STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018660	A. BUILDING: _____ B. WING _____	C 11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE TERRACE	5883 WEST RIVERSIDE DRIVE GREENDALE, WI 53129

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N 000	Initial Comments On 11/29/2023, Surveyor completed a complaint investigation and review of a facility self-report at Riverside Terrace. The complaint was unsubstantiated. Review of the self-report resulted in 1 deficient practice. Census: 4	N 000		
N 448	83.41(2)(a) Nutrition: diet. Diets. 1. The CBRF shall provide each resident with palatable food that meets the recommended dietary allowance based on current dietary guidelines for Americans and any special dietary needs of each resident. 2. The CBRF shall provide a therapeutic diet as ordered by a resident ' s physician. This Rule is not met as evidenced by: Based on record review, observations, and interviews, the provider did not ensure a therapeutic diet was provided as ordered by Physician C for 1 of 1 resident (Resident 1). Resident 1 had a physician order for a mechanical soft diet. The order, dated 02/28/2023, was not included on the Individual Service Plan (ISP). On 06/17/2023, Caregiver B gave Resident 1 toast with peanut butter on it. Resident 1 slumped over and became unresponsive. Emergency responders were called. Resident 1 was transported to a hospital and passed away. The hospital staff found peanut butter and bread in	N 448		

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

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N 448	Continued From page 1 Resident 1's throat. Findings include: On 06/29/2023, at 7:03 p.m., the department received a self-report via fax The self-report identified on 06/17/2023 at approximately 11:55 a.m., a resident became unresponsive while eating toast with peanut butter. Emergency responders were called. Emergency medical services (EMS) staff attempted cardiopulmonary resuscitation (CPR). The resident was taken to the hospital, where s/he was later pronounced dead. The self-report did not identify the resident's name. On 07/06/2023 at 8:08 a.m., the department received another self-report from Licensed Practical Nurse (LPN) G. This self-report identified Resident 1 and Caregiver B. The self-report stated, "[Caregiver B] was getting lunch ready for residents. [Caregiver B] checked [Resident 1] BS (blood sugar) = 87. [Caregiver B] brought [Resident 1] 2 pieces of peanut butter toast. After [Resident 1] finished the 1st piece, [s/he] slumped over + [and] became unresponsive. [Caregiver B] called 911. Paramedics arrived & [and] started CPR. [Caregiver B] notified [Registered Nurse (RN) D] of incident. Paramedics left with [Resident 1]. Staff was later notified that [Resident 1] passed away. They found peanut butter & [and] bread in [Resident 1's] throat." On 11/08/2023 at approximately, 1:05 p.m., Surveyor observed a form posted on the refrigerator titled, "Texture Modified Diets." The form included a description of foods allowed and not allowed on a 'Dysphagia Soft Diet.' Foods not allowed included dry, crumbly, or chewy bread	N 448		

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products and crunchy or smooth nut butters, like peanut butter.

On 11/08/2023 at approximately 12:20 p.m., Surveyor reviewed Resident 1's record and identified the following:

-Resident 1 was admitted on 03/02/2023 with diagnoses of diabetes Type 2 (long-term insulin dependent), chronic obstructive pulmonary disease, heart failure requiring a pacemaker, bipolar disorder, anxiety, and hypertension.
-Resident 1's admission risk assessment, dated 03/02/2023, identified Resident 1 was not at risk of choking.
-Resident 1's face/information sheet identified Resident 1 required a mechanical soft diet.
-Resident 1's ISP, dated 03/02/2023, identified, "Choking...Current Status: Exhibits no choking episodes or need for supervision....Special Dietary Needs: Directions: Monitor and assist with resident's special dietary needs...Current Status: Resident needs consistent assistance with all dietary needs (Calorie Monitoring, Nutritional Supplements/Shakes, etc.) Resident's Desired Goals and Outcomes: Maintain diet parameters and provide nutritious food choices within diet parameters. Resident 1's ISP identified Resident 1 required a diabetic diet and to receive snacks at specified times. Resident 1's ISP did not identify Resident 1's need for a mechanical soft diet or specifics regarding any additional special dietary needs. Resident 1's ISP did not mention Resident 1 was missing teeth.
-Progress Note, dated 06/17/2023 and timestamped 1:15 PM, authored by Caregiver B stated, "On 06/17/2023 around 11:55am [sic] [Caregiver B] went to get [Resident 1] up for lunch and [Resident 1] appeared to get out of bed ok [sic] and roughly 3 to 4 minutes later

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[Caregiver B] found [Resident 1] on the floor leaning against the bed by the room door. [Caregiver B] immediately tested [Resident 1's] BS [blood sugar] 65 was the result, [Caregiver B] administered [Resident 1] some toast with peanut butter and [Resident 1] stopped responding within seconds [Caregiver B] called 911 and notified nurse for further instructions. [Resident 1] was transported to St. Luke's Hospital for further assessments." There was no mention if Resident 1 was able to get up off the floor, if there were any injuries, or what Resident 1's mental state was, i.e., alert, or drowsy.
-Surveyor was not able to locate a physician order for a diet in the record. Administrator 1 stated s/he would look through the old records and send it to the Surveyor.

On 11/27/2023 at 1:33 p.m., Surveyor reviewed Resident 1's physician order sent from the provider. Resident 1's physician order, dated 02/28/2023, signed by Physician C, identified Resident 1 required a mechanical soft diet.

On 11/27/2023 at 4:04 p.m., Surveyor received an email from RN E indicating the MCO did not have a record of a diet order. Per the email. Resident 1 moved from an adult family home (AFH) to this community based residential facility (CBRF) after several hospitalizations, a fall, and general decline. The AFH residents at the previous placement went to day programming during the day and Resident 1 was no longer able to attend day programs due to weakness and a general decline. Resident 1 moved from the AFH to the CBRF. RN E indicated the admission orders went directly to the CBRF from Physician C.

On 11/28/2023 at 1:44 p.m., Surveyor reviewed managed care organization (MCO) records.

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Resident 1's assessment, dated 04/18/2023, identified Resident 1 was missing teeth.

On 11/21/2023, at 10:15 a.m., Surveyor received and reviewed hospital records. Surveyor identified on 06/17/2023, according to EMS, they were called to the facility for a diabetic issue. They were called at 12:20 p.m. Upon arrival, EMS found Resident 1 PEA (Pulseless Electrical Activity) and Resident 1 never had a return of pulse. The facility staff told EMS Resident 1's blood sugar was low, so they gave Resident 1 a peanut butter and jelly sandwich at noon. Resident 1 had a blood sugar of 96 upon arrival of EMS. EMS was not able to place an airway and performed a cricothyroidotomy (an incision made in the throat to establish an airway during life-threatening situations, such as airway obstruction by a foreign body) as they were trying to remove the sandwich in Resident 1's airway. The emergency room record indicated Resident 1 had a down time of approximately 20 minutes prior to EMS arrival to the facility. Resident 1 arrived in the Emergency Room at 1:13 p.m. Resident 1 had been resuscitated for close to an hour without any spontaneous return of pulses despite 8 rounds of epinephrine and continuous CPR. Resident 1 was pronounced deceased at 1:18 p.m.

On 11/08/2023 at approximately 12:20 p.m., Surveyor reviewed Caregiver B's record. Caregiver B was hired on 02/03/2023 and was on the Nurse Aide Registry. Caregiver B's record did not indicate any training in special diets.

On 11/29/2023 at 3:00 p.m., Surveyor interviewed Administrator A, LPN F, Owner H, and RN D. Administrator A, LPN F, Owner H, and RN D confirmed Resident 1 had a physician order for a

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mechanical soft diet. LPN F reported s/he was responsible for developing the initial ISP. LPN F reported s/he overlooked adding a mechanical soft diet to Resident 1's ISP. LPN F reported all staff were trained on special diets upon hire and the resident names and their diet and allergies were posted on the refrigerator of the home. If there were any changes in diet, they were communicated verbally to staff and the sheet on the refrigerator was updated. The form posted on the refrigerator was titled, "Texture Modified Diets." The form included a description of foods allowed and not allowed on a "Dysphasia Soft Diet." LPN F confirmed Resident 1 received the incorrect diet texture when s/he was given toast with peanut butter on it.

Administrator A, LPN F, Owner H, and RN D reported Caregiver B was terminated due to other performance concerns, and they were unsure why s/he gave Resident 1 toast with peanut butter. RN D reported s/he was unable to obtain Caregiver B's training information from their online training program and was unsure if s/he completed the dietary training.

LPN F reported after this incident they had purchased a LifeVac Choking Rescue Device for use in case a resident choked in the future. LPN F stated staff were required to initiate the Heimlich maneuver if choking was suspected and then use the LifeVac if needed. Surveyor asked what measures would put in to place to maintain compliance. Owner H stated additional diet training for all staff was initiated after this incident occurred. RN D does the training on diets and plans to be more specific with special diets and document exactly what was taught.