STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355097	A. BUILDING _____ B. WING _____	C 05/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LARIMORE	501 E FRONT ST LARIMORE, ND 58251

(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 An unannounced onsite facility incident survey was completed on April 28, 2021. The sample included one sampled residents for focused review. Based on the findings, an extended survey was conducted on May 24-25, 2021.	F 000		
F 675 SS=J	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy, incident report, and staff interview, the facility failed to follow the physician's order for a regular diet with cut up meat for 1 of 1 resident closed record reviewed (Resident #1). Failure to serve meat ordered by the physician resulted in Resident #1 experiencing a choking episode resulting in death. During an on-site facility incident investigation on 04/28/2021 the survey determined a deficiency at F675. Based on the review of the results of the survey, the State Survey Agency (SSA) team determined an Immediate Jeopardy (IJ) situation existed, but this was not conveyed to the facility until	F 675	1. Resident no longer resides in facility. 2. All residents on a therapeutic or mechanically altered diet have the potential to be affected by this deficient practice. Resident care plans were reviewed on May 21, 2021 for Diet Order accuracy, review of resident diagnosis in regards to choking or swallowing difficulties, special diet instructions, and if the resident has had a swallow evaluation, or is in need of one. Updates were made as needed to residents care plans to ensure all diet orders are being followed as prescribed by physician order. 3. Education completed for all dietary staff on May 21, 2021 on following resident's diet orders and care plan. They	5/25/21

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

Electronically Signed | 06/09/2021

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F 675	Continued From page 1 05/21/2021. The facility failed to follow the physician's orders for cut up meat when serving shrimp to a resident. The resident experienced a choking episode. Facility staff responded and emergency personal were called to assist. The episode resulted in the resident's death. The potential for harm for other residents could still exist. On 05/21/2021 at 8:14 a.m., the SSA notified the Regional Office (RO) of the IJ and the RO staff agreed. On 05/21/2021 at 8:37 a.m., the SSA management team called the facility and notified the administrator and director of nursing of the IJ and requested a removal plan be submitted to the SSA. The SSA emailed the IJ template to the administrator of the facility. On 05/21/2021 at 5:00 p.m., the SSA received by email and then approved the removal plan from the facility. At 5:12 p.m., the SSA sent an email notification to the facility of the approval and notified the RO. The approval plan contained the following: All Staff meetings were held on May 3, 2021. Education was provided to all staff on the following: any resident with concerns of swallowing or choking issues need to be reported to the charge nurse immediately, and the following policies were reviewed with all staff members; Care Plan/Rehab Skilled, Heimlich maneuver, and Dining Room Service Rehab/Skilled. All residents care plans were reviewed by May	F 675	were also educated on the following policies; Finger Foods – Food and Nutrition Services, Texture – Modified Diets – Food and Nutrition Services, Diet Orders – Food and Nutrition. All staff were educated on 5/21/21 on cut meats being no larger than 1.5cm x 1.5cm. Per IDDSI “Bite-sized” pieces is no bigger than 1.5cm x 1.5cm in size. 4. Director of Nursing or designee will monitor by auditing 5 resident care plans for dietary order accuracy, the orders sheet used by dietary staff, and observing meal pass for those selected residents. Audits will occur weekly for 4 weeks, and then monthly for 2 months. Audits began May 6th, 2021. Results of audits will be submitted to QAPI committee for further recommendation.	

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F 675	Continued From page 2 21, 2021 for Diet Order accuracy, review of resident diagnosis in regard to choking or swallowing difficulties, special diet instructions, and if the resident has had a swallow evaluation or is in need of one. Updates were made as needed to resident's care plans to ensure all diet orders are being followed as prescribed by physician order. The plan of care was also validated and matched the order sheet used by dietary staff. Education was implemented immediately post event and completed for all dietary staff as of May 21, 2021 on following resident's diet orders and care plan. They were also educated on the following policies: Finger Foods - Food and Nutrition Services, Texture - Modified Diets - Food and Nutrition Services, Diet Orders - Food and Nutrition. All staff were educated on 5/21/21 on cut meats being no larger than 1.5cm x 1.5cm. Per IDDSI "Bite-sized" pieces is no bigger than 1.5cm x 1.5cm in size. Director of Nursing or designee will monitor by auditing 5 resident care plans for dietary order accuracy, the orders sheet used by dietary staff, and observing meal pass for those selected residents. Audits will occur weekly for 4 weeks, and then monthly for 2 months. Audits began May 6, 2021. During the extended survey on May 24 - 25, 2021, the team verified the implementation of the removal plan and the IJ removal on 05/21/2021. On 05/24/2021 at 5:20 p.m., the team notified the administrator of the IJ removal. F675 scope/severity of J reduced to a	F 675		

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F 675	Continued From page 3 scope/severity of G. Findings include: Review of facility policy titled, "DYSPHAGIA (difficulty swallowing) - Food and Nutrition" occurred on 04/28/21. This policy, revised May 2020, stated, ". . . A resident with dysphagia receives safe and adequate nutrition . . . based on the resident's ability to chew/swallow and on his or her nutrition needs. . . ." Review of Resident #1's medical record occurred on 04/28/21. Diagnoses included dementia, cerebral vascular accident (stroke), and dysphagia. Resident #1's physician orders, dated 05/08/20, stated, ". . . Regular diet . . . cut meats . . ." Resident #1's current care plan also stated, ". . . Eating: . . . Diet, Reg [regular] L4 [level 4 per diet manual], . . . cut meats. . . ." A speech therapy discharge summary, dated 05/05/2020, identified ". . . assistance with meal prep (cutting up meats) . . . set-up assistance. Occasional supervision/supervision from afar . . . small bites and sips . . ." The progress note identified the following: * 4/23/21 at 12:07, "Late Entry: . . . 11am resident having brunch in the dinning [sic] room. Approx. [approximately] 11:10am Restorative care . . . asked writer as she's rush walking towards writer saying: "Can you help (Resident #1) she's choking!" Looking at resident sitting in wheelchair while on the rush towards nurses station, resident face, especially lips were already purple as she tried to cough the food that was stuck out. CNA [certified nurse's assistant] . . . came to	F 675		

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F 675	Continued From page 4	F 675		

help. Writer asked CNA . . . and restorative care . . . to help resident stand up and writer did Heimlich maneuver but nothing came out. Nurse . . . came and writer had her take over and do Heimlich maneuver as well but still nothing came out. While nurse . . . is doing Heimlich on resident, writer called 911 right away to rush to facility. While writer is on the phone with 911, nurse, CNA . . . and [restorative care] took resident to her room . . . and laid her on the floor on the back board that nurse . . . brought. Writer ran to resident's room after calling 911. Nurse . . . brought oxygen tank and CNA . . . brought oxygen mask. Put resident initially on 4L [4 liters of oxygen] while resident is on her left side. Writer still attempted back blows [sic] resident's back and also tried doing abdominal thrusts again. Before writer came, nurse . . . said she also did abdominal thrusts on resident. Resident has some pureed yellow food came out. Approx. 11:20am 911 responders came lead [sic] by . . . When residents [sic]started working on resident they removed her dentures and suctioned out 4 and a half shrimps from resident. Resident is on a regular diet and kitchen staff does cut up most meats due to her inability to cut them up herself. Shrimp does not require kitchen staff to assist with cutting up. Resident still continued to be unresponsive. While 911 responders were attending to resident, writer went to nurses' station and took POLST [physicians order for life sustaining treatment] copy for responders. They can not do CPR [cardiopulmonary resuscitation] as resident is DNR [do not resuscitate]. Writer also called resident's daughter . . . and was on her way. Responders' noted time of death at 11:37 am . . ."

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F 675	Continued From page 5 Review of the incident report dated 04/27//21, identified the following: * A cook (#8) stated, " . . . We were serving in the dining room as normal. When I got to her name I put 6 shrimp on her [plate] . . . We cut her meat so it is easier for her to eat . . . We do not cut finger food though and that is what the shrimp were. . . ." * A dietary aide (#9), stated ". . .We serve [sic] breaded shrimp . . . to the resident. The resident eats shrimp every time we serve it as it is one of her favorites. . . . When we cleaned up her plate there were only 2 left on her plate, she had eaten everything else on her plate. . . ." * Restorative therapy/CNA (#1) stated, ". . . I was in dining room helping [Resident #2] eat when I saw across the table [Resident #1] was choking and as I started to walk over to her I saw something come out of her mouth and then [Resident #1] put it back in her mouth. Then I went over there and and [sic] it looked like she was choking. I then ran to hall and yelled for a nurse. I wheeled resident to nurses station and [nurse] (#5) jumped up and started the heimlich right away. . . ." * A nurse (#4), stated ". . . EMT [emergency medical technician] got 4 ½ shrimp they were about the size of a 50 cent piece [from residents mouth] . . . EMT did back blows and finger sweeps and requested oxygen at 15 liters. Initially started choking [sic] the dining room at her table. [Nurse #4] states [Resident #1] has choked before but not the extent she needed this kind of medical intervention. . . ." * A nurse (#7) stated, ". . . saw the shrimp after [EMS] emergency medical staff had removed from resident's mouth and they were not chewed up at all. . . ."	F 675		

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F 675	Continued From page 6 During an interview on 04/28/21 at 12:35 p.m., a dietary manager (#6) stated, "I consider shrimp a two bite food." The dietary manager (#6) confirmed the facility did not cut up Resident #1's shrimp on the day of the incident.	F 675		