STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355110	A. BUILDING _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELM CREST MANOR	**100 ELM AVE, #396 NEW SALEM, ND 58563**

(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 investigation survey regarding a facility reported incident and a complaint was completed on June 25, 2024. During the report investigation the facility was found noncompliant with regulatory requirements. During the complaint investigation the facility was found in compliance with regulatory requirements.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and review of the facility reported incident investigation, the facility failed to provide food textures according to the resident's prescribed diet for 1 of 1 sampled resident (Resident #1) who had a choking incident. Failure to ensure Resident #1's diet is followed while serving snacks resulted in a hospital emergency room transfer and treatment for choking. This citation is considered past noncompliance based on review of the corrective action the facility implemented immediately following the incident. Findings include:	F 684	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/10/2024

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F 684	Continued From page 1 This surveyor determined a deficient practice existed on 06/14/24. The facility implemented corrective action and education on 06/14/24. Review of the facility policy titled "Therapeutic Diet Order Policy" occurred on 06/25/24. This policy, dated, 02/24/24, stated, ". . . Therapeutic Diet is a diet ordered by a physician or delegated registered dietician, a part of treatment for a disease or clinical condition . . . dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form as prescribed . . . NDD1 Level 1 (National Dysphagia Diet) Level 1 . . . Dysphagia Pureed diet . . . this diet consists of pureed food . . . food should be 'pudding-like'. . . meats . . . recommended . . . pureed meats . . . breads . . . recommended facility prepared pureed bread . . ." Review of Resident #1's medical record occurred on 06/25/24 and included diagnoses of dementia. Physician orders showed a regular NDD1 Level 1 diet, also known as a Dysphagia-pureed diet with small portions. The resident's current care plan stated, "Resident to receive ordered diet NDD1-pureed diet . . . small portions . . ." Resident #1's progress notes, dated 06/14/24 at 6:44 a.m., stated, "Late entry . . . Resident began choking and unable to breathe . . . O2 Sats [oxygen saturation rate] was 87-88% . . . asked if the certified nurse aide [CNA] had done any Heimlich maneuver [abdominal thrusts] . . . she had and said some of the obstruction came out . . . resident stated had something in her throat and that it hurt . . . call to on call provider . . . said she should be looked at . . . ambulance called . . . ER	F 684		

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F 684	Continued From page 2 [emergency room] given report of incident . . . resident's daughter informed . . resident is on a pureed diet . . . she had snacks that did not meet her diet requirement . . . " Review of physician notes, dated 06/14/24 at 2:53 p.m., ". . . resident was seen today following an emergency room visit for a choking episode . . . she is currently on a regular diet with pureed consistency . . . she was given a granola bar and a piece of beef jerky and choked on them . . . recommend to continue a pureed diet and do not offer foods that are difficult for her to chew or swallow . . ." The facility's investigation report, dated 06/14/24, stated, ". . . resident was given a snack . . . resident started to cough and was struggling with her airway . . . asked resident if there was something in her throat . . . she shook her head yes . . . was given a couple of back blows . . . called on call doctor and received orders to send to ER . . . resident was given a beef jerky stick, milk and a granola bar . . . the staff member stated they did not look at the resident's diet as they did not think about it at that time . . ." Based on the following information, noncompliance at F684 is considered past noncompliance. The facility implemented corrective actions on 06/14/24 to ensure the deficient practice does not recur by: * The facility completed an investigation with interviews of staff that determined the cause of the incident. Resident #1's morning snack on 06/14/24 consisted of a granola bar and beef jerky. Staff failed to follow the pureed diet order. * The facility provided immediate staff education	F 684		

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F 684	Continued From page 3 to the CNA and nurse present during the incident. * The facility provided education to nursing staff through the communication book. * The facility placed binders noting all resident diets in the resident's coffee/snack area and the nurses' station. * On-going education with all staff will continue to occur.	F 684		