STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAGECREST NURSING AND REHABILITATION	2029 SAGECREST COURT LAS CRUCES, NM 88011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0166 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Try to resolve each resident's complaints quickly.** Based on record review and interview, the facility failed to ensure that efforts were completed by the facility to resolve resident grievances for three (R #58, R #19 and R #46) of four residents (R #159, R #58, R #19 and R #46) who were reviewed for grievances. This deficient practice could lead to residents not getting their grievances resolved and them feeling ignored by the facility. The findings are: A. Review of R #194's clinical record revealed a document titled Nurse's Notes dated on 10/31/13. The document revealed an interdisciplinary team meeting with the power of attorney (POA) for R #194; the POA had concerns about R #194's toileting and care by the staff. B. An interview was conducted with R #58 on 06/09/14 at 10:57 am. R #58 stated that other residents in the facility often come to her room and steal her clothes; the staff were aware of this on-going issue and did nothing to correct the problem. C. An interview was conducted with the SSD on 06/11/14 at 9:13 am regarding R #58's complaints of residents stealing her clothes. The SSD stated she was aware there were two residents known to go into other residents' rooms and take items from other residents; staff try to re-direct those residents when that happens. She was not aware of the issue for R #58 as staff never told her R #58 had these complaints. D. An interview with the Social Services Director (SSD) on 06/11/14 at 4:20 pm revealed that there was no grievance filed for R #194 POA's concerns. The SSD confirmed there should have been a grievance filed and responded to, per the facility policy. E. Interview on 06/09/14 at 10:58 am with the family of R #19 revealed her glasses went missing about six months ago. They reported it to staff, but never heard if anyone looked for them. As a result, the resident had to wear her old glasses. F. Interview on 06/09/14 at 3:27 pm with R #46 revealed a stuffed animal was missing that she had received from the family of a friend who was no longer in the facility. She had informed the SSD, but R #46 said she did not hear back from the SSD or anyone else that they were looking for the stuffed animal. G. Interview on 06/10/14 at 3:13 pm with the SSD revealed she was not aware of R #19's missing glasses or R #46's missing stuffed animal. The SSD started in the social service position in April 2014. Review of the grievance log during the interview indicated there had been no report about missing property for R #19 or R #46. H. Review of the facility policy Filing Grievances/Complaints (copyright 2001 MED-PASS, Inc. (Revised August 2008)) revealed Grievances and / or complaints may be submitted orally or in writing. Social Service is delegated the responsibility to investigate the grievance or complaint within five working days. The resident or person filing the grievance will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. I. Review of the facility policy Investigating Grievances/Complaints (copyright 2001 MED-PASS, Inc. (Revised August 2008)) revealed the Resident Grievance/Complaint Investigation Report Form is to be filed with the Administrator with five working days of the incident, and the resident or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any actions recommended within seven working days after the grievance or complaint was filed. J. Review of the facility policy Grievances/Complaints - Staff Responsibility (copyright 2001 MED-PASS, Inc. (Revised August 2008)) revealed if a staff member overhears or receives a complaint about the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the staff member is encouraged to guide the resident, or person acting on the resident's behalf, as to how to file a written complaint with the facility. Staff members are to provide information on where to get a Resident Grievance/Complaint Form.
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide a mechanical soft diet to a resident with swallowing difficulties. Resident #92 had [DIAGNOSES REDACTED]. The Speech Therapist had assessed that the resident needed a mechanical soft diet and Safety awareness was ongoing during treatment due to patient's cognitive deficits. On [DATE] during the evening meal, Resident #92 was given a hamburger and a whole lunch meat sandwich that was cut in to four pieces. Two CNAs and a cook provided the hamburger and sandwich and one nurse watched from outside while the resident was feeding himself so fast that he did not take breaths between taking bites. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on [DATE] at 2:30 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included retraining of all facility staff on ensuring that the residents get the diets as ordered, and proper monitoring of the residents while they eat. Based on the Plan of Removal and observation, the IJ was lifted on [DATE] at 3:30 pm. This resulted in the scope and severity being reduced from a scope and severity of J to Level 3, Scope G. Based on record review and interview, the facility failed to ensure that one (R #92) of three residents (#s 37, 80, and 92) sampled due to risk of choking was free from neglect. The facility failed to: 1. Monitor residents in the dining room who had swallowing difficulties, 2. Follow the physician's diet order, and 3. Act immediately when one (R #92) resident was observed at risk for choking. This failed practice possibly led to R #92 experiencing a choking episode in the facility and subsequently expired. The findings are: A. Review of the Resident Incident Report dated [DATE] at 6:30 pm revealed that R #92 was in the dining room when staff noticed that he was hunched over his wheelchair. The resident appeared blue in face, lips purple and residents (sic) airway occluded (blocked); food chunks removed from residents (sic) mouth. B. Review of the Intake Information form dated [DATE] revealed that there were 14 questions (#1- #14) that required answers. The following information was obtained from #5, #6, #7 and #8: 1. #5. What happened? Resident (R #92) was in dining room. Resident had a mechanical soft diet. Resident requested regular sandwich and hamburger. Resident choked on dinner. Care is given to resident. Abdominal thrusts, suctioning, 911 called. Resident expired at hospital. Resident is transferred to hospital and expired at hospital. Safety of all residents is ensured, verify all diet orders, re-educate staff to textures, refer residents to speech as indicated investigation is instituted. 2. #6. When did the problem occur? [DATE] 6:30 pm 3. #7. Is the resident/patient still in the facility? No, expired 4. #8. How did it happen? Neglect C. Review of the clinical record for R #92 revealed that he was admitted to this facility on [DATE] with [DIAGNOSES REDACTED]. D. Review of the nutritional care plan revised on [DATE] revealed that R #92 had a mechanical soft diet and per the activities of daily living care plan, also dated [DATE], R #92 had dementia and a stroke with [MEDICAL CONDITION] ([DIAGNOSES REDACTED]). E. Review of the Speech Therapist's (ST #2) Summary of Dysphagia Treatment. for R #92 dated [DATE] through [DATE] revealed the following information: 1. Skilled therapeutic treatment included: Patient education on the swallowing process, signs/symptoms of aspiration, as well as, establishment of compensatory strategies and precautionary measures. Safety and compensatory strategies included diet analysis and diet management for established diet, alternating solids/liquids, alternating

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) temperatures/textures for increased sensation, placement of food on stronger and unaffected side to decrease oral residue on weaker side, [MEDICATION NAME] sweeps, slower rate of presentations, multiple swallows, trunk positioning at 90 degree angle, and use of chin tuck to facilitate oral and pharyngeal control of the bolus by widening the valleculae (a depression behind the roof of the tongue) to prevent spillage to the pyriform sinuses (a recess on either side of the voice box) or trachea. 2. During treatment, education on the need for a modified diet reiterated to prevent risk of aspiration. 3. Safety awareness was ongoing during treatment due to patient's cognitive deficits. F. Review of the Plan of Treatment dated [DATE] through [DATE] revealed a Clinical Narrative that read, . He (R #92) does not consistently recognize his deficits and that his memory is not intact nor does he recognize that is (SIC) deficits are problematic. Cognitive function impedes overall safety awareness, thought organziation (SIC), sequential planning, judgment/reasoning, and functional problem solving. G. An interview with the Speech Therapist (ST #2) on [DATE] at 9:50 am confirmed that she was the therapist that had worked with R #92 relative to his cognition deficit and his swallowing difficulties. ST #2 confirmed that R #92 was not able to make his own decisions of daily care because his cognitive function impedes his overall safety awareness. H. Review of the investigation completed by the facility and the statements from staff revealed the following information: 1. A Certified Nursing Assistant (CNA #10) wrote that she was picking up meal tickets in the dining room the night of [DATE] when R #92 stated that he did not want the regular meal, he wanted a hamburger and a cold cut sandwich. CNA #10 asked him again to make sure that was what he wanted. CNA #10 wrote the residents diet order. 2. The cook, C #1, wrote that on [DATE] between the hours of 5:30 pm and 6:00 pm, she was working the evening shift in the kitchen serving line. She received a ticket for a cold cut sandwich and a hamburger. C #1 made the order according to the ticket but did not check it against the diet order. C #1 added that the CNAs then picked up the tray and took it into the dining room. 3. CNA #9 wrote that she went to the dining room around 5:00 pm and she started passing out drinks until dietary was ready to give out the meal trays. She gave R #92 his meal tray which consisted of a sandwich (which she cut into 4 pieces) and a hamburger. CNA #9 wrote, I left him (pt) (patient) with his food and went to pass out more trays. 4. A Licensed Practical Nurse (LPN #4) wrote that on [DATE] at 6:15 pm she was walking past the dining room window and noted that R #92 was eating his meal. She noted that he was bent over his food and gulping a sandwich very fast using his fingers to shove it in his mouth with no time to chew. After 10 minutes someone beat on the dining room window and called me STAT (immediately) to the dining room. When she reached the resident she noted blue palor (SIC) and choking sounds. I. An interview with LPN #4 on [DATE] at 10:02 am revealed that she was walking past the dining room when she observed R #92 shoving food into his mouth. When interviewed about if she was aware that R #92 had swallowing difficulties and was at risk for choking, LPN #4 stated she was aware. When interviewed about why she did not act immediately when she first observed R #92 shoving food into his mouth she stated, I was on a break and going out to smoke. When interviewed about if she immediately alerted the CNAs in the dining room that R #92 was shoving food into his mouth and not taking time to chew, LPN #4 stated, No, I did not. J. An interview with the Director of Operations and the Administrator (Adm #2) on [DATE] at 3:45 pm revealed that it was the facility's policy to always act immediately when they observed residents shoving food into their mouths especially if they are at risk for choking. They stated that the staff involved were neglectful when they: 1) Changed R #92's meal ticket from mechanical soft to a regular hamburger and a cold cut sandwich without getting approval, 2) prepared the meal ticket before checking the diet against the physician's orders [REDACTED].#92 then walked away without monitoring him, and 4) did not act immediately when he was first observed choking.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide a mechanical soft diet to a resident with swallowing difficulties. Resident #92 had [DIAGNOSES REDACTED]. The Speech Therapist had assessed that the resident needed a mechanical soft diet and Safety awareness was ongoing during treatment due to patient's cognitive deficits. On [DATE] during the evening meal, Resident #92 was given a hamburger and a whole lunch meat sandwich that was cut in to four pieces. Two CNAs and a cook provided the hamburger and sandwich and one nurse watched from outside while the resident was feeding himself so fast that he did not take breaths between taking bites. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on [DATE] at 2:30 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included retraining of all facility staff on ensuring that the residents get the diets as ordered, and proper monitoring of the residents while they eat. Based on the Plan of Removal and observation, the IJ was lifted on [DATE] at 3:30 pm. This resulted in the scope and severity being reduced from a scope and severity of J to Level 3, Scope G. Based on record review and interview, the facility failed to implement policies and procedures that prohibit neglect when the facility failed to: 1) Monitor residents in the dining room who had swallowing difficulties, 2) Follow the physician's diet order, and 3) Act immediately when one (R #92) resident was observed at risk for choking. This failed practice possibly led to R #92 experiencing a choking episode in the facility and subsequently expired. The findings are: A. Review of the facility's undated Abuse and Neglect Policy defined neglect as, Failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. B. Review of the Resident Incident Report dated [DATE] at 6:30 pm revealed that R #92 was in the dining room when staff noticed that he was hunched over his wheelchair. The resident appeared blue in face, lips purple and residents (sic) airway occluded (blocked) ; food chunks removed from residents (sic) mouth. C. Review of the Intake Information form dated [DATE] revealed that there were 14 questions (#1 - #14) that required answers. The following information was obtained from #5, #6, #7 and #8: 1. #5. What happened? Resident (R #92) was in dining room. Resident had a mechanical soft diet. Resident requested regular sandwich and hamburger. Resident choked on dinner. Care is given to resident. Abdominal thrusts, suctioning, 911 called. Resident expired at hospital. Resident is transferred to hospital and expired at hospital. Safety of all residents is ensured, verify all diet orders, re-educate staff to textures, refer residents to speech as indicated investigation is instituted. 2. #6. When did the problem occur? [DATE] 6:30 pm 3. #7. Is the resident/patient still in the facility? No, expired 4. #8. How did it happen? Neglect D. Review of the clinical record for R #92 revealed that he was admitted to this facility on [DATE] with [DIAGNOSES REDACTED]. E. Review of the nutritional care plan revised on [DATE] revealed that R #92 had a mechanical soft diet and per the activities of daily living care plan, also dated [DATE], R #92 had dementia and a stroke with [MEDICAL CONDITION] ([DIAGNOSES REDACTED]). F. Review of the Speech Therapist (ST) #2's Summary of Dysphagia Treatment. for R #92 dated [DATE] through [DATE] revealed the following information: 1. Skilled therapeutic treatment included: Patient education on the swallowing process, signs/symptoms of aspiration, as well as, establishment of compensatory strategies and precautionary measures. Safety and compensatory strategies included diet analysis and diet management for established diet, alternating solids/liquids, alternating temperatures/textures for increased sensation, placement of food on stronger and unaffected side to decrease oral residue on weaker side, [MEDICATION NAME] sweeps, slower rate of presentations, multiple swallows, trunk positioning at 90 degree angle, and use of chin tuck to facilitate oral and pharyngeal control of the bolus by widening the valleculae (a depression behind the roof of the tongue) to prevent spillage to the pyriform sinuses (a recess on either side of the voice box) or trachea. 2. During treatment, education on the need for a modified diet reiterated to prevent risk of aspiration. 3. Safety awareness was ongoing during treatment due to patient's cognitive deficits. G. Review of the Plan of Treatment dated [DATE] through [DATE] revealed a Clinical Narrative that read, . He (R #92) does not consistently recognize his deficits and that his memory is not intact nor does he recognize that is (SIC) deficits are problematic. Cognitive function impedes overall safety awareness, thought organziation (SIC), sequential planning, judgment/reasoning, and functional problem solving. H. An interview with the ST #2 on [DATE] at 9:50 am confirmed that she was the therapist that had worked with R #92 relative to his cognition deficit and his swallowing difficulties. ST #2 confirmed that R #92 was not able to make his own decisions of daily care because his cognitive function impedes his overall safety awareness. I. Review of the investigation completed by the facility and the statements from staff revealed the following information: 1. A Certified Nursing Assistant (CNA #10) wrote that she was picking up meal tickets in the dining room the night of [DATE] when R #92 stated that he did not want the regular meal, he wanted a hamburger and a cold cut sandwich. CNA #10 asked him again to make sure that was what he wanted. CNA #10 wrote the residents diet order. 2. The cook, C #1, wrote that on [DATE] between the hours of 5:30 pm and 6:00 pm, she was working the evening shift in the kitchen serving line. She received a ticket for a cold cut sandwich and a hamburger. C #1 made the order according to the ticket but did not check it against the diet order. C #1 added that the CNAs then picked up the tray and took it into the dining

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) room. 3. CNA #9 wrote that she went to the dining room around 5:00 pm and she started passing out drinks until dietary was ready to give out the meal trays. She gave R #92 his meal tray which consisted of a sandwich (which she cut into 4 pieces) and a hamburger. CNA #9 wrote, I left him (pt) (patient) with his food and went to pass out more trays. 4. A Licensed Practical Nurse (LPN #4) wrote that on [DATE] at 6:15 pm she was walking past the dining room window and noted that R #92 was eating his meal. She noted that he was bent over his food and gulping a sandwich very fast using his fingers to shove it in his mouth with no time to chew. After 10 minutes someone beat on the dining room window and called me STAT (immediately) to the dining room. When she reached the resident she noted blue palor (SIC) and choking sounds. J. An interview with LPN #4 on [DATE] at 10:02 am revealed that she was walking past the dining room when she observed R #92 shoving food into his mouth. When interviewed about if she was aware that R #92 had swallowing difficulties and was at risk for choking, LPN #4 stated she was aware. When interviewed about why she did not act immediately when she first observed R #92 shoving food into his mouth she stated, I was on a break and going out to smoke. When interviewed about if she immediately alerted the CNAs in the dining room that R #92 was shoving food into his mouth and not taking time to chew, LPN #4 stated, No, I did not. K. An interview with the Director of Operations and the Administrator (Adm #2) on [DATE] at 3:45 pm revealed that it was the facility's policy to always act immediately when they observed residents shoving food into their mouths especially if they are at risk for choking. They stated that the staff involved were neglectful when they: 1) Changed R #92's meal ticket from mechanical soft to a regular hamburger and a cold cut sandwich without getting approval, 2) prepared the meal ticket before checking the diet against the physician's orders [REDACTED].#92 then walked away without monitoring him, and 4) did not act immediately when he was first observed choking.
F 0253 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observation, interview and record review, the facility failed to ensure that effective maintenance services were provided in the rooms for 3 of 3 sampled residents (# 24, 45, and 125) whose rooms were reviewed and one common area that were not in good repair. This deficient practice could lead to resident living in a non-homelike, poorly maintained environment. The findings are: A. Observation on 06/11/14 from 5:20 pm to 6:30 pm, the following was observed: 1. The door sweep on the door located at the entrance of the facility was not secure and it was uneven. 2. In R #125's room, the light fixture was rusted on the wall near the bed closest to the door. 3. In R #45's room, the bathroom counter had yellow stains ingrained on the counter. 4. In R #24's, the wall behind a lounge chair had a large patch of white plaster. B. Interview on 06/11/14 at 6:30 pm with the Maintenance Director revealed there was no policy or procedure on preventive maintenance. If a staff or family member noticed a problem, they were to submit a work order to the receptionist at the front desk. There were monthly audits; one day they may check blinds, or fixtures. On a weekly basis they reviewed what happened to be trending and addressed every issue. The Maintenance Director was not aware of these items until it was brought to his attention. C. Interview with a Certified Nursing Assistant (CNA) #5 on 06/13/14 at 10:05 am regarding procedures for noticing maintenance concerns, CNA #5 revealed that if she identified a housekeeping/maintenance issue, she was to call the Charge Nurse and Maintenance and complete a report to Maintenance. Per CNA #5, a Maintenance log or book was at the nurses station. D. Observation on 06/13/14 at 10:10 am and 10:15 am of the two nurses stations revealed blank Repair Requisition forms; however, a Maintenance book or log was not available.
F 0279 **Level of harm -** Actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an individualized accident care plan designed to prevent choking accidents and which reflected the resident's behaviors, diet refusals, and need for specific feeding techniques identified by the Speech Therapist for one (R #92) of one residents that expired because of a risk for choking. Resident #92 experienced a choking episode in the facility and subsequently expired. The findings are: A. Review of the Resident Incident Report dated [DATE] at 6:30 pm revealed that R #92 was in the dining room when staff noticed that he was hunched over his wheelchair. The resident appeared blue in face, lips purple and residents (sic) airway occluded; food chunks removed from residents (sic) mouth. Further review of facility records revealed that in response, R #92 was transferred to the hospital, where he expired on [DATE]. B. Review of the clinical record for R #92 revealed that he was admitted to this facility on [DATE] with [DIAGNOSES REDACTED]. 1. R #92's current physician's orders [REDACTED]. 2. According to R #92's most current Minimum Data Set ((MDS) dated [DATE], the resident had swallowing problems, received a mechanically altered diet, and required supervision during meals, with the physical assistance of one staff. C. Review of the incident report dated [DATE] revealed that R #92 did not want his mechanical soft diet, consequently staff provided him with a hamburger and a cold cut sandwich (of regular consistency). D. Review of the investigation that the facility completed on [DATE] revealed many written statements from staff which indicated that R #92 had refused his meal often, was non-compliant with his diet order and he had demanded that they provide him with an alternate meal. The following information was obtained from the written statements that staff provided relative to R #92's choking incident that ultimately resulted in his death. 1. A Certified Nursing Assistant (CNA #10) wrote that she was picking up meal tickets in the dining room the night of [DATE] when R #92 stated that he did not want the regular meal he wanted a hamburger and a cold cut sandwich. CNA #10 asked him again to make sure that was what he wanted. CNA #10 wrote the residents meal order. 2. The cook, C #1, wrote that on [DATE] between the hours of 5:30 pm and 6:00 pm she was working the evening shift in the kitchen serving line. She received a ticket for a cold cut sandwich and a hamburger for this resident. C #1 made the order according to the ticket but did not check it against the diet order. C #1 added that the CNAs then picked up the tray and took it into the dining room. 3. CNA #9 wrote that she went to the dining room around 5:00 pm and she started passing out drinks until dietary was ready to give out the meal trays. She gave R #92 his meal tray which consisted of a sandwich (which she cut into 4 pieces) and a hamburger. CNA #9 wrote, I left him (pt) (patient) with his food and went to pass out more trays. 4. A Licensed Practical Nurse (LPN #4) wrote that on [DATE] at 6:15 pm she was walking past the dining room window and noted that R #92 was eating his meal. She noted that he was bent over his food and gulping a sandwich very fast using his fingers to shove it in his mouth with no time to chew. After 10 minutes someone beat on the dining room window and called me STAT (immediately) to the dining room. When she reached the resident she noted blue palor (SIC) and choking sounds. E. An interview with LPN #4 on [DATE] at 10:02 am revealed that she was walking past the dining room when she observed R #92 shoving food into his mouth. When interviewed about if she was aware that R #92 had swallowing difficulties and was at risk for choking, LPN #4 stated she was aware. When interviewed about why she did not act immediately when she first observed R #92 shoving food into his mouth, she stated, I was on a break and going out to smoke. When interviewed about if she immediately alerted the CNAs in the dining room that R #92 was shoving food into his mouth and not taking time to chew, LPN #4 stated, No, I did not. F. Review of thirteen additional statements that staff documented relative to R #92's behaviors in the dining room revealed that he was non-compliant with his diet order, he would demand regular texture foods, he would leave the dining room if staff did not adhere to his demands, he requested a hamburger and a cold cut sandwich often and he could become physically and verbally abusive to staff. H. An interview with the Director of Nursing (DON) and the Administrator (Adm #2) on [DATE] at 10:00 am confirmed that R #92 was non-compliant with his mechanically altered diet. I. Review of the clinical record and the care plans developed for R #92 revealed staff failed to develop a care plan relative to R #92's potential for accidents (choking) due to his non-compliance with his diet and his resulting behaviors. J. Review of the Speech Therapist's, (ST #2) Summary of Dysphagia Treatment. for R #92 dated [DATE] through [DATE] revealed the following information: 1. Skilled therapeutic treatment included: Patient education on the swallowing process, signs/symptoms of aspiration, as well as, establishment of compensatory strategies and precautionary measures. Safety and compensatory strategies included diet analysis and diet management for established diet, alternating solids/liquids, alternating temperatures/textures for increased sensation, placement of food on stronger and unaffected side to decrease oral residue on weaker side, [MEDICATION NAME] sweeps. slower rate of presentations, multiple swallows, trunk positioning at 90 degree angle, and use of chin tuck to facilitate oral and pharyngeal control of the bolus by widening the valleculae (a depression behind the roof of the tongue) to prevent spillage to the pyriform sinuses (a recess on either side of the voice box) or trachea. 2. During treatment, education on the need for a modified diet reiterated to prevent risk of aspiration. 3. Safety awareness was ongoing during treatment due to patient's cognitive deficits. K. Review of R #92's current care plan revealed it did not include the compensatory techniques described by the ST to prevent

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F 0279 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) aspiration/choking accidents. L. Review of the Plan of Treatment dated [DATE] through [DATE] revealed the following information under the heading for Clinical Narrative: . He (R #92) does not consistently recognize his deficits and that his memory is not intact nor does he recognize that is (sic) deficits are problematic. Cognitive function impedes overall safety awareness, thought organization (sic), sequential planning, judgment/reasoning, and functional problem solving. M. An interview with the Speech Therapist (ST #2) on [DATE] at 9:50 am confirmed that she was the therapist that had worked with R #92 relative to his cognition deficit and his swallowing difficulties. ST #2 confirmed that R #92 was not able to make his own decisions of daily care because his cognitive function impedes his overall safety awareness. N. An interview with the DON on [DATE] at 9:30 am confirmed that the facility had failed to care plan R #92's non-compliance with diet and behaviors so as to prevent choking accidents. When the staff failed to develop the non-compliance care plan, staff were uninformed of how to intervene when R #92 exhibited behaviors in the dining room which placed R #92 at risk for accidents.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide a mechanical soft diet to a resident with swallowing difficulties. Resident #92 had [DIAGNOSES REDACTED]. The Speech Therapist had assessed that the resident needed a mechanical soft diet and Safety awareness was ongoing during treatment due to patient's cognitive deficits. On [DATE] during the evening meal, Resident #92 was given a hamburger and a lunch meat sandwich that was cut in to four pieces. Two CNAs and a cook provided the hamburger and sandwich and one nurse watched from outside while the resident was feeding himself so fast that he did not take breaths between taking bites. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on [DATE] at 2:30 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included retraining of all facility staff on ensuring that the residents get the diets as ordered, and proper monitoring of the residents while they eat. Based on the Plan of Removal and observation, the IJ was lifted on [DATE] at 3:30 pm. This resulted in the scope and severity being reduced from a scope and severity of K to Level 3, Scope G. Based on interview and record review, the facility failed to ensure that each resident's environment was free of accidents hazards and they received the necessary supervision to prevent accidents. The facility failed to: 1) Monitor residents in the dining room who had chewing/swallowing difficulties (R#s 37, 52, 80, & 92), 2) Follow the physician's diet order (R #92), 3) Act immediately when a resident was at risk for choking (R #92), and 4) Develop a care plan to reduce their risk for choking accidents (R #92). This deficient practice adversely affected one (R #92) resident and had the potential to affect three (R #52, R #80, and R #37) additional residents who were at risk for accidents. Resident #92 experienced a choking episode in the facility and subsequently expired. The findings are: Resident #92 A. Review of the Resident Incident Report dated [DATE] at 6:30 pm revealed that R #92 was in the dining room when staff noticed that he was hunched over his wheelchair. The resident appeared blue in face, lips purple and residents (sic) airway occluded; food chunks removed from residents (sic) mouth. Further review of facility records revealed that in response, R #92 was transferred to the hospital, where he expired on [DATE]. B. Review of the clinical record for R #92 revealed that he was admitted to this facility on [DATE] with [DIAGNOSES REDACTED]. 1. R #92's current physician's orders [REDACTED]. 2. According to R #92's most current Minimum Data Set ((MDS) dated [DATE], the resident had swallowing problems, received a mechanically altered diet, and required supervision during meals, with the physical assistance of one staff. C. Review of the incident report dated [DATE] revealed that R #92 did not want his mechanical soft diet, consequently staff provided him with a hamburger and a cold cut sandwich (of regular consistency). D. Review of the investigation that the facility completed on [DATE] revealed many written statements from staff which indicated that R #92 had refused his meal often, was non-compliant with his diet order and he had demanded that they provide him with an alternate meal. The following information was obtained from the written statements that staff provided relative to R #92's choking incident that ultimately resulted in his death. 1. A Certified Nursing Assistant (CNA #10) wrote that she was picking up meal tickets in the dining room the night of [DATE] when R #92 stated that he did not want the regular meal he wanted a hamburger and a cold cut sandwich. CNA #10 asked him again to make sure that was what he wanted. CNA #10 wrote the residents meal order. 2. The cook, C #1, wrote that on [DATE] between the hours of 5:30 pm and 6:00 pm she was working the evening shift in the kitchen serving line. She received a ticket for a cold cut sandwich and a hamburger for this resident. C #1 made the order according to the ticket but did not check it against the diet order. C #1 added that the CNAs then picked up the tray and took it into the dining room. 3. CNA #9 wrote that she went to the dining room around 5:00 pm and she started passing out drinks until dietary was ready to give out the meal trays. She gave R #92 his meal tray which consisted of a sandwich (which she cut into 4 pieces) and a hamburger. CNA #9 wrote, I left him (pt) (patient) with his food and went to pass out more trays. 4. A Licensed Practical Nurse (LPN #4) wrote that on [DATE] at 6:15 pm she was walking past the dining room window and noted that R #92 was eating his meal. She noted that he was bent over his food and gulping a sandwich very fast using his fingers to shove it in his mouth with no time to chew. After 10 minutes someone beat on the dining room window and called me STAT (immediately) to the dining room. When she reached the resident she noted blue palor (SIC) and choking sounds. E. An interview with LPN #4 on [DATE] at 10:02 am revealed that she was walking past the dining room when she observed R #92 shoving food into his mouth. When interviewed about if she was aware that R #92 had swallowing difficulties and was at risk for choking, LPN #4 stated she was aware. When interviewed about why she did not act immediately when she first observed R #92 shoving food into his mouth, she stated, I was on a break and going out to smoke. When interviewed about if she immediately alerted the CNAs in the dining room that R #92 was shoving food into his mouth and not taking time to chew, LPN #4 stated, No, I did not. F. An interview with the Director of Operations and the Administrator (Adm #2) on [DATE] at 3:45 pm revealed that it was the facility's policy to always act immediately when they observed residents shoving food into their mouths especially if they are at risk for choking. G. Review of thirteen additional statements that staff documented relative to R #92's behaviors in the dining room revealed that he was non-compliant with his diet order, he would demand regular texture foods, he would leave the dining room if staff did not adhere to his demands, he requested a hamburger and a cold cut sandwich often and he could become physically and verbally abusive to staff. H. An interview with the Director of Nursing (DON) and the Administrator (Adm #2) on [DATE] at 10:00 am confirmed that R #92 was non-compliant with his mechanically altered diet. I. Review of the clinical record and the care plans developed for R #92 revealed staff failed to develop a care plan relative to R #92's potential for accidents (choking) due to his non-compliance with his diet and his resulting behaviors. J. An interview with the DON on [DATE] at 9:30 am confirmed that the facility had failed to care plan R #92's non-compliance with diet and behaviors so as to prevent choking accidents. When the staff failed to develop the non-compliance care plan, staff were uninformed of how to intervene when R #92 exhibited behaviors in the dining room which placed R #92 at risk for accidents. K. Review of the Speech Therapist's, (ST #2) Summary of Dysphagia Treatment. for R #92 dated [DATE] through [DATE] revealed the following information: 1. Skilled therapeutic treatment included: Patient education on the swallowing process, signs/symptoms of aspiration, as well as, establishment of compensatory strategies and precautionary measures. Safety and compensatory strategies included diet analysis and diet management for established diet, alternating solids/liquids, alternating temperatures/textures for increased sensation, placement of food on stronger and unaffected side to decrease oral residue on weaker side, buccal sweeps. slower rate of presentations, multiple swallows, trunk positioning at 90 degree angle, and use of chin tuck to facilitate oral and pharyngeal control of the bolus by widening the valleculae (a depression behind the roof of the tongue) to prevent spillage to the pyriform sinuses (a recess on either side of the voice box) or trachea. 2. During treatment, education on the need for a modified diet reiterated to prevent risk of aspiration. 3. Safety awareness was ongoing during treatment due to patient's cognitive deficits. L. Review of R #92's current care plan revealed it did not include the compensatory techniques described by the ST to prevent aspiration/choking accidents. M. Review of the Plan of Treatment dated [DATE] through [DATE] revealed the following information under the heading for Clinical Narrative: . He (R #92) does not consistently recognize his deficits and that his memory is not intact nor does he recognize that is (sic) deficits are problematic. Cognitive function impedes overall safety awareness, thought organization (sic), sequential planning, judgment/reasoning, and functional problem solving. N. An interview with the Speech Therapist (ST #2) on [DATE] at 9:50 am confirmed that she was the therapist that had worked with R #92 relative to his cognition deficit and his swallowing difficulties. ST #2 confirmed that R #92 was not able to make his own decisions of daily care because his cognitive function impedes his overall safety awareness. O. An interview with the Director of Operations and the Administrator (Adm #2) on [DATE] at 3:45 pm confirmed that there was a potential for accidents when staff : 1) changed

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) R #92's meal ticket from mechanical soft to a regular hamburger and a cold cut sandwich without getting approval, 2) prepared the meal ticket before checking the diet against the physician's orders [REDACTED]. 3) gave the meal to R #92 then walked away without monitoring him, 4) did not act immediately when he was first observed at risk for choking, and 5) did not develop an individualized accident care plan designed to prevent choking accidents and which reflected the resident's behaviors, diet refusals, and need for specific feeding techniques identified by the ST. Resident #52 P. Observation of R #52 during lunch on [DATE] at 12:00 pm revealed that R #52 had part of her meat cut by the staff and the resident was feeding herself. R #52 was observed picking up the remainder of the uncut meat, place the large uncut piece of meat in her mouth, and then tear off a piece of the meat with her teeth. The surveyor left the room and soon after, on return to the dining room, R #52 was observed to have a choking episode. R #52 was taken from the dining room to an adjacent room and was attended to by the facility staff. Q. Review of facility documentation for R #52 revealed a Resident Incident Report dated on [DATE] at 12:32 pm. The record documented the following events Res (resident) in back dining room, fed by ST (speech therapist). Res started choking when fed piece of meat. Res diet recently changed to regular texture. ST notified nurse and (Nurse Practitioner (NP)) of choking episode which rushed to resident, noticed resident breathing. Res spitting up phlegm. Res instructed to cough with 0 (no) results. (NP) dislodged piece of meat from residents throat. Res given liquids to clear throat. Res noted not able to keep anything down. Order from (NP) to send res to (hospital) non-emergent. Res sent to (hospital) at 12:50 pm. R. Interview with the Speech Therapist (ST) on [DATE] at 3:30 pm revealed that the incident report was incorrect. The ST stated she was not feeding R #52 at the time of the choking incident; she happened to be in the dining room when R #52 began choking and she attended to the resident. She did not feel R #52 was having a choking episode. The ST continued to explain that her definition of a choking episode is when a resident is unable to talk or breathe. S. Interview with the Nurse Practitioner (NP) on [DATE] at 8:47 am regarding R #52's choking episode during lunch on [DATE] also revealed the facility incident report was incorrect. The NP stated she did not dislodge anything from R #52's throat during this episode. She continued to state when she put a tongue depressor into R #52s mouth to assess her when she was choking, R #52 had a gag reflex and the resident continued to vomit stomach contents. T. An interview was conducted with LPN #1 on [DATE] at 9:00 am regarding R #52's choking episode on [DATE] during lunch. LPN #1 stated she was not present when R #52 began to choke, the ST told her R #52 was choking on a piece of rice and was having a problem with something lodged in her throat. She thought the ST was feeding R #52, the NP told her she dislodged a piece of meat from R #52's mouth. She thought the resident was choking. She had documented the events on R #52's incident report by what she was told, which she confirmed was incorrect. Resident #80 U. Review of the clinical record for R #80 revealed that she was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. V. Review of the quarterly Minimum Data Set (MDS) assessment for R #80 revealed that the facility coded her as having a swallowing disorder in Section K. W. Review of the Departmental Notes dated [DATE], [DATE], [DATE], [DATE], and [DATE] revealed that R #80 experienced choking episodes. Staff documented that R #80 tended to eat fast, not chew her food properly, was on a mechanical soft diet with thickened liquids and required close supervision when dining. X. Review of the Speech Therapy (ST #2) Progress Note dated [DATE] through [DATE] revealed that R #80 had episodes of choking while dining on a mechanical soft diet with thickened liquids. Per the notes, R #80 refused a pureed diet and her thickened liquids. Y. Review of two Incident Reports dated [DATE] and [DATE] revealed that R #80 experienced a choking episode and staff had to perform the Heimlich maneuver. Z. Review of the hand written note from the Physical Therapist (PT) dated [DATE] revealed that, At approximately 11:45 am on tues (Tuesday) feb (February) 4th a resident (R #80) by the name of (provided the name) demonstrated the universal choking sign. I approached resident while she was still choking leaned her forward tapped her back with base of palm. The resident went silent could not see in her mouth finger swept and didn't feel any obstruction. I then proceeded to do Heimlich maneuver. After 5 or 6 thrusts resident started to wheeze and stared forcefully gasping for air. AA. Review of the Incident Report dated [DATE] at 12:30 pm confirmed that R #80 was in the dining room when she started to choke on her food. The PT noticed that the resident was choking and performed abdominal thrusts. No further investigation was documented. BB. An interview with PT on [DATE] at approximately 10:45 am confirmed that he had performed the Heimlich maneuver and abdominal thrusts when R #80 choked in the dining room on [DATE]. When interviewed what he did after that, he stated, Nothing. When asked about if he discussed this incident with ST or nursing; he stated No, I did not, I just documented what happened on an incident report. When interviewed about why he did not follow up with nursing or ST to ensure that R #80 would not experience another accident and choking incident, PT stated he was unsure. CC. Review of the nutritional care plan dated [DATE] revealed that R #80 was at risk for choking and staff documented that one of her goals was to . not suffocate related to choking food dated [DATE]. Review of the hand written revisions revealed that R #80 was an increased risk for aspiration related to being non-compliant with her mechanical diet and nectar thickened liquids. The goal written on [DATE] was Resident will not aspirate x (times) 90 days. One of the interventions was dated [DATE] and it read that the Speech Therapist was to complete a screening for R #80. DD. An interview with the DON and ST #2 on [DATE] at approximately 1:30 pm revealed that the facility had failed to complete the screening for R #80 and she continued to be at risk for accidents related to swallowing difficulties and choking. When interviewed why the screening had not been completed, ST2 and the DON stated that they were uncertain. R #80 remained at risk for accidents and choking episodes. Resident #37 EE. Review of the medical record for R #37 revealed that she was admitted to this facility on [DATE] with the [DIAGNOSES REDACTED]. FF. An interview with R #37 on [DATE] at 7:30 am revealed that she stayed in bed most of the day and she stated that she had experienced a choking episode recently while eating in her room. GG. Review of the Incident Log dated [DATE] through [DATE] revealed that R #37 experienced a choking incident on [DATE]. Review of the nutritional care plan dated [DATE] confirmed that R #37 had a choking episode and she was referred to the Speech Therapist. HH. Review of the Modified Barium Swallow Study Report (MBSS) dated [DATE] revealed that R #37 had Significant esophageal impairment to include tertiary peristalsis (the food would not go down her throat), diminished esophageal motiligy (sic), a large gas volume, and symptoms of reflux. The recommendations included: 1. Regular diet 2. Aggressive pharmaceutical management of reflux 3. Alternate a bit of food followed by a sip of liquid 4. Slow rate of presentation 5. Reflux precautions 6. GI consult may be warranted. II. Review of the ST #1's Plan of treatment dated [DATE] (approximately 50 days after the choking incident) revealed the Closing Summary read, The patient was evaluated and educated on normal swallow function; esophageal dysphagia (poor swallowing), and appropriate diet for GERD (gastroesophageal reflux disease). JJ. Review of the care plans dated [DATE] and revised on [DATE], [DATE], [DATE], [DATE], [DATE], and on [DATE] revealed that the recommendations from the MBSS and ST #1 had not been added to the care plan which left R #37 at continued risk for accidents and choking. KK. An interview with the DON on [DATE] at approximately 2:00 pm confirmed that the recommendations from the MBSS and ST #1 were not implemented which left R #37 at continued risk for accidents and choking.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on observation and interview, the facility failed to ensure sufficient staff were available to respond to resident needs for two (R #19 and R #46) of two (R #19 and R #46) residents with concerns about sufficient staff and one randomly observed resident (R #37) who was affected by the unavailability of staff. The deficient practice possibly resulted in residents not receiving the care they needed to reach their highest practical physical, mental, and psychosocial well-being. The findings are: A. Interview on 06/09/14 at 10:54 am with the family for R #19 revealed that it took 30 - 60 minutes for staff to answer the call light when the family used it to call for assistance. They stated that R #19 was not capable of using it herself. R #19 used a bed alarm and wheelchair alarm because she would try to get up and they were not confident the staff would respond quickly. The family stated that they had arrived one morning and found that R #19 had numerous bruises on her chin, arms, and legs. They believed that was in the last year, maybe six months ago. Staff were not able to tell the family what had happened, and that was why the family have chosen to stay with R #19 throughout the day. B. Interview on 06/09/14 at 3:16 pm with R #46 revealed some staff had said No when she asked them to help her use the toilet rather than using the bed pan. She said that staff explained to her that it was because she doesn't stand up right. R #46 said she believed it was that staff either needed more training on how to help her or they needed more staff so that her assigned staff person could find another staff person to help her use the toilet. C. Observation on 06/11/14 at 9:45 am revealed R #37's call light was on. There was no audible sound at the nurse's desk for her light. Interview a minute after this observation with R #37 revealed she had turned the light on a little more than a half hour ago. She explained that she

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F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) wanted to take a shower she was ready for therapy, which was at 10:30 am. CNA #8 responded to R #37's call light at 10:03 am. Observation at 10:05 am revealed R #37 had to direct the CNA with how to arrange her bed and TV stand so that she was able to transfer into her wheelchair. Observation at 10:25 am revealed R #37 and CNA #8 entered the shower room and CNA #8 stated to R #37 that she would have to wait until another resident was done before she could take her shower. D. Interview on 06/11/14 at 10:41 am with CNA #8 revealed he had worked at the facility for about two months. He had started on the night shift and then moved to the day shift. He had different resident assignments throughout the facility since he started and said he still had to get to know the residents. He said it took time. He explained that he didn't know R #37's routine but stated she was helpful with giving directions. CNA #8 stated he wasn't aware that R #37's call light was on because he was busy on South 2 helping his teammate with a lot of two person lifts and getting multiple people ready for podiatric appointments in the facility. His current assignment that day included 12 residents. E. During interview on 06/10/14 at 9:55 am with Licensed Practical Nurse (LPN) #1, she explained how the certified nursing assistant (CNA) assignments are divided up on South unit. She stated the residents that are assigned to the CNAs change every day but that the CNAs stay on this unit and work together as a team. F. Interview on 06/11/14 at 10:39 am revealed Certified Medication Assistant (CMA) #1 helped the CNAs when she was not passing medications. CMA #1 explained the CNA assignment breakdowns and that there was generally a buffer, a CNA who floated around to help where needed, but there was no one in that assignment today. She said staff are rotated so that they do not get burned out, because some residents are very heavy lifting or demanding. She stated the LPN was responsible for monitoring the completion of assignments.
F 0365 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide food in a way that meets a resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to provide a mechanical soft diet to a resident with swallowing difficulties. Resident #92 had [DIAGNOSES REDACTED]. The Speech Therapist had assessed that the resident needed a mechanical soft diet and Safety awareness was ongoing during treatment due to patient's cognitive deficits. On 05/30/14 during the evening meal, Resident #92 was given a hamburger and a lunch meat sandwich that was cut in to four pieces. Two CNAs and a cook provided the hamburger and sandwich and one nurse watched from outside while the resident was feeding himself so fast that he did not take breaths between taking bites. These deficient practices resulted in an Immediate Jeopardy (IJ) being identified at the facility on 06/11/14 at 2:30 pm. The facility took corrective action by providing an acceptable Plan of Removal. Based on the plan, interventions included retraining of all facility staff on ensuring that the residents get the diets as ordered, and proper monitoring of the residents while they eat. Based on the Plan of Removal and observation, the IJ was lifted on 06/13/14 at 3:30 pm. This resulted in the scope and severity being reduced from a scope and severity of J to Level 3, Scope G. Based on observation, record review, and interview, the facility failed to ensure that each resident who was assessed to have chewing and/or swallowing difficulties received the appropriate food texture and/or food form. This deficient practice adversely affected one (R#92) resident but it had the potential to affect 69 of the 103 residents who currently resided in this facility that were assessed to need modified food forms. Residents were identified by the Resident Census list provided by the Director of Nursing on 06/09/14. The findings are: A. Review of a complaint that was investigated by the facility on 05/31/14 revealed that R #92 had received food from the kitchen that was not prepared appropriately per his physician ordered diet. R #92 was ordered a mechanically altered diet and he received a hamburger and a sandwich that were regular in texture. R #92 began to choke in the dining room and subsequently passed away. B. Review of the clinical record for R #92 revealed that he had a physician ordered mechanically soft diet due to a swallowing disorder. R #92 suffered a [MEDICAL CONDITIONS] which left him with swallowing difficulties. C. Review of the incident report dated 05/31/14 revealed that R #92 died on [DATE] after he experienced a choking incident at 6:45 pm in the facility's dining room. D. Review of the statement provided by the cook (C) #1 revealed that she was working the kitchen tray line on 05/30/14 between 5:30 pm and 6:00 pm when she received a ticket for a cold cut sandwich and a hamburger for R #92. C #1 prepared the ticket but failed to check R #92's diet order to ensure that he was able to receive a regular sandwich and hamburger. C #1 provided R #92 with an inappropriate diet texture per his physician's orders [REDACTED]. E. Review of the Resident Count By All Diet Restrictions Report dated 06/13/14 revealed that there were 69 residents currently residing in this facility with therapeutic diet orders. Thirty-six residents had a mechanical soft diet, 13 were ordered a pureed diet, one resident had a finger foods diet, four residents had a ground diet, and 15 residents were ordered thickened liquids. All of these resident had the potential to be affected if the staff did not ensure that they received the correct therapeutic diet. F. Observation of the kitchen on 06/10/14 at 10:30 am revealed that a dietary worker (D) #3 was prepared to puree some food for those residents who required texture change for chewing or swallowing concerns. D #3 removed the lid from the blender, added some hot food, then poured in some food thickener. D #3 did not measure any of the ingredients or follow a recipe. G. An interview with the Registered Dietitian (RD) #1 on 06/10/14 at 10:35 am confirmed that the kitchen staff did not have any recipes for thickening foods. She stated that there was a recipe printed on the side of the box that the thickening agent came in; however it only provided a recipe for thickening liquids, not how to thicken solid food. Consequently, there was a potential for the thickened foods to be prepared incorrectly with different textures than ordered, which could lead to the residents experiencing difficulties chewing and swallowing their food.
F 0469 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observation and interview, the facility failed to provide an effective pest control program to keep the facility free of ants for three (R #35, R #125, & R #195) of 3 sampled residents sampled for ants and ant bites. This deficient practice could lead to a pest infestation and residents getting bitten by the pests. The findings are: A. During an interview with R #125 on 06/09/14 at 10:51 am, she stated that her room had a pest problem. R #125 stated that she has to kill ants on her floor and window sill and she was not comfortable in her room. B. Observation of R #125's room on 06/09/14 at 10:55 am revealed that she had several dead ants on her floor and on her window sill. C. Observation of the back area near the kitchen on 06/10/14 at 2:30 pm revealed that the outside door to the garbage area was not secure. There were spaces between the door and the wall which had the potential to allow pests an entrance into the facility. The door was locked but when pushed the door shook and the seal around the sides and bottom was missing and/or broken and it allowed for an large opening of about one inch all the way around the door. Also, the bottom shield was bowed and did not fit well. D. Observation of the door to the garden area on 06/10/14 at 2:40 pm revealed that it was not secure. Around the sides and bottom of the door was a large space which had the potential to provide a way for pests to enter into the facility. E. An interview with the Maintenance Director on 06/10/14 at 3:00 pm confirmed that both doors were not maintained well. He stated that the bottom seal was missing and each door needed to be adjusted to ensure that pests would not be afforded an entry way. F. Interview on 06/11/14 at 9:00 am with R #47 revealed she had seen three spiders about a month ago. She related she had heard there was a problem with ants and saw someone throw something that looked like sand around the outside of the building up next to the outer wall, which she was told that was to get rid of the ants. G. Interview on 06/11/14 at 9:03 am with R #3 revealed she had a roommate in her room for two days and that resident had complained about ants. H. Interview on 06/11/14 at 9:35 am with Housekeeping (H) #1 revealed ants had been found in the shared room of R #60 and R #91. He explained there was a small hole found on the exterior wall outside of their room and he showed where ants were found in that room. I. Interview on 06/11/14 at 9:45 am with R #37 revealed she had ants in her room and it started with her roommate, R #35. She stated that R #35 ate with her fingers and kept food in her wheelchair, and that staff forgot to wash R #35's hands after mealtime and clean the chair. R #37 said that housekeeping and maintenance staff were in her room a couple of days ago cleaning R #35's side of the room. J. Interview on 06/11/14 at 10:05 am with Certified Nursing Assistant (CNA) #6 revealed that R #195 had been a resident at the facility for about 2 1/2 weeks before her family took her home. She had been in the room at the end of the short hall on South 1. R #195 was found with ants on her bed and ant bites on her face and neck. After that, the resident was moved to R #3's room. CNA #6 was not aware of any other resident on South 1 that had problems with the ants. K. Observation on 06/11/14 at 10:15 am of R #195's previous room revealed the door was closed and locked with sign on the door that said the room was being remodeled. L. Observation and interview on 06/11/14 at 11:40 am reveaIed the Maintenance Director and a contractor from Eco Lab were going about on South 1 unit to spray rooms

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F 0469 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) for ants while the residents were at lunch. The Maintenance Director stated the ant problem started on South 1, but they had been found in other areas, including on the North unit. He said they were trying to get a handle on the pest problem. He had not heard from anyone about other bugs or spiders and had not seen any spiders.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to ensure that clinical records were complete, accurate and systemically organized. This had the potential to affect three (R #194, R #52, and R #47) of 49 residents who were reviewed for clinical record completeness and accuracy (#'s 1, 3, 4, 6, 7, 8, 11, 14, 15, 17, 19, 23, 24, 33, 35, 37, 39, 43, 46, 47, 48, 52, 58, 60, 70, 77, 80, 84, 85, 90, 91, 92, 97, 100, 104, 106, 116, 118, 120, 121, 125, 139, 148, 154, 176, 177, 193, 194, & 195). This deficient practice could lead to residents not getting the services needed to improve their health. The findings are: A. Review of R #194's clinical record revealed that R #194 was admitted to the facility on [DATE] with diabetes mellitus, [MEDICAL CONDITIONS] and progressive decline. 1. The resident's medical record revealed physician orders for [MEDICATION NAME] (a blood thinner) 3 mg tablets every Tuesday and Friday and [MEDICATION NAME] 2 mg every Monday, Wednesday, Thursday, Saturday and Sunday. 2. The resident's initial Skin Assessment dated on 07/09/14 revealed documentation that R #194 had surgical knee replacement scars on both knees, bruises to the lower extremities, redness and scabs to both ears and [MEDICAL CONDITION] of the both feet. The document did not reflect the size of the scars, bruises or scabs. 3. Further review of R #194's clinical record revealed Nurse's Notes dated on 08/20/13, revealed that R #194 had bumped her hand on the arm of her wheelchair, and had a large bruise on the left hand. 4. Weekly Skin Integrity Review notes were reviewed for R #194, which revealed the resident had skin assessments completed on 07/09/13, 07/16/13, 07/23/13, 08/06/13, 08/13/13, 08/20/13, 08/27/13, 09/03/13, 09/10/13, 09/17/13, 09/24/13, 10/01/13, 10/07/13, 10/08/13, 12/03/13, 12/10/13 and 12/17/13. There were no measurements on any of these skin assessments of R #194's bruising or scabbing of the skin. B. Interview with the Director of Nursing (DON) on 06/11/14 at 11:35 am revealed that the nurses were supposed to conduct a weekly skin assessment on R #194 for her skin bruising or any potential bleeding. According to the DON, it was important to follow any increased bruising or bleeding for R #194 because she was taking blood thinners, which could cause internal bleeding. During the interview with the DON, she further revealed there was no specific facility policy on the assessment of a resident's skin; the facility followed the policy for assessing resident's skin under the Pressure Ulcer Risk Assessment. D. Review of the facility policy Pressure Ulcer Risk Assessment revised March 2005 revealed Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. The following information should be recorded in the resident's medical record: .4) Any change in the resident's condition, 5) The condition of the resident's skin (i.e., the size and location of any red or tender areas, 6) How the resident tolerated the procedure and his/her ability to participate in the procedure, 7) Any problems or complaints made by the resident related to the procedure, 8) If the resident refused the assessment and the reason(s) why, 9) Observations of anything unusual exhibited by the resident. E. Observation of R #52 during lunch on 06/09/14 at 12:00 pm revealed that R #52 had part of her meat cut by the staff and the resident was feeding herself. R #52 was observed picking up the remainder of the uncut meat, place the large uncut piece of meat in her mouth, and then tear off a piece of the meat with her teeth. The surveyor left the room and soon after, on return to the dining room, R #52 was observed to have a choking episode. R #52 was taken from the dining room to an adjacent room and was attended to by the facility staff. F. Review of facility documentation for R #52 revealed a Resident Incident Report dated on 06/09/14 at 12:32 pm. The record documented the following events Res (resident) in back dining room, fed by ST (speech therapist). Res started choking when fed piece of meat. Res diet recently changed to regular texture. ST notified nurse and (Nurse Practitioner (NP)) of choking episode which rushed to resident, noticed resident breathing. Res spitting up phlegm. Res instructed to cough with 0 (no) results. (NP) dislodged piece of meat from residents throat. Res given liquids to clear throat. Res noted not able to keep anything down. Order from (NP) to send res to (hospital) non-emergent. Res sent to (hospital) at 12:50 pm. G. Interview with the Speech Therapist (ST) on 06/09/14 at 3:30 pm revealed that the incident report was incorrect. The ST stated she was not feeding R #52 at the time of the choking incident; she happened to be in the dining room when R #52 began choking and she attended to the resident. She did not feel R #52 was having a choking episode. The ST continued to explain that her definition of a choking episode is when a resident is unable to talk or breathe. H. Interview with the Nurse Practitioner (NP) on 06/12/14 at 8:47 am regarding R #52's choking episode during lunch on 06/09/14 also revealed the facility incident report was incorrect. The NP stated she did not dislodge anything from R #52's throat during this episode. She continued to state when she put a tongue depressor into R #52s mouth to assess her when she was choking, R #52 had a gag reflex and the resident continued to vomit stomach contents. I. An interview was conducted with LPN #1 on 06/13/14 at 9:00 am regarding R #52's choking episode on 06/09/14 during lunch. LPN #1 stated she was not present when R #52 began to choke, the ST told her R #52 was choking on a piece of rice and was having a problem with something lodged in her throat. She thought the ST was feeding R #52, the NP told her she dislodged a piece of meat from R #52's mouth. She thought the resident was choking. She had documented the events on R #52's incident report by what she was told, which she confirmed was incorrect. J. Observation on 06/09/14 at 2:59 pm during an interview with R #47 revealed the front teeth on R #47's bottom jaw were in poor condition with dark discoloration between the teeth. She had mouth odor when she spoke. R #47 stated that she had problems with her bottom teeth and they hurt periodically. K. Interview on 06/10/14 at 10:05 am with R #47 revealed she used a soft toothbrush because of a sensitive cap on a tooth on her bottom jaw. R #47 explained that the cap needed to be replaced and it had been over a year since she was advised to get it replaced, but she did not yet have a plan for visiting a dentist. L. Review of R #47's clinical record revealed none of the following documentation sources identified the condition of the resident's teeth nor that she was having discomfort because of their condition: 1. The Consult section of R #47's record revealed no dental consult documentation. 2. The Nursing Data Collection Tool dated 09/03/13 revealed R #47's admitted was 09/03/13. None of the sections on that form related to an assessment of the resident's dental condition or oral status. 3. The interdisciplinary team (IDT) review dated 09/04/13 on the Nurse's Notes and on the Nutritional Progress Notes also dated 09/04/13 revealed no documentation related to R #47's dental condition or oral status. 4. An undated Interim Plan of Care for R #47 revealed for Dental Problems to Evaluate diet and Assess for referral. No documentation was found in R #47's record to indicate that the evaluation and assessment had occurred. 5. The admission Minimum Data Set (MDS) assessment for R #47 dated 09/10/13 indicated that R #47 needed two or more persons to provide extensive weight bearing physical assistance for personal hygiene, which could include brushing teeth. There were no dental problems checked. 6. A Dietary Data Set & (and) Progress Note dated 09/10/13 for R #47 revealed the resident was alert and oriented, able to make needs known, was independent with feeding self, and had no impairment with chewing. There was no documentation related to R #47's dental condition or oral care. 7. A Nutritional Data Set and Progress Note dated 09/23/13 for R #47 revealed Natural Teeth was checked under Identification of Risk Indicators. There was no indication of dental concerns. 8. The quarterly MDS assessment for R #47 dated 03/11/14 revealed the Brief Interview for Mental Status (BIMS) had a summary score of 14, which indicated that R #47 was cognitively intact. The Oral/Dental Status section of the MDS indicated no problems related to that assessment reference date. The MDS indicated that R #47 had improved so that only one person was needed to provide limited non-weight bearing physical assistance for personal hygiene, which could include brushing teeth. M. Interview the morning of 06/12/14 with MDS1 revealed an oral assessment was to be conducted at the time of the MDS and the impact of dental/oral concerns were to be documented as part of the nutritional assessment. N. Review of two Care Plan Conference Summary forms, one dated 12/11/13 and the other dated 03/19/14, revealed there was no row for dental or oral under the column heading Topics Discussed. On both of those forms, the nutrition row was blank. R #47 had signed as attendee on both of the forms, and the daughters had signed as attendees on the 03/19/14 form. O. Interview on 06/10/14 at 3:13 pm with the Social Services Director (SSD) revealed oral care and dental needs were to be addressed during the care plan meetings. The SSD was not aware that R #47 had a dental need. She explained how conversation occurred during the care plan meetings, in that each department representative will report the care plan information for that resident related to the respective department. If no dental or oral concerns are reported by the family or resident, that topic would not be discussed. The SSD concurred there wasn't a row on the Care Plan Conference Summary related to dental/oral concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325039	A. BUILDING _____ B. WING _____	06/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAGECREST NURSING AND REHABILITATION	2029 SAGECREST COURT LAS CRUCES, NM 88011

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7)
F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that the Quality Assurance Performance Improvement (QAPI) committee identified concerns in the building and developed interventions with measurable goals and timetables to ensure that improvements could be realized in a timely fashion. The facility's QAPI committee did not discuss improvements that needed to be completed in the environment or take action to correct identified concerns. The QAPI committee failed to address quality of care issues (choking on food) that occurred in the facility which were identified through multiple incident reports. This had the potential to affect all of the residents who resided in this facility. Residents were identified by the Resident Census list provided by the Director of Nursing on 06/09/14. The findings are: A. Observation of the kitchen and the dish machine area on 06/09/14 at 9:00 am, revealed that the equipment and the environment had not been well maintained. The walk-in refrigerator did not have an internal thermometer and the door was rusted at the bottom, the reach-in refrigerator was broken, the freezer condenser was leaking a fluid on to the floor, the steamer was broken and placed into a storage closet, the right half of the oven was inoperable, the floor drains and sink pipes were leaking and backing up, a pellet (metal plate warmer) warmer was used as a plate warmer (dangerous due to excessive heat on the residents' plates), the floor was cracked and missing pieces and grout, the walls under the dish machine had large holes which were covered by a big piece of card board, the garbage disposal was leaking a white liquid all over the dish room floor, and the entire dish room smelled of rotten meat. B. An interview with the Dietary Specialist on 06/13/14 at 12:30 pm revealed that the facility's Dietary Manager passed away suddenly on 04/29/14 and the facility did not have a full time Dietary Manager at this time. The Dietary Specialist stated that on 05/07/14 she completed a sanitary audit of the facility's kitchen and documented her findings on a report. Her findings included those concerns addressed above and she had additional concerns as well. She provided that report to the Administrator (Adm #1) on 05/07/14. The Dietary Specialist recommended that the kitchen concerns should be rectified as soon as possible. However, at the time of survey, on 06/09/14 through 06/13/14, those concerns had not been addressed. C. An interview with the Director of Operations, (DO) the Director of Nursing (DON) and the Administrator (Adm #2) on 06/12/14 at approximately 4:00 pm confirmed that the facility had failed to provide the necessary education and training for the kitchen staff and they were aware that the kitchen required maintenance. The DO stated that the steamer had been ordered on [DATE] and the reach-in refrigerator had been repaired. When interviewed about why it took over 30 days to order or repair those two pieces of equipment, the DO was uncertain. D. An interview with the DO and the Adm #2 on 06/13/14 at approximately 4:00 pm revealed that the QAPI committee met monthly however, during the 05/30/14 meeting they did not discuss the concerns that were identified in the kitchen by the Dietary Specialist on 05/07/14. Consequently those concerns were not addressed in QAPI and the facility failed to develop a plan of action with measurable goals with time tables to ensure that the identified concerns were addressed timely. E. Review of the Incident Log dated from 01/01/14 through 06/10/14 revealed that six residents had experienced an accident in the facility that included choking on food. F. When interviewed on 06/12/14 at 10:00 am about the discussion in QAPI relative to choking, the DON and the Medical Director stated that choking was not one of the topics that was discussed during the QAPI meetings. Consequently, a plan of action with measurable goals and timetables had not been realized or discussed.