in color. Scrambled eggs were noted on Resident #1's shirt sleeves. RN #3 stated that RN #1 was pulling eggs out of Resident #1's mouth using finger sweeps. She stated Resident #1 slumped over and became unresponsive. Suction was set up and RN #1 suctioned pieces of food out of his mouth, mainly eggs. She stated Resident #1 remained unresponsive. RN #3 revealed the MD pronounced Resident #1 at that time. RN #3 also confirmed Resident #1 had a history of choking during mealtime. RN #3 stated Resident #1 should have always been supervised during meals because he shoved large amounts of food into his mouth. She revealed Resident #1 had an incident on 04/29/2020 where a roll was stuck in his throat. RN #3 stated Resident #1 was able to cough up the roll with assistance. RN #3 further stated the doctor ordered an x-ray, Speech Therapy was consulted, and antibiotics ordered.

An interview, on 09/04/2020 at 10:00 AM, with the Medical Director (MD), revealed, Resident #1 had a history of choking. The MD stated Resident #1 was impulsive and had several other behaviors. He stated Resident #1 should have had one on one supervision, 24 hours a day due to his behaviors. The MD further stated he was called to the Memory Care Unit on 05/15/2020 and was at the bedside while the staff suctioned the food

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particles from the resident's mouth. The MD said Resident #1 became unresponsive, stopped breathing, and was pronounced at 7:28 AM. The MD confirmed the cause of death was Hypoxia due to choking and aspirating his breakfast. The MS further stated he was involved in the Quality Assurance (QA) meetings after the incident in which everything was discussed, and he approved the facility's plan of action.

During an interview, on 09/04/2020 at 5:00 PM, the Director of Nursing (DON) confirmed, Resident #1 had a history of choking as well as other behaviors. The DON stated she did not know the Speech Therapist had requested a special spoon to prevent choking until 05/01/2020, when it was discussed in a meeting. The DON stated the staff informed her the resident was not getting the spoon with all meals because the facility only had one. The DON revealed she told the Dietary Manager to order more spoons. The DON stated she was not aware the Speech Therapist recommended one on one supervision, serving Resident #1 last, and to offer sips of water in between bites until after the resident's death. The DON stated she did not know the Speech Therapist had in-serviced the CNAs on 05/01/2020 with behavior modifications to Resident #1. The DON said she discussed with the Administrator and the Owner of the facility, that the Memory Care Unit should have a nurse during meals. She stated the Administrator and Owner refused.

Review of the facility's Removal Plan, revealed, the facility took the following actions to remove the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC):

1. Sixty-three (63) residents were assessed by

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M 500	Continued From page 16 the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. 2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM. 3. Eight (8) of eight (8) Registered Nurses(RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.	M 500		

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M 500	Continued From page 17 4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM. 5. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPN's, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy. 6. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPNs, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location. 7. Eight (8) of eight (8) RN's, 22 of 38 CNA's, eight (8) of 13 LPN's, two (2) of seven (7) Housekeeper's, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the	M 500		

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M 500	Continued From page 18 State Agency. 8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have	M 500		

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M 500	Continued From page 19 been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting. 9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were	M 500		

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M 500	Continued From page 20 assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events. No staff will be allowed to work until they are in-serviced. The facility alleges the IJ and SQC was removed on September 5, 2020. The State Agency (SA) validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets. 1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm. 2. The SA validated through interviews and record review of all residents were assessed by the speech therapist for swallowing difficulties and choking aspiration.	M 500		

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M 500	Continued From page 21 3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards. 4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets. 5. The SA validated through interviews and in-services by the Social Worker on meal Supervision. 6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location. 7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the state agency. 8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet. 9. The SA validated that all corrective actions listed were accomplished by 09/05/2020. 10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced. 11. The SA validated that all corrective actions were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/05/2020.	M 500		

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M 640	Continued From page 22	M 640		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observation, interviews, record review and facility policy review the facility failed to provide a resident with supervision required and needed to prevent accidents and hazards, choking injury and death during meal consumption for one (1) of four (4) residents reviewed for choking, Resident #1. Resident #1 was left unattended in the Memory Care Dining Room. Resident #1 choked and aspirated on breakfast meal which caused him to die in the facility. The facility's failure to provide supervision and leaving Resident #1 unattended placed other residents in a situation caused harm, injury, impairment and death. This situation was determined to be an Immediate Jeopardy (IJ), which began on 05/15/2020, when the facility left Resident #1 unsupervised with food in the dining room. Resident #1 had was known for shoveling food in his mouth and a choking risk. There were no licensed personnel in the dining room. The facility ' s Administrator was notified of the Immediate Jeopardy (IJ) and Substandard Quality	M 640		

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of Care (SQC) on 09/02/2020. The facility submitted an acceptable credible Removal Plan on 09/05/2020, in which the facility alleged all corrective actions were completed as of 09/04/2020, and the IJ and SQC was removed on 09/05/2020.

The SA validated the Removal Plan and determined the IJ to be removed as of 09/02/2020, prior to exit. Therefore, the scope and severity for the IJ at CFR(s): 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices (F-689), was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

A review of the facility's "Accident and Supervision Policy", dated November 2018, revealed, the facility shall establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. Using specific interventions to try to reduce a resident's risk from hazards in the environment by communicating interventions with staff, assigning responsibility, providing training, ensuring that the interventions are put into action. The facility's definition of supervision is an intervention and a means of mitigating accident risk. He facility will provide adequate supervision to prevent accident. Adequacy of supervision.

A review of the facility's "Meal Supervision and Assistance Policy", dated November 2018, revealed, the resident will be prepared for a well-balanced meal in a calm environment, location of his/her preference and with adequate

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supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event this includes identifying hazards and risk, evaluating and analyzing hazards and risk, implementing interventions to reduce hazards and risks, monitoring for effectiveness and modifying interventions when necessary. He facility will utilize a systemic approach to ensure safety throughout the resident's environment and among all staff. Do not serve the meal until attendant is ready to assist the resident. Supervision/adequate supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and frequency of supervision needed. This determination is based on individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

A review of the facility's Nurses' Notes for Resident #1, dated 11/05/2019, documented, a nurse was called to the Memory Care Unit. The notes revealed, a Certified Nursing Assistant (CNA) reported Resident #1 shoved a roll into his mouth and choked. The CNA also reported she had to dig the roll out of his mouth. The CNA further revealed the resident choked yesterday on green beans because eats so fast.

Review of the facility's Nurses' Notes for Resident #1, dated 12/31/2019, revealed, Resident #1 fed himself with cueing and supervision. Resident #1 gulps food unless monitored. A review of Resident #1's Nurses' Notes, dated 05/15/2020,

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documented by Registered Nurse (RN) #1, revealed she entered the Memory Care Unit and observed Resident #1 standing up with a bluish-gray, pale tint to his face and around his lips. Resident #1 appeared to be choking. Resident #1 was unable to cough to clear his airway. The Heimlich maneuver performed times two (2). Resident #1 became weak and collapsed to the floor. Mouth sweeps were performed with food particles removed. Resident #1 was transferred to his room. The Medical Doctor was at bedside, Oxygen administer as well as suctioning. Food particles were removed from Resident #1's airway. The staff was unable to clear airway. The Medical Doctor pronounced Resident #1 at 7:28 AM.

Record review of the facility's Physicians Notes, dated 05/15/2020 at 7:45 AM, revealed, Resident #1 was eating breakfast without swallowing, and aspirated with collapse. The Heimlich and mouth sweeps performed by the nursing code team. Large chunks of scrambled eggs removed from air way before he arrived from down the hall. Resident #1 was awake, eyes open sitting up, no coughing but spontaneous respirations. Within a minute Resident #1 collapsed again, transferred to bed the staff yanker suctioned more food debris. Resident #1 noted to be a Do Not Resuscitate (DNR), no spontaneous respiration effort, no gag reflex, oxygen added, ambulance in route, agonal heartbeat but no pulse, no heartbeat, eyes fixed and dilated. Ambulance canceled. Resident #1 pronounced at 7:28 AM.

A review of the facility's Speech Therapy Plan of Care, dated 11/08/2019, revealed, Resident #1 was referred to Speech Therapy because he exhibit new onsets of decreased safety during oral intake, coughing, choking during oral intake,

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risk for aspiration, decreased safety awareness, increased behaviors, decreased verbal communication, increased need for assistance from others, decreased ability to use compensatory strategies and cognitive-communicative deficits placing patient at risk for aspiration, weight loss and further decline in functions and falls. The Speech Therapist revealed, Resident #1 was at risk for aspiration, had impulsive tendencies, to restrict the resident's performance in unsupervised tasks, reduce background noise, stand directly in front of the resident and speak in a deep voice when communicating. The Speech Therapist recommended a Mechanical Soft Diet with supervision and assistance required being determined by the resident's mood and impulsive tendencies at that moment dated 01/02/2020.

Record review of the Speech Therapy Plan of Care, dated 05/01/2020, revealed, Resident #1 was referred to Speech after a new onset of decreased safety during a meal which was evidenced by Resident #1 severely choking during a meal when food was stuck in the resident's throat. As a result, nursing monitored Resident #1 and took Pneumonia precautions with X-ray, after the resident's temperature spiked. ATherapist standardized test dated 05/01/2020, revealed, Resident #1 was given the bedside Dysphagia evaluation, which Resident #1 was found to have both oral and pharyngeal dysphagia which put him at risk for aspiration. Resident #1 was impulsive and put large spoon/bites in mouth and sometimes two (2) or more spoon/bites in his mouth causing severe choking episodes. Resident #1 was found to be a candidate for skilled dysphagia therapy to implement training strategies for both resident and caregivers to decrease choking risk.

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M 640	Continued From page 27 A record review of in-service instructions related to Resident #1, dated 05/01/2020, by the Speech Therapist, revealed, Certified Nursing Assistant (CNA) #1 and CNA #2 was in-serviced on: purpose of a small spoon, to encourage liquids between swallows during meal time, strategies to recognize impulsive behavior during meal time also have the ability to recognize mood of patient and determine level of assistance needed that day. Then, implement use of compensatory strategies (i.e. Hand over Hand, diet modifications "not giving roll", removing tray from patient and calming patient down, giving meal tray last, and being one-on-one, handing patient something to drink in between bites and ultimately removing tray from patient and feeding patient) to decrease impulsive behavior and to ensure meal time safety. An interview, on 09/03/2020 at 10:15 AM, with CNA #2, revealed, she was assisting another resident in the dining room. CNA #2 stated Resident #1 came out of the dining room with CNA #1 patting him on his back, because he had stuffed food in his mouth. CNA #2 stated Resident #1 fell to the floor, and CNA #1 was trying to get food out of his mouth. She revealed there was not a nurse in the dining room at that time. CNA #2 stated the nurse made rounds on the unit periodically. CNA #2 stated she called for help, and Registered Nurse (RN) #1 came on the unit and pulled eggs out of Resident #1 mouth. CNA #2 revealed Resident #1 would hoard food and pocket food in his mouth. CNA #2 stated the Speech Therapist in-serviced all the CNAs on the Memory Care unit instructing that Resident #1 should eat last, should drink in between bites, and should be supervised during meals because he had a history of choking by shoveling large	M 640		

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amounts of food down his throat. CNA #2 stated Resident #1 had several behaviors that required one on one supervision.

Observation of the lunch meal, on the Memory Care Unit, on 09/03/2020 at 11:45 AM, revealed, two (2) CNAs assisting eight (8) residents with lunch. The residents were spread out around the dining room. There were no licensed nurses noted in the dining room during the meal. The CNAs uncovered the lunch trays and the residents fed themselves without difficulty.

During an interview, on 09/03/2020 at 12:30 PM, with CNA #1, she stated that she was assisting Resident #1 with his breakfast on 05/15/2020 (day of incident). CNA #1 stated another resident came into the dining room. CNA #1 confirmed she left Resident #1 at the table unattended. CNA #1 revealed she assisted another resident by unwrapping her food and setting up her tray, and CNA #2 was assisting another resident at that time. CNA #1 stated when she turned around to check on Resident #1, she noticed Resident #1 stuffing food from his tray and another resident's tray, into his mouth. She revealed Resident #1 was turning gray. CNA #1 stated she tried to get Resident #1 to open his mouth, but he clenched his teeth together. CNA #1 stated she tried to assist Resident #1 to the bathroom to clean his mouth, and he started turning blue, and fell to the ground in the day area by the nurse's station. She stated that CNA #2 called for a nurse. There were no nurses on the unit at that time. CNA #1 stated the nurses are not on the unit during meals. CNA #1 stated she was in-serviced by the Speech Therapist to give Resident #1 meals last and to assist him with his meals, because he stuffed food in his mouth that would choke him. CNA #1 further stated she should have asked CNA #2 to

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assist with the other resident's breakfast. CNA #1 confirmed Resident #1 should not have been left unattended because he was impulsive and had a history of shoving food in his mouth.

During an interview, on 09/03/2020 at 1:00 PM, with Registered Nurse (RN) #1, revealed, she was called into the Memory Care Unit by CNA #1. RN #1 stated she was the Supervisor for the day. RN #1 revealed Resident #1 was blue when she entered the unit and lying on the floor. RN #1 revealed she performed the Heimlich maneuver and was not successful. RN #1 said Resident #1 was taken to his room and suction was initiated. She stated large amounts of scrambled eggs were removed from Resident #1's mouth. RN #1 also stated, Resident #1 had a history of choking on his food because he puts large amounts of food in his mouth at one time. RN #1 confirmed Resident #1 needed one on one supervision with meals.

During an interview, on 09/03/2020 at 1:30 PM, the Speech Therapist (ST) revealed, Resident #1 had a history of choking and aspirating. She stated Resident #1 was impulsive and shoveled food in his mouth. The ST stated there were several things put in place for Resident #1's behavior medication and safety, such as: Resident #1 should receive his tray last, one on one supervision with meals, ordered a small spoon and receive sips of water between each bite. The ST stated she in-serviced the CNAs on May 1, 2020 of Resident #1's feeding instructions. She also stated that she talked to the Director of Nursing (DON) about Resident #1's behavior modification and safety. The Speech Therapist stated the facility refused to follow her recommendations. She stated, on 04/31/2020, the Assistant Director of Nursing (ADON) told her

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that Resident #1 had swallowed a roll whole. She stated Resident #1 was able to cough up the roll with her (ADON) and RN #3 patting him on his back. She stated RN #3 received an order to consult Speech Therapy on 04/31/2020. The ST stated Resident #1 was re-evaluated on 05/01/2020. The Speech Therapist stated she also in-serviced the CNAs with instructions on how to provide behavior modifications to keep Resident #1 from choking. The ST stated she in-serviced the CNAs because they were the ones taking care of Resident #1. She stated she place instructions for Resident #1 in her notes. The ST said the facility had a communication issue between Nursing and Therapy. She stated that she monitored the CNAs for several days to make sure they followed the protocol. The ST stated the CNAs demonstrated passing out the other resident's trays first, and Resident #1 received his tray last. She revealed Resident #1 had one on one supervision, sips of water in between each bite, and a small spoon used with no difficulty. The ST revealed, the facility had a Utilization Review (UR) Meeting on Fridays, which included the Medical Doctor (MD), Director of Nursing (DON), Care Plan Nurse, Minimum Data Set (MDS), Therapy, and Quality Assurance.

During an interview, on 09/04/2020 at 9:30 AM, RN #3/Nursing Supervisor stated she observed Resident #1 laying on his right side, on the floor. She stated Resident #1 was gray in color, and had scrambled eggs noted on his shirt sleeves. RN #3 stated that RN #1 was pulling eggs out of Resident #1's mouth with finger sweeps. She stated Resident #1 was slumped over and unresponsive. She stated suction was set up and RN #1 suctioned pieces of food out of his mouth, mainly eggs. She revealed Resident #1 remained unresponsive. RN #3 stated the MD pronounced

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Resident #1 at that time. RN #3 confirmed Resident #1 had a history of choking during meal time. RN #3 stated Resident #1 should have always been supervised during meals because he shoved large amounts of food in his mouth. She revealed Resident #1 had an incident on 04/29/2020, when a roll was stuck in his throat. RN #3 stated Resident #1 was able to cough up the roll with assistance. RN #3 also stated the doctor ordered an X-ray, speech was consulted, and antibiotics ordered.

An interview, on 09/04/2020 at 10:00 AM, with the Medical Director (MD) revealed, he stated that Resident #1 had a history of choking. The MD stated Resident #1 was impulsive and had several other behaviors. He revealed Resident #1 should have had one on one supervision 24 hours a day due to all of his behaviors. The MD revealed he was called to the Memory Care Unit, on 05/15/2020 (day of incident), and was at the bedside while the staff suctioned the food particles from Resident #1's mouth. The MD said Resident #1 became unresponsive, stopped breathing, and was pronounced at 7:28 AM. The MD confirmed the cause of death was Hypoxia due to Resident #1 choking and aspirating his breakfast.

During an interview, on 09/04/2020 at 5:00 PM, the Director of Nursing (DON) confirmed Resident #1 had a history of choking as well as other behaviors. The DON stated she did not know the Speech Therapist had requested a special spoon to prevent choking until 05/01/2020 during a meeting. The DON stated the staff informed her that Resident #1 was not getting the spoon with all meals because the facility only had one. The DON stated she told the Dietary Manager to order more spoons. The DON further

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stated she was not aware that the Speech Therapist had recommended one on one supervision for Resident #1, to serve Resident #1 last, and to offer him sips of water in between bites, until after the resident's death. The DON stated she did not know the Speech Therapist had in-serviced the CNAs on 05/01/2020 with behavior modifications for Resident #1. The DON revealed she discussed with the Administrator and the Owner of the facility, that the Memory Care Unit should have a nurse during meals, but the Administrator and Owner refused.

Review of the facility's Removal Plan revealed the facility took the following actions to remove the Immediate Jeopardy:

1. Sixty-three (63) residents were assessed by the Licensed Social Worker and the Social Services Director for behaviors that may lead to self-injury or harm on September 4, 2020 completed at 12:30 PM. Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM.

2. Sixty-three (63) residents were assessed by the Speech Therapist for swallowing difficulties and choking. Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by

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the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 2:30 PM.

3. Eight (8) of eight (8) Registered Nurses(RN), seven (7) of 13 Licensed Practical Nurses(LPN), 30 of 38 Certified Nursing Assistants (CNA), four (4) of 12 Dietary Aides, five (5) of seven (7) Housekeepers, five (5) of seven (7) Activity Personnel, two (2) of three (3) Laundry Personnel, one (1) of three (3) Therapist, four (4) of four (4) Administrative Staff were in-serviced on September 2, 2020 by the Assistant Director of Nursing (ADON) from 2:30 PM until 3:00 PM on supervising and monitoring risk for aspiration and choking hazards.

4. A total of 64 residents' charts were reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/ Quality Assurance Nurse. All 64 residents' charts were reviewed and assessed based on their prescribed diets and diagnosis related to those diets were found to be 100% accurate. A total of 64 residents care plans were reviewed at this time with 100% accuracy. The chart reviews were completed on September 2, 2020 at 5:30 PM.

5. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on September 2-3, 2020 by the Social Services Director and the ADON from 6:00 PM until 10:00 AM on Meal Supervision and Assistance Policy.

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M 640	Continued From page 34 6. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in- serviced on September 2, 2020 by the Owner of the facility from 2:30 PM until 3:00 PM on the accessibility of care plans and nutritional systems location. 7. Eight (8) of eight (8) RNs, 22 of 38 CNAs, eight (8) of 13 LPNs, two (2) of seven (7) Housekeepers, one(1) of three (3) Laundry, one (1) of 12 Dietary, three (3) of five (5) Activity Personnel, four (4) of four (4) Administrative Staff were in-serviced on the facility's Abuse, Neglect, and exploitation policy to include information regarding who, when, and how to report to the State Agency. 8. The Quality Assurance Committee (QA) comprised of the Medical Director, Administrator, Director of Nursing, Infection Control Preventionist, Quality Assurance, Owner of facility, Certified Recreational Therapist, Certified Dietary Manager, Assistant Director of Nursing, Licensed Social Worker, Social Services Director, Admissions Nurse, Minimum Data Set Nurse, Medical Records Nurse and Care Plan Nurse met on September 2, 2020 at 1:00 PM. A plan of action was implemented at this time to ensure that all staff is in-serviced on supervising and monitoring risk for aspiration and choking hazards, Meal Supervision and Assistance Policy, systematic communication within the facility related to residents that are deemed to be at risk for aspiration or a choking hazard, implementation of the nursing/therapy communication form, accessibility of care plans and nutritional systems location. If a resident is	M 640		

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identified as being a choking or aspiration risk, the resident will be assessed by a Speech Therapist to determine the adequate level of supervision needed. This determination will be based on the individual needs of the resident and identified hazards. A nursing/therapy communication form was implemented at this time to ensure all residents that are deemed at risk for aspiration or choking will be reviewed and discussed by the Interdisciplinary Team (IDT) and reviewed by the Quality Assurance Committee. The Care Plan Nurse will review all charts and diet orders of the resident who is at risk for aspiration or choking and refer to the Quality Assurance Committee for review and implementation of any negative outcomes. All residents' charts that were identified according to their prescribed diet and aspiration risk have been reviewed by the Care Plan Nurse, the Admissions Nurse, and the Infection Control Preventionist/Quality Assurance Nurse. A total of 64 residents care plans were updated on September 2, 2020 at 5:30 PM by the Care Plan Nurse. The IDT reviewed all policy and procedures related to the adverse event and deemed all policies and procedures do not require any revision at this time. QA reviewed the state and federal regulation and facility guideline requirements for reporting incidents to the State Agency and the Attorney General's office. All reported incidents will be reviewed in the monthly QA meeting.

9. The QA Committee met on September 4, 2020 at 8:00 AM for review and implementation to have all 63 residents assessed for behaviors that may lead to self-injury or harm, to identify anyone who is at risk and implement person centered interventions, and to in-service all staff members on recognizing behaviors and potential for

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M 640	Continued From page 36 self-harm and injury and whom to report to. The findings were as followed: Six (6) of the 63 residents that were assessed were found to be at risk for self-injury or harm to themselves. Person-centered interventions were identified for each resident and reviewed by the Medical Director and the Psychiatric Nurse Practitioner, who is in agreement with the course of action and no further recommendations were made at this time. Six (6) of the 63 residents care plans were reviewed and updated on September 4, 2020 at 12:30 PM. The QA Committee determined all 63 residents will be assessed by the Speech Therapist for difficulty swallowing and choking and to review and implement a plan of care to prevent any adverse reactions related to findings by the Speech Therapist. The findings were as followed Six (6) of 63 residents that were assessed were found to be at risk for difficulty swallowing and choking at this time. Person-centered interventions and care plans were identified for each resident and reviewed by the Medical Director, Interdisciplinary Team (IDT), and the Dietician. No further recommendations were made at this time. All residents that have a diet order or diet changes will be reviewed during the weekly care plan meeting by the IDT to prevent any further adverse events. All residents that are reported on the Nurse/Therapy documentation form will be immediately reviewed by the IDT, recommendations discussed, and a plan of care will be put into effect. The Nurse/Therapy documentation forms will be reviewed weekly during the care plan meeting with the IDT to prevent any further adverse events. No staff will be allowed to work until they are in-serviced.	M 640		

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M 640	Continued From page 37 The facility alleges the Immediate Jeopardy and SQC removed on September 5, 2020. The State Agency (SA) validated the facility's Corrective Actions through observation, interview, record review, and review of sign-in sheets. 1. The SA validated through interviews and record review of all residents were assessed by the licensed Social Worker and the director of Social Services for behaviors that may lead to self-injury or harm. 2. The SA validated through interviews and record review of all residents were assessed by the Speech Therapist for swallowing difficulties and choking aspiration. 3. The SA validated through interviews and were in-serviced on supervising and monitoring risk for aspiration and choking hazards. 4. The SA validated through record review that all residents in the facility charts were reviewed by the care plan nurse for accuracy of all Residents diets. 5. The SA validated through interviews and in-services by the Social Worker on meal Supervision. 6. The SA validated through interview and in-services on the accessibility of care plans and nutritional systems location. 7. The SA validated through interview and in-services on the facilities Abuse, Neglect, and exploitation policy to include information regarding who, when and how to report to the State Agency.	M 640		

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M 640	Continued From page 38 8. The SA validated a Quality Assessment and Assurance Committee meeting was held on September 2, 2020 and September 4, 2020 by interview and review of the sign-in sheet. 9. The SA validated that all corrective actions listed were accomplished by 09/05/2020. 10. The SA validated through interviews and record review that staff were not allowed to work until in-serviced. 11. The SA validated that all corrective actions were completed as of 09/05/2020, and the IJ was removed prior to exit on 09/5/2020.	M 640		