STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185354**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/12/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORDSVILLE NURSING AND REHABILITATION CENTER	**313 MAIN STREET** **FORDSVILLE, KY 42343**

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Hospital Emergency Department Records and review of the facility's policies and procedures it was determined the facility failed to notify the physician for one (1) of four (4) sampled residents (Resident #1). On 01/23/15 , Resident #1 experienced a choking episode while being fed scalloped potatoes during the lunch meal and, experienced another choking episode on 01/23/15 while being fed the supper meal. The Speech Therapist (ST) evaluated the resident and determined the resident needed to sit at a ninety degree angle when fed. Registered Nurse (RN) #1 noted the resident was speaking in a deeper voice as if he/she needed to cough but she was unable to get the resident to cough. RN #1 decided to monitor the resident's temperature due to the resident's choking episodes and risk for aspiration; however, she did not notify the physician. At 8:40 PM, RN #2 obtained Resident #1's temperature which was elevated at 99.1 degrees Fahrenheit (F) and the resident had an audible rattle when breathing. RN #2 tried unsuccessfully to get the resident to cough and observed a thick glob of mucus the resident had coughed up later in the shift; however, RN #1 failed to notify the physician of these observations. On 01/24/15 at 7:55 AM, Resident #1 was found in severe respiratory distress and was gasping for air. The resident's oxygen saturation was fluctuating in the 80s (normal 98-100) with oxygen at eight (8) liters per minute. The resident's pulse was 102 (normal 60 to 80), respirations were 30 per minute (normal 16-20), temperature of 100.8 F and blood pressure of 100/50 (normal 120/80). The resident was transported to the hospital. A piece of undercooked potato with the skin intact was removed from the resident's throat during intubation. The resident was admitted to the Intensive Care Unit (ICU) in critical condition and diagnosed with [REDACTED]. The facility's failure to notify the physician has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 02/02/15 and determined to exist on 01/23/15. An acceptable Allegation of Compliance (AoC) was received on 02/10/15 alleging the Immediate Jeopardy was removed on 02/05/15. The State Survey Agency validated the Immediate Jeopardy was removed on 02/05/15, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance monitors the effectiveness of the system changes. The findings include: Review of the facility's policy titled, Notification of Resident Change in Condition, (no date), revealed clinicians should immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). Record review revealed the facility admitted Resident #1 on 06/26/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 07/03/14, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) score of 99, which indicated the resident was not interviewable. The facility also assessed the resident as requiring the extensive assistance of one (1) person for eating. Review of the January 2015 physician's orders [REDACTED]. Review of Resident #1's Nursing Note, dated 01/23/15 at 3:28 PM, revealed a late entry for 11:45 AM which stated the CNA (Certified Nursing Assistant) reported the resident seemed to be having trouble swallowing fluids with meal. Nurse reported to Speech Therapy (ST). ST stated she would evaluate. Interview with CNA #1, on 01/30/15 at 2:00 PM, revealed Resident #1 was on a mechanical soft diet and preferred to sit on the bed and lean against the wall when he/she ate, which he/she did that day. CNA #1 stated when she was feeding Resident #1 scalloped potatoes on 01/23/15 during lunch, the resident became red in the face and was coughing and spit up some of what he/she had been fed. CNA #1 stated she reported the incident to the nurse who requested the ST to see the resident. Interview, on 01/30/15 at 2:15 PM with RN #1, revealed CNA #1 reported to her that Resident #1 was having trouble swallowing milk at lunch on 01/23/15. RN #1 stated she requested the ST to look at the resident. RN #1 stated she noticed the resident had a deeper voice like he/she needed to cough but she was unable to get the resident to cough. She stated she did not notify the physician as she decided to observe the resident's temperature every shift just in case he/she had aspirated. Interview with CNA #2, on 01/30/15 at 3:10 PM, revealed he attempted to feed Resident #1 his/her supper meal on 01/23/15 and when he gave Resident #1 a bite, the resident would chew and attempt to swallow, but couldn't. CNA #2 stated the resident coughed, got red in the face and he thought the resident had swallowed the wrong way. CNA #2 stated the resident did the same thing when he/she was offered milk. He stated the resident acted like he/she didn't want to eat so he notified LPN #1. Review of Nursing Notes, dated 01/23/15, revealed there was no documented evidence the physician was notified. Interview with LPN #1, on 01/30/15 at 3:20 PM, revealed she did not recall any staff notifying her that Resident #1 choked and the physician was not notified. Review of Resident #1's Nursing Note, dated 01/23/15 at 8:40 PM, revealed the resident's temperature was 99.1 F and he/she had coughed up some thick mucus. Interview, on 01/31/15 at 8:40 PM with RN #2, revealed on 01/23/15 she had been told in report to check Resident #1's temperature due to the resident having difficulty swallowing earlier in the day and the ST had seen the resident but didn't know anything for sure about the resident having difficulty swallowing. RN #2 stated Resident #1 had a little rattle when breathing and she had tried to get the resident to cough but he/she wouldn't or couldn't. RN #2 stated when she checked the resident later she observed a thick glob of mucous in the resident's beard and the resident was sounding clearer then. RN #2 revealed she did not notify the resident's physician of the elevated temperature, the rattle noted when the resident breathed; or, the mucus she had noted in the resident's beard. Review of a Nursing Note, dated 01/24/15 at 7:55 AM, revealed the resident presented with difficulty breathing, was gasping for air and his/her oxygen saturation was fluctuating in the 80s with oxygen at eight (8) liters (L) per minute. The resident's pulse was 102 , respirations were 30 per minute, his/her temperature of 100.8 F and blood pressure of 100/50. The resident was transported by ambulance to the hospital. Further interview with RN #1, on 01/30/15 at 2:15 PM, revealed on the morning of 01/24/15 staff reported to her Resident #1 was not acting or breathing right. RN #1 stated when she assessed Resident #1 at approximately 7:55 AM, the resident seemed to be struggling to breath and his/her oxygen saturation was in the low 80s. She stated the resident's oxygen saturation continued to fluctuate after 8/L of oxygen was administered. RN #1 stated the resident's breathing was short and labored so

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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NAME OF PROVIDER OF SUPPLIER **FORDSVILLE NURSING AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **313 MAIN STREET** **FORDSVILLE, KY 42343**	

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) she transferred the resident to the hospital. Review of the Hospital Emergency Department records, dated 01/24/15, revealed the resident suffered from Acute [MEDICAL CONDITION] with [MEDICAL CONDITION] (body deprived o oxygen). Further review revealed a slice of uncooked potato, the size of a silver dollar and one-fourth inch thick was removed from the resident's throat during intubation. The resident also had a collapse/consolidation of the right lung, lower lobe; posterior medial basal segments left lower lobe and pneumonia. The resident was placed on a ventilator and admitted to the Intensive Care Unit (ICU) in critical condition. Interview with the Director of Nursing (DON), on 02/02/15 at 11:50 AM, revealed she would have expected staff to notify the Physician when there was any incident or change of condition of a resident. Interview, on 02/03/15 at 11;45 AM, with the Medical Director, who is also Resident #1's Primary Physician revealed he recalled being informed when the resident was sent out in respiratory distress on 01/24/15, but he did not recall being informed of the episodes of difficulty swallowing and choking the day before but staff should have informed him. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 01/24/15, Resident #1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet; the facility downgraded the diet to puree on 01/28/15. 2. On 01/30/15, the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted an assessment of Resident #1 to determine if there were any medical needs, and or ongoing assessments required that were not already being completed or any significant change in condition that required MD notification. Resident #1's assessment revealed no change in condition that required further Physician notification and noted that appropriate assessments were on-going. 3. The MDS Nurse on 01/30/15 reviewed Resident #1's plans of care and determined that all interventions were in place. 4. Beginning on 01/30/15 and completed on 02/02/15 the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current residents' plan of care to determine if all interventions were being followed. No further concerns were identified. 5. On 01/31/15, the Dietary Services Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. The Dietary Services Manager also observed the meal tray line during lunch and noted that staff was following the recipe and spreadsheet and providing the diet as ordered for Resident #1 and food was properly prepared. 6. On 01/30/15, the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted assessments of all current residents to determine if there were any medical needs requiring Physician notification and or ongoing assessments required that were not already being completed. Any identified residents who had a change in condition had their Physician notified with orders obtained and follow up assessments. 7. On 01/31/15, the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and noted that the recipe was followed, diet was correct and served per Physician order [REDACTED]. 8. On 01/30/15, the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse on conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. The INTERACT process is an evidence based program developed under funding from CMS to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms. A competency test was administered to validate understanding. In addition, they were educated and a competency test was given related to following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the Physician must be notified 9. On 01/30/15 ,the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse began re-education with all licensed nursing staff related to conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. A competency test was administered to validate understanding. No licensed staff will work after 02/04/15 without having completed this re-education and competency test. In addition, reeducation was provided on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. No licensed Nurse worked after 01/30/15 without having received this re-education and competency test. 10. Beginning 02/03/15, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after 02/03/15 without having received this re-education and competency test. 11. On 02/02/15 and 02/03/15, the Regional Dietician reviewed all current recipes to determine if any recipe called for food products that according to the spreadsheet would not be appropriate for mechanically altered diets. No other concerns were identified. 12. On 01/30/15, the Regional Dietician conducted re-education with the Dietary Services Manager including competency testing related to following the recipe and serving foods per the spreadsheet for correct prescribed diet. 13. Beginning 01/31/15 and ongoing, the Dietary Service Manager will conduct re-education with all Dietary Staff related to following the recipe and the spreadsheet to assure diets are served per the Physician order. This re-education will include a competency test and will be conducted prior to any staff beginning work. No Dietary staff worked after 01/31/15 without having completed the re-education and competency test. 14. On 02/03/15, a contract provider verified the convection oven was working appropriately and the regular oven in which the potatoes were cooked was cooking hotter than the setting on the oven. A new stove/oven was ordered and approved on 03/03/15. 15. Beginning 02/03/15, all dietary staff was instructed by the Dietary Service Manager to only cook on the convection oven. No staff will work after 03/03/15 without having had this re-education. Beginning 02/04/15, all dietary staff will be educated by the Dietary Service Manager that if a concern is identified with the food prepared it should be removed from the tray line and if already served dietary staff should report the concerns to the Nurse. No dietary staff will work after 02/04/15 without having received this education. 16. Beginning 01/28/15 and ongoing, all nursing staff was educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager MDS Nurse or Medical Records Nurse on notification of the nurse if meals appear to be prepared incorrectly such as overcooked, undercooked or hard to cut foods. No nursing staff will work after 02/04/15 without having received this education. In addition, beginning on 02/03/15 and on going, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after 02/03/15 without having received this re-education and competency test. 17. Beginning 01/31/15, the Director of Nursing, Assistant Director of Nursing or Unit Manager will review with the facility staff the residents' condition each shift to determine if licensed staff are notifying the Physician of significant changes in condition as well as completing ongoing assessment as needed. This will continue every shift until abatement then five (5) times per week for twelve (12)weeks thereafter. 18. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter. 19. Beginning 02/01/15, the Director of Nursing, Assistant Director of Nursing or Unit Manager will review all Nurses Notes daily to determine if any significant change in condition has occurred without Physician notification or any significant change in condition requiring ongoing assessment that has not occurred. This will occur daily until abatement of Immediate Jeopardy and then five (5) times per week for twelve (12) weeks. 20. Beginning 01/31/15, a Dietary Service Manager or a Registered Dietician will observe one meal service per day to assure staff are following the recipe, serving and using the diet spreadsheet and that food is properly prepared to meet the individual needs. This will continue until abatement of the Immediate Jeopardy and then five (5) times per week for twelve (12) weeks thereafter. 21. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee (QAPI) weekly until

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

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substantial compliance then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter. Members of the QAPI Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Services Director, Maintenance Director, Activity Director and Business Office Manager with the Medical Director participating at least quarterly and as needed.
22. On 01/30/15, an ad hock Quality Assurance and Performance Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Medical Director who attended via phone. In attendance was the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Medical Records Clerk, MDS Nurse, Social Services Director, Dietary Services Manager and Activity director. No further recommendations were made at this time.
The State Survey Agency validated the corrective actions taken by the facility as follows:
1. Review of the Nursing Notes and Physician order [REDACTED].#1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet and the facility downgraded the diet to pureed on 01/28/15. Observation of the lunch meal on 02/12/15 at 12:00 PM, revealed the resident was being fed by the Speech Therapist. The food was in pureed form, as per the resident's diet card on the tray.
2. Review of an assessment conducted by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse of Resident #1 on 01/30/15, revealed there were no change in condition that required further Physician notification and noted that appropriate assessments were on-going.
3. Review of documentation by the MDS Nurse, dated 01/30/15, revealed she reviewed Resident #1's plans of care and determined that all interventions were in place.
4. Review of documentation verified on 01/30/15 through 02/02/15 the DON, ADON, Unit Manager, MDS Nurse and Medical Records
Nurse reviewed all current resident's plans of care to determine if all interventions were being followed. The documentation revealed which residents' plans of care were reviewed by which administrative staff.
5. Review of documentation by the Dietary Manager, dated 01/31/15, revealed the Dietary Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. In addition, the documentation revealed she also observed the tray line and determined staff was following the recipe and spreadsheet and providing the diets as ordered.
6. Review of residents' assessments conducted on 01/30/15 revealed all resident assessments were completed and any residents who had an identified change in condition had their physician notified. The assessments were conducted by the DON, ADON, Unit Manager MDS Nurse and Medical Records Nurse.
7. Review of documentation dated 01/31/15 revealed the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and verified the recipe was followed, diet was correct and served per Physician Order, to meet the needs of the resident and properly prepared.
8. Review of documentation of re-education by the Regional Quality Manager to the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse, dated 01/30/15, verified they were reeducated on the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on 01/30/15.
9. Review of inservice sign in sheets and competency tests, beginning 01/30/15, revealed all licensed staff was re-educated beginning 01/30/15 and competency tests were administered and passed related to the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on 01/30/15.
Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed the DON provided education to the staff related to assessments, INTERACT tool for assessments and Physician notification. Staff was educated about care plan interventions ensuring their appropriateness and implementation
Interview with the DON, on 02/12/15 at 1:30 PM, revealed she provided education on the INTERACT tool for assessments and Physician notification and had also educated staff on updating care plans according to their scope of practice. The Twenty Four Hour Report was also topic. Nursing staff was given competency tests on following the INTERACT tool and nursing judgement. CNAs required a post test as well.
Interview with RN #3, on 02/12/15 at 12:30 PM, revealed she received education related to the INTERACT system utilized by the facility which was a tool for assessments and included why, when, who and Physician notification. The education included follow up documentation on any type of complaint or anything out of the normal for a resident. Information was to be passed on to the next shift if not resolved and follow up was to be done the next day. A post test was given which RN #3 passed.
Interview with LPN #3, on 02/12/15 at 12:35 PM, revealed education was provided to her by the DON that resident assessments should be conducted before, during, and after any type of an event and gave examples of elevated temperature, shortness of breath, and chest pain. LPN #3 was given a post test and passed. Education was also given to her about Physician notification, follow up documentation and implementing the care plan. She stated if the care plan needed changed or could not be implemented to notify the DON.
Interview with LPN #4, on 02/12/15 at 12:40 PM, revealed she had been educated by the DON related to the INTERACT tools for resident assessment, physician notification and documentation. The Physician was to be notified for any significant change. Assessments were to be completed, the resident monitored and reassessed. The assessments were to include the resident's vital signs as blood pressure, respiration, oxygen saturation, pulse and temperature. LPN #4 was required to pass a post test.
Interview with RN #1, on 02/12/15 at 12:50 PM, revealed she had been provided education by the DON related to a change in condition of a resident including if the resident was having trouble swallowing. For any emergency 911 was to be called and then notify the Physician. The INTERACT tool which reflects how, what and when to notify the Physician was to be utilized, as well, as the Stop and Watch tool which anyone could fill out and give to the nurse. Any change of condition of a resident required a complete assessment, including if a resident became choked while eating. Seventy-two (72)hour documentation was required for any changes, this included the resident's vital signs and if symptoms persisted the physician should be notified again. In addition, care plan education was provided related how to access that information from the headsets worn by the CNAs. The care plan had to match the resident's needs and if not the CNAs were to notify the nurse. A post test was completed to validate understanding.
Interview with RN #4, on 02/12/15 at 12:55 PM, revealed she had recent education by the DON related to assessments. The INTERACT tool was a step by step guide on how, what and when to do anything and Physician notification. In addition, education was provided on care plans that included information about carrying out the interventions and revising when needed. CNAs were to report any problems with the care plan and the Physician was to be notified. She stated she had to take a post test and pass.
10. Interview with CNA #5, on 02/12/15 at 1:00 PM, revealed education was provided on care plans related to accessing the information on the CNA headset and to always inform the nurse when something did not seem right about the information. A post test was taken and had to be passed.
Interview with CNA #6, on 01/12/15 at 1:05 PM, revealed education was provided on care plans and she was to ensure the care plan was followed and if the care plan did not seem appropriated she was to speak with the nurse immediately.
Interview with CNA #7, on 02/12/15 at 1:10 PM, revealed she was educated on implementation of care plans and a post test was given and she passed.
Interview with CNA #8, on 02/12/15 at 1:15 PM, revealed she had recently been educated that she was required to be familiar with each resident's care plan an it was accessible through the head set that she wears. CNA #8 stated if she could not follow the resident's care plan she was to go to the nurse for clarification. She revealed she had to take a post test and pass.
11. Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed the spread sheets and recipes were reviewed and the spread sheet for the scalloped potato recipe was revised to include peeling potatoes before cooking.
Interview with the Registered Dietician, on 02/12/15 at 11:35 AM, revealed she had revised the spread sheet and recipe for scalloped potatoes to indicate peeling the potatoes.

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F 0157

Level of harm - Immediate jeopardy

Residents Affected - Few

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12. Interview with the Dietary Manager, on 02/12/15 at 11:30 AM, revealed she had received inservice from the Registered Dietician on reading and following spreadsheets and recipes. Education was provided that potato skins were not part of the Mechanical Soft Diet. She was educated on reading and calibrating thermometers and using only the left oven on the stove instead of the malfunction right side oven and the recipe and spread sheet for scalloped potatoes had been revised to instruct to peel the potatoes. One meal every day was being monitored to ensure the spread sheet and recipe as well as the tray cards were being followed.
13. Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed dietary staff was educated over recipes and spread sheet, meal preparation and diets per the physician's orders [REDACTED].>Interview with the Registered Dietician, on 02/12/15 at 11:35 AM, revealed she had provided education to the dietary staff related to the spread sheets and recipes. She stated the reading of the tray cards was also covered in education as well as what to do if a food item did not turn out that included not serving that food item.
Interview with Cook #1, on 02/12/15 at 11:40 AM, revealed she had been educated about how to set and use thermometers for checking food temperatures and about how to follow the spread sheet recipes. She stated a test was given to verify she understood the education.
Interview with Dietary Aide #3, on 02/12/15 at 11:45 AM, revealed she had received education by the Dietary Manager on how to follow the spread sheets and recipes. She stated she also had to take a test to verify she understood the education.
14. On 02/03/15 a contract provider verified that the convection oven was working appropriately and that the regular oven in which the potatoes were cooked was cooking hotter than the setting on the oven. A new stove/oven was ordered and approved on 02/03/15.
Interview with the Administrator, on 02/12/15, revealed a new stove had been ordered for the facility and should be installed in about three weeks. The facility was also getting a new :Leer (blender/mixer) for puree foods and also a meat slicer for evenness.
15. Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed the dietary staff had been educated to use the left oven until the new stove was installed.
Interview with Cook #1, on 02/12/15 at 11:40 AM, revealed she had been educated that the oven on the right side of the stove was not to be used until the new stove was delivered. Cook #1 stated she also received educated on what to do if food does not turn out right for any reason, The food is to be pulled off the tray line and not served. She stated if a food item was discovered to not be right after it goes out to the residents she was to tell the nurse.
Interview with Dietary Aide #3, on 02/12/15 at 11:45 AM, revealed she had received education by the Dietary Manager not to use the left side oven of the stove. Dietary Aide #3 stated she also received education by the Dietary Manager to double check residents' diet cards and if food was not right for some reason it was to be pulled off the line and not served. She stated if it was discovered after it goes out, the nurse was to be notified.
16. Interview with the DON, on 02/12/15 at 1:30 PM, revealed she started education related to small bites, under and over cooked food on 01/28/15. Staff was not to serve any food that did not match the meal ticket and CNAs were to report to the nurse and then the dietary staff was to be notified.
Interview with RN #3, on 02/12/15 at 12:30 PM, revealed she had received education from the Director of Nursing (DON) related to ensuring food that was served was properly prepared and gave example of over or undercooked food. Certified Nurse Aides were to inform the nurse if something did not seem right about a resident's tray and it was not to be served. A post test was given which RN #3 passed.
Interview with LPN #3, on 02/12/15 at 12:35 PM, revealed education was provided to her by the DON related to notifying the nurse if a food item to be served to a resident was wrong. She stated the first thing was to not give it to the resident then notify the nurse and the kitchen. The meal ticket was to be followed; staff was to ensure the residents were given small bites. LPN #3 was given a post test and passed.
Interview with LPN #4, on 02/12/15 at 12:40 PM, revealed she had been educated by the DON related to residents' meals and following the appropriate diets. She

F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

Provide care by qualified persons according to each resident's written plan of care.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, review of Hospital emergency room Records and review of facility policy/procedures, it was determined the facility failed to implement the plan of care for one (1) of four (4) sampled residents (Resident #1), related to providing a therapeutic mechanical soft diet; and, monitoring the resident's tolerance of the texture of the diet and signs and symptoms of aspiration.
The facility admitted Resident #1 with multiple [DIAGNOSES REDACTED]. Resident #1 was assessed and care planned for staff to provide a diet of mechanical soft foods, and to monitor for tolerance of diet texture and for signs and symptoms of aspiration. On [DATE], Resident #1 became choked during the lunch meal after Certified Nurse Aide (CNA) #1 fed the resident scalloped potatoes that had been identified as undercooked and had not been peeled. The resident became choked a second time the same day when CNA #2 attempted to feed him/her the supper meal and he/she was unable to swallow. The incidents were reported to licensed staff; however, the licensed staff failed to monitor the resident for tolerance to the diet and for signs and symptoms of aspiration after the choking incidents. On the morning of [DATE], Resident #1 was sent to the hospital in [MEDICAL CONDITION]. While at the hospital, a piece of scalloped potato that was undercooked and had the peel on it was removed from the resident's throat during intubation. The resident was admitted to the Intensive Care Unit (ICU) with [MEDICAL CONDITION], Pneumonia [MEDICAL CONDITION] in critical condition on a ventilator.
The facility's failure to ensure staff implemented the care plan caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE] alleging the IJ was removed on [DATE]. The State Survey Agency validated on [DATE] that the Immediate Jeopardy was removed on [DATE], as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance monitors the effectiveness of the system changes.
The findings include:
Review of the facility's policy titled, Resident Comprehensive Care Plan, dated ,[DATE], revealed the resident's comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility.
Review of a manual titled, Simplified Diet Manual, eleventh edition, utilized by the facility, revealed a Mechanical Soft Diet is designed to permit easy chewing. The General Diet is modified in consistency and texture by cooking, grinding, chopping, mincing or mashing. The diet includes foods soft in texture such as cooked fruits and vegetables, moist ground meat and soft bread and cereal products. Foods that dissolve readily when held in the mouth such as graham crackers and some ready-to-eat cereals are also appropriate. It is most important to individualize or adjust it to the tolerance of the resident. Table 3.1 Mechanical Soft revealed to avoid raw or undercooked vegetables and those with tough skins, whole kernel corn and fried vegetables.
Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident with a Brief Interview of Mental Status (BIMS) score of 99, indicating the resident was not interviewable. Further review of the assessment revealed the resident required extensive assistance of one person for eating and had a therapeutic diet of mechanically altered foods.
Review of a Speech Therapy Evaluation, dated [DATE], revealed the resident was at risk for weight loss and aspiration; and, required close supervision during meal intake and assistance with all meals due to risk of [MEDICAL CONDITION] and requiring maximum cues to not talk while eating, and swallowing everything before taking another bite.
Review of Resident #1's Comprehensive Care Plan for Risk for Alteration in Nutrition, dated [DATE], revealed interventions to provide diet as ordered, mechanically soft; and monitor for tolerance to diet texture and signs and symptoms of aspiration.
Review of Nursing Note, revealed a late note, dated [DATE] at 3:28 PM, which stated at 11:45 AM, the CNA reported Resident #1 was having problems swallowing fluids with his/her meal. The nurse reported the incident to the Speech Therapist (ST) and the ST said she would assess the resident
Interview on [DATE] at 2:00 PM with CNA #1 revealed on [DATE] during the lunch meal, Resident #1 became choked when she fed

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORDSVILLE NURSING AND REHABILITATION CENTER	**313 MAIN STREET FORDSVILLE, KY 42343**

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 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 4)
the resident scalloped potatoes. The resident coughed, spitting up some of the potatoes and his/her face became red. The CNA stated she reported the incident to Registered Nurse (RN) #1.
Interview on [DATE] at 2:15 PM with RN #1 revealed CNA #1 had reported to her on [DATE] that Resident #1 was having trouble swallowing milk at lunch. RN #1 stated she requested the ST to look at the resident. During her observation, she noted that Resident #1 had a deeper voice like he/she needed to cough but she was unable to get the resident to cough. RN #1 stated she did not assess the resident for signs and symptoms of aspiration by assessing the resident's lung sounds, obtaining the resident's oxygen saturation and vital signs; and she did not monitor to ensure the resident's diet was appropriate.
Interview with facility Cook #1, on [DATE] at 1:00 PM, revealed on [DATE] she used fresh potatoes to make scalloped potatoes for the lunch meal on [DATE]. Cook #1 stated she sliced the potatoes but did not peel them. She then cooked the potatoes according to the spread sheet. Cook #1 revealed she was alerted by a staff member that the scalloped potatoes were not cooked enough when meal trays were served in the dining room. Cook #1 stated she was aware that one of the hall tray carts had already been delivered to the hall for residents to be served meals in their rooms to include residents on a mechanical soft diet but she did not take any action to retrieve the residents' trays with the scalloped potatoes. Cook #1 revealed she continued to serve the scalloped potatoes by picking out the thinner slices. She stated she placed the thicker slices of potatoes in the refrigerator with a note indicating the potatoes required cooking if served again.
Interview, on [DATE] at 2:15 PM with RN #1, revealed CNA #1 reported Resident #1 was having trouble swallowing milk at lunch on [DATE]. RN #1 stated she requested the ST to look at the resident. RN #1 revealed when she observed Resident #1 with the ST there was no coughing and the resident's color was good. RN #1 stated she noticed the resident had a deeper voice like he/she needed to cough but she was unable to get the resident to cough. RN #1 stated she did not notify the physician but decided to observe the resident's temperature every shift just in case he/she had aspirated.
Interview with CNA #2, on [DATE] at 3:10 PM, revealed he attempted to feed Resident #1's supper meal on [DATE] and when he gave Resident #1 a bite, the resident would chew and attempt to swallow, but couldn't. CNA #2 stated the resident coughed, got red in the face and the CNA thought the resident had swallowed the wrong way. CNA #2 revealed the resident did the same thing when milk was offered and acted like he/she didn't want to eat so the CNA #2 notified Licensed Practical Nurse (LPN) #1. CNA #2 stated he did not know if LPN #1 had assessed Resident #1 or not.
Interview with LPN #1, on [DATE] at 3:20 PM, revealed she did not recall anyone reporting to her that Resident #1 had choked on his/her supper meal. She stated she did not monitor Resident #1 for signs and symptoms of aspiration or to ensure the resident was able to tolerate the diet.
Review of a Nursing Note, dated [DATE] at 8:40 PM by RN #2, revealed the resident's temperature was 99.1 F, the resident coughed up some thick mucus, drank chocolate milk without difficulty, and there was no noted swallowing problems.
Interview on [DATE] at 8:40 PM with RN #2 revealed on [DATE] she was told in report to check Resident #1's temperature due to the resident having difficulty swallowing earlier in the day and the ST had looked at the resident but didn't know anything for sure. RN #2 stated Resident #1 had a little rattle when breathing and she was unsuccessful in getting the resident to cough and she saw a glob of mucus in the resident's beard. RN #2 stated she did not monitor for signs and symptoms of aspiration by assessing the resident's lung sounds with a stethoscope and obtaining the resident's oxygen saturation and vital signs because she was afraid the resident would hit her.
Review of a Nursing Note, dated [DATE] at 8:32 AM, revealed at 7:55 AM, the resident presented with difficulty breathing, gasping for air, and oxygen saturation was fluctuating in the 80s (normal ,[DATE]). Oxygen was administered at 8/L per minute with oxygen saturation continuing to fluctuate up and down. The resident's pulse was 102 (normal ,[DATE]), respirations were 30 (normal ,[DATE]) per minute, temperature was 100 F (normal 98.6). Notifications were made to the Guardian and Physician and the resident was transported to the hospital by ambulance.
Review of Resident #1's Hospital emergency room Records, dated [DATE], revealed the resident suffered from Acute [MEDICAL CONDITION] with [MEDICAL CONDITION] (body deprived of oxygen) and a slice of uncooked potato the size of a silver dollar and one-fourth inch thick was removed from the resident's throat during intubation. There was collapse/consolidation of the right lung, lower lobe and posterior medial basal segments left lower lobe; and pneumonia. The resident was placed on a ventilator and admitted to the Intensive Care Unit (ICU) in critical condition.
Interview with the Emergency Department (ED) Physician, on [DATE] at 11:00 AM revealed on [DATE], Resident #1 was very mentally challenged and was in [MEDICAL CONDITION]. He stated when intubating the resident a one and one-half inch circular piece of potato that still had the peel on it was in the resident's throat. The Physician revealed the resident might have been able to swallow some liquids because the circular piece of potato may have acted like a ball valve. He stated the resident couldn't get the epiglottis to close over the trachea. The physician revealed the resident did have pneumonia from aspiration. He revealed the circular potato piece was removed intact and was very firm. He further stated Resident #1 could have died from the potato piece cutting off his/her airway or could have died from the Aspiration Pneumonia.
Interview with the Director of Nursing (DON), on [DATE] at 12:15 PM, revealed the ST did evaluate Resident #1, but if a wrong food item was sent out and served to the resident then obviously the care plan was not followed. She stated she expected the resident's care plan to be followed and if it couldn't be followed or changed the physician should have been notified and a change made.
Interview with the Administrator, on [DATE] at 11:40 AM, revealed CNA #1 had said she mashed the potatoes with a fork but was unable to explain why a whole potato slice was found lodged in Resident #1's throat. She additionally stated she had never heard of leaving the peel on potatoes when preparing scalloped potatoes. The Administrator expected resident care plans to be followed.
**The facility implemented the following actions to remove the Immediate Jeopardy:
1. On [DATE], Resident #1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet; the facility downgraded the diet to puree on [DATE].
2. On [DATE], the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted an assessment of Resident #1 to determine if there were any medical needs, and or ongoing assessments required that were not already being completed or any significant change in condition that required MD notification. Resident #1's assessment revealed no change in condition that required further Physician notification and noted that appropriate assessments were on-going.
3. The MDS Nurse on [DATE] reviewed Resident #1's plans of care and determined that all interventions were in place.
4. Beginning on [DATE] and completed on [DATE] the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current residents' plan of care to determine if all interventions were being followed. No further concerns were identified.
5. On [DATE], the Dietary Services Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. The Dietary Services Manager also observed the meal tray line during lunch and noted that staff was following the recipe and spreadsheet and providing the diet as ordered for Resident #1 and food was properly prepared.
6. On [DATE], the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted assessments of all current residents to determine if there were any medical needs requiring Physician notification and or ongoing assessments required that were not already being completed. Any identified residents who had a change in condition had their Physician notified with orders obtained and follow up assessments.
7. On [DATE], the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and noted that the recipe was followed, diet was correct and served per Physician order [REDACTED].
8. On [DATE], the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse on conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. The INTERACT process is an evidence based program developed under funding from CMS to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms. A competency test was administered to validate understanding. In addition, they were educated and a competency test was given related to following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the Physician must be notified
9. On [DATE] ,the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse began re-education with all licensed nursing staff related to conducting an assessment based on resident condition to

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORDSVILLE NURSING AND REHABILITATION CENTER	**313 MAIN STREET FORDSVILLE, KY 42343**

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F 0282

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 5)
include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. A competency test was administered to validate understanding. No licensed staff will work after [DATE] without having completed this re-education and competency test. In addition, reeducation was provided on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. No licensed Nurse worked after [DATE] without having received this re-education and competency test.
10. Beginning [DATE], all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after [DATE] without having received this re-education and competency test.
11. On [DATE] and [DATE], the Regional Dietician reviewed all current recipes to determine if any recipe called for food products that according to the spreadsheet would not be appropriate for mechanically altered diets. No other concerns were identified.
12. On [DATE], the Regional Dietician conducted re-education with the Dietary Services Manager including competency testing related to following the recipe and serving foods per the spreadsheet for correct prescribed diet.
13. Beginning [DATE] and ongoing, the Dietary Service Manager will conduct re-education with all Dietary Staff related to following the recipe and the spreadsheet to assure diets are served per the Physician order. This re-education will include a competency test and will be conducted prior to any staff beginning work. No Dietary staff worked after [DATE] without having completed the re-education and competency test.
14. On [DATE], a contract provider verified the convection oven was working appropriately and the regular oven in which the potatoes were cooked was cooking hotter than the setting on the oven. A new stove/oven was ordered and approved on [DATE].
15. Beginning [DATE], all dietary staff was instructed by the Dietary Service Manager to only cook on the convection oven. No staff will work after [DATE] without having had this re-education. Beginning [DATE], all dietary staff will be educated by the Dietary Service Manager that if a concern is identified with the food prepared it should be removed from the tray line and if already served dietary staff should report the concerns to the Nurse. No dietary staff will work after [DATE] without having received this education.
16. Beginning [DATE] and ongoing, all nursing staff was educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager MDS Nurse or Medical Records Nurse on notification of the nurse if meals appear to be prepared incorrectly such as overcooked, undercooked or hard to cut foods. No nursing staff will work after [DATE] without having received this education. In addition, beginning on [DATE] and on going, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after [DATE] without having received this re-education and competency test.
17. Beginning [DATE], the Director of Nursing, Assistant Director of Nursing or Unit Manager will review with the facility staff the residents' condition each shift to determine if licensed staff are notifying the Physician of significant changes in condition as well as completing ongoing assessment as needed. This will continue every shift until abatement then five (5) times per week for twelve (12)weeks thereafter.
18. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter.
19. Beginning [DATE], the Director of Nursing, Assistant Director of Nursing or Unit Manager will review all Nurses Notes daily to determine if any significant change in condition has occurred without Physician notification or any significant change in condition requiring ongoing assessment that has not occurred. This will occur daily until abatement of Immediate Jeopardy and then five (5) times per week for twelve (12) weeks.
20. Beginning [DATE], a Dietary Service Manager or a Registered Dietician will observe one meal service per day to assure staff are following the recipe, serving and using the diet spreadsheet and that food is properly prepared to meet the individual needs. This will continue until abatement of the Immediate Jeopardy and then five (5) times per week for twelve (12) weeks thereafter.
21. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee (QAPI) weekly until substantial compliance then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter. Members of the QAPI Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Services Director, Maintenance Director, Activity Director and Business Office Manager with the Medical Director participating at least quarterly and as needed.
22. On [DATE], an ad hock Quality Assurance and Performance Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Medical Director who attended via phone. In attendance was the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Medical Records Clerk, MDS Nurse, Social Services Director, Dietary Services Manager and Activity director. No further recommendations were made at this time.
The State Survey Agency validated the corrective actions taken by the facility as follows:
1. Review of the Nursing Notes and Physician order [REDACTED].#1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet and the facility downgraded the diet to pureed on [DATE]. Observation of the lunch meal on [DATE] at 12:00 PM, revealed the resident was being fed by the Speech Therapist. The food was in pureed form, as per the resident's diet card on the tray.
2. Review of an assessment conducted by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse of Resident #1 on [DATE], revealed there were no change in condition that required further Physician notification and noted that appropriate assessments were on-going.
3. Review of documentation by the MDS Nurse, dated [DATE], revealed she reviewed Resident #1's plans of care and determined that all interventions were in place.
4. Review of documentation verified on [DATE] through [DATE] the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current resident's plans of care to determine if all interventions were being followed. The documentation revealed which residents' plans of care were reviewed by which administrative staff.
5. Review of documentation by the Dietary Manager, dated [DATE], revealed the Dietary Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. In addition, the documentation revealed she also observed the tray line and determined staff was following the recipe and spreadsheet and providing the diets as ordered.
6. Review of residents' assessments conducted on [DATE] revealed all resident assessments were completed and any residents who had an identified change in condition had their physician notified. The assessments were conducted by the DON, ADON, Unit Manager MDS Nurse and Medical Records Nurse.
7. Review of documentation dated [DATE] revealed the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and verified the recipe was followed, diet was correct and served per Physician Order, to meet the needs of the resident and properly prepared.
8. Review of documentation of re-education by the Regional Quality Manager to the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse, dated [DATE], verified they were reeducated on the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on [DATE].
9. Review of inservice sign in sheets and competency tests, beginning [DATE], revealed all licensed staff was re-educated beginning [DATE] and competency tests were administered and passed related to the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on [DATE].
Interview with the Administrator, on [DATE] at 1:35 PM, revealed the DON provided education to the staff related to assessments, INTERACT tool for assessments and Physician notification. Staff was educated about care plan interventions

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) ensuring their appropriateness and implementation Interview with the DON, on [DATE] at 1:30 PM, revealed she provided education on the INTERACT tool for assessments and Physician notification and had also educated staff on updating care plans according to their scope of practice. The Twenty Four Hour Report was also topic. Nursing staff was given competency tests on following the INTERACT tool and nursing judgement. CNAs required a post test as well. Interview with RN #3, on [DATE] at 12:30 PM, revealed she received education related to the INTERACT system utilized by the facility which was a tool for assessments and included why, when, who and Physician notification. The education included follow up documentation on any type of complaint or anything out of the normal for a resident. Information was to be passed on to the next shift if not resolved and follow up was to be done the next day. A post test was given which RN #3 passed. Interview with LPN #3, on [DATE] at 12:35 PM, revealed education was provided to her by the DON that resident assessments should be conducted before, during, and after any type of an event and gave examples of elevated temperature, shortness of breath, and chest pain. LPN #3 was given a post test and passed. Education was also given to her about Physician notification, follow up documentation and implementing the care plan. She stated if the care plan needed changed or could not be implemented to notify the DON. Interview with LPN #4, on [DATE] at 12:40 PM, revealed she had been educated by the DON related to the INTERACT tools for resident assessment, physician notification and documentation. The Physician was to be notified for any significant change. Assessments were to be completed, the resident monitored and reassessed. The assessments were to include the resident's vital signs as blood pressure, respiration, oxygen saturation, pulse and temperature. LPN #4 was required to pass a post test. Interview with RN #1, on [DATE] at 12:50 PM, revealed she had been provided education by the DON related to a change in condition of a resident including if the resident was having trouble swallowing. For any emergency 911 was to be called and then notify the Physician. The INTERACT tool which reflects how, what and when to notify the Physician was to be utilized, as well, as the Stop and Watch tool which anyone could fill out and give to the nurse. Any change of condition of a resident required a complete assessment, including if a resident became choked while eating. Seventy-two (72)hour documentation was required for any changes, this included the resident's vital signs and if symptoms persisted the physician should be notified again. In addition, care plan education was provided related how to access that information from the headsets worn by the CNAs. The care plan had to match the resident's needs and if not the CNAs were to notify the nurse. A post test was completed to validate understanding. Interview with RN #4, on [DATE] at 12:55 PM, revealed she had recent education by the DON related to assessments. The INTERACT tool was a step by step guide on how, what and when to do anything and Physician notification. In addition, education was provided on care plans that included information about carrying out the interventions and revising when needed. CNAs were to report any problems with the care plan and the Physician was to be notified. She stated she had to take a post test and pass. 10. Interview with CNA #5, on [DATE] at 1:00 PM, revealed education was provided on care plans related to accessing the information on the CNA headset and to always inform the nurse when something did not seem right about the information. A post test was taken and had to be passed. Interview with CNA #6, on [DATE] at 1:05 PM, revealed education was provided on care plans and she was to ensure the care plan was followed and if the care plan did not seem appropriated she was to speak with the nurse immediately. Interview with CNA #7, on [DATE] at 1:10 PM, revealed she was educated on implementation of care plans and a post test was given and she passed. Interview with CNA #8, on [DATE] at 1:15 PM, revealed she had recently been educated that she was required to be familiar with each resident's care plan an it was accessible through the head set that she wears. CNA #8 stated if she could not follow the resident's care plan she was to go to the nurse for clarification. She revealed she had to take a post test and pass. 11. Interview with the Administrator, on [DATE] at 1:35 PM, revealed the spread sheets and recipes were reviewed and the spread sheet for the scalloped potato recipe was revised to include peeling potatoes before cooking. Interview with the Registered Dietician, on [DATE] at 11:35 AM, revealed she had revised the spread sheet and recipe for scalloped potatoes to indicate peeling the potatoes. 12. Interview with the Dietary Manager, on [DATE] at 11:30 AM, revealed she had received inservice from the Registered Dietician on reading and following spreadsheets and recipes. Education was provided that potato skins were not part of the Mechanical Soft Diet. She was educated on reading and calibrating thermometers and using only the left oven on the stove instead of the malfunction right side oven and the recipe and spread sheet for scalloped potatoes had been revised to instruct to peel the potatoes. One meal every day was being monitored to ensure the spread sheet and recipe as well as the tray cards were being followed. 13. Interview with the Administrator, on [DATE] at 1:35 PM, revealed dietary staff was educated over recipes and spread sheet, meal preparation and diets per the physician's orders [REDACTED].>Interview with the Registered Dietician, on [DATE] at 11:35 AM, revealed she had provided education to the dietary staff related to the spread sheets and recipes. She stated the reading of the tray cards was also covered in education as well as what to do if a food item did not turn out that included not serving that food item. Interview with Cook #1, on [DATE] at 11:40 AM, revealed she had been educated about how to set and use thermometers for checking food temperatures and about how to follow the spread sheet recipes. She stated a test was given to verify she understood the education. Interview with Dietary Aide #3, on [DATE] at 11:45 AM, revealed she had received education by the Dietary Manager on how to follow the spread sheets and recipes. She stated she also had to take a test to ve
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of Hospital emergency room Records and review of facility policies it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1), received the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance the comprehensive assessment and plan of care. The facility failed to provide a mechanical soft diet for Resident #1 and failed to assess Resident #1 for signs and symptoms of aspiration after two (2) episodes of choking. On [DATE], during the lunch meal, Resident #1 became choked when Certified Nurse Aide (CNA) #1 fed the resident scalloped potatoes. The resident coughed spitting up some of the potatoes and his/her face became red. CNA #1 informed the nurse, who did not assess the resident, but notified the Speech Therapist (ST). The ST gave the resident chocolate milk and determined the problem was the resident needed to be sitting at a ninety degree angle when fed. The ST did not look in the resident's mouth or do any hands on assessment. The nurse did not assess the resident for lung sounds, obtain oxygen saturation levels, or obtain vital signs. The resident experienced another choking episode when being fed the supper meal. The CNA notified Licensed Practical Nurse (LPN) #1 who did not assess the resident. At 8:40 PM, the resident presented with an elevated temperature of 99.1 F (normal 98.6 F), coughed up some thick mucus, and had a noted little rattle when breathing; however, the nurse (RN #2), did not assess the resident's respiratory status, lung sounds or oxygen saturation. Resident #1 was found to be in respiratory distress the next morning on [DATE] at 7:55 AM. The resident was sent to the Emergency Department and a circular piece of potato with the skin on it was found in the resident's throat during intubation. The resident was admitted to the hospital with [REDACTED]. The facility's failure to ensure the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care was provided has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE] alleging the IJ was removed on [DATE]. The State Survey Agency validated the Immediate Jeopardy was removed on [DATE], as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance monitors the effectiveness of the system changes. The findings include: Review of the facility's policy titled, Resident Comprehensive Care Plan, dated ,[DATE], revealed the resident's comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185354**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/12/2015**

NAME OF PROVIDER OF SUPPLIER **FORDSVILLE NURSING AND REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **313 MAIN STREET** **FORDSVILLE, KY 42343**

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) resident living in the facility. Review of a manual titled, Simplified Diet Manual, eleventh edition, utilized by the facility, revealed a Mechanical Soft Diet is designed to permit easy chewing. The General Diet is modified in consistency and texture by cooking, grinding, chopping, mincing or mashing. The diet includes foods soft in texture such as cooked fruits and vegetables, moist ground meat and soft bread and cereal products. Foods that dissolve readily when held in the mouth such as graham crackers and some ready-to-eat cereals are also appropriate. It is most important to individualize or adjust it to the tolerance of the resident. Table 3.1 Mechanical Soft revealed to avoid raw or undercooked vegetables and those with tough skins; and whole kernel corn and fried vegetables. Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated [DATE], revealed the facility assessed the resident's cognitive status with a Brief Interview of Mental Status score of 99, indicating the resident as not interviewable; the facility assessed the resident as requiring extensive assistance of one (1) person for eating. Review of Resident #1's physician's orders [REDACTED]. Review of Resident #1's Comprehensive Care Plan for Risk for Alteration in Nutrition, dated [DATE], revealed interventions to monitor intake and offer alternates/substitutes as needed, provide diet as ordered; mechanically soft, assist with meals, and to monitor tolerance to diet texture and for signs and symptoms of aspiration. Observation, on [DATE] at 9:40 AM, revealed Resident #1 lying on the bed which was in a low position and fall mats covering most of the room floor. The resident made eye contact when spoken to and responded only with repetitive guttural sounds. Observation at 11:45 AM revealed the resident sitting in a wheelchair and the Speech Therapist (ST) attempting to feed the resident. The resident repeatedly turned his/her head to the side and said no repeatedly. A Late Entry Nursing Note, dated [DATE] at 3:28 PM for 11:45 AM, revealed a CNA had reported Resident #1 had trouble swallowing and the nurse reported to the Speech Therapist (ST) who said she would evaluate. There was no documented evidence the nurse had assessed the resident for signs and symptoms of aspiration. Interview with CNA #1, on [DATE] at 2:00 PM, revealed Resident #1 normally ate very well and she knew the resident's diet order was for mechanical soft. CNA #1 stated Resident #1 was resistive at times to sitting in a chair and preferred to sit on the bed and lean against the wall, which he/she did that day. CNA #1 revealed when she was feeding Resident #1 scalloped potatoes on [DATE] during lunch, the resident got really red in the face and was coughing and had spit up some of what he/she had been fed. CNA #1 stated she reported the incident to the nurse who requested the ST to see the resident. CNA #1 revealed the ST came fairly quickly and gave the resident two (2) to three (3) sips of chocolate milk after sitting the resident in a more upright position. Interview with CNA #3, on [DATE] at 12:36 PM, revealed at lunch time on [DATE], CNA #1 came and got her and said the resident was coughing. CNA #3 stated she went and saw Resident #1 who looked red faced. CNA #3 was in the room when the ST gave Resident #1 chocolate milk. Interview, on [DATE] at 2:15 PM with RN #1, revealed CNA #1 reported Resident #1 was having trouble swallowing milk at lunch on [DATE] and she had the ST look at the resident. RN #1 revealed when she observed Resident #1 with the ST there was no coughing and the resident's color was good. RN #1 stated she noticed the resident had a deeper voice like he/she needed to cough but she was unable to get the resident to cough. RN #1 stated she did not assess the resident for signs and symptoms of aspiration but decided to observe the resident's temperature every shift just in case he/she had aspirated. Interview with the Speech Therapist (ST), on [DATE] at 10:40 AM, revealed she had received a call from a nurse on [DATE] stating Resident #1 had a choking episode during lunch. She stated she went to Resident #1's room and determined the resident required better positioning and needed to be sitting up at 90 degrees for meals and educated the CNAs that day. The ST stated she did not assess the resident's oral cavity or ability to swallow food but had observed him/her to drink chocolate milk while sitting at a 90 degree position without difficulty. Interview with CNA #2, on [DATE] at 3:10 PM, revealed he attempted to feed Resident #1 the supper meal on [DATE] and when he gave Resident #1 a bite, the resident would chew and attempt to swallow, but couldn't. CNA #2 stated the resident coughed, got red in the face and he thought the resident had swallowed the wrong way. CNA #2 revealed the resident did the same thing when milk was offered and acted like he/she didn't want to eat so the CNA #2 notified LPN #1. CNA #2 stated he did not know if LPN #1 had assessed Resident #1 or not. Interview with Cook #1, on [DATE] at 1:00 PM, revealed fresh potatoes had been used to make scalloped potatoes for the lunch meal on [DATE]. Cook #1 stated she did not peel the potatoes and had cooked them for one and one half hours. She revealed she was notified by a staff member the scalloped potatoes were not cooked enough when the meal trays were served to residents in the dining room. Further interview revealed she was aware at that time the hall tray carts had already been delivered for residents to be served meals in their rooms and she took no action to retrieve the residents' trays with the scalloped potatoes. She revealed she continued to serve the scalloped potatoes by picking out the thinner slices and refrigerated the remaining potatoes with a note on the pan indicating the potatoes required cooking if served again. Interview with LPN #1, on [DATE] at 3:20 PM revealed she did not recall CNA #2 saying anything to her about Resident #1 and Resident #1 was not her resident and if someone reported something about a resident she would tell them to talk to that resident's nurse. LPN #1 did not assess the resident. Review of Nursing Note, dated [DATE] at 8:40 PM, revealed Resident #1's temperature was 99.1 F; he/she had coughed up thick mucus, drank chocolate milk without difficulty, and had no swallowing problems. Interview, on [DATE] at 8:40 PM with RN #2, revealed on [DATE] she had been told in report to check Resident #1's temperature due to the resident having difficulty swallowing earlier in the day and the ST had looked at the resident but didn't know anything for sure. RN #2 stated Resident #1 had a little rattle when breathing and she had tried to get the resident to cough but he/she wouldn't or couldn't. RN #2 revealed when she checked the resident later she had observed a thick glob of mucous in the resident's beard and the resident was sounding clearer then. RN #2 stated she did not assess the resident's lung sounds or obtain oxygen saturation and stated the resident had behaviors and would have hit me. Review of a Nursing Note, dated [DATE] at 7:55 AM, revealed Resident #1 was found in severe respiratory distress and was gasping for air. The resident's oxygen saturation was fluctuating in the 80s (normal ,[DATE]) with oxygen at eight (8) liters per minute. The resident's pulse was 102 (normal 60 to 80), respirations were 30 per minute (normal ,[DATE]), temperature of 100.8 F and blood pressure of ,[DATE] (normal ,[DATE]). The resident was transported to the hospital. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 2:35 PM, revealed on the morning of [DATE], staff had informed her Resident #1 didn't sound right and was having a hard time breathing. She stated she assessed the resident with a stethoscope but couldn't hear any lung sounds due to the noise of the resident trying to breath and gasping. Resident #1 was assisted to sit up and was gasping for air when transferred out by EMS (Emergency Medical Services). Review of Hospital Emergency Department Records, dated [DATE], revealed the resident suffered from Acute [MEDICAL CONDITION] with [MEDICAL CONDITION] (a condition where the body is deprived of adequate oxygen supply). Further review revealed a slice of uncooked potato the size of a silver dollar and one-fourth inch thick was removed from the resident's throat during intubation. Resident #1 had a collapse/consolidation of the right lung, lower lobe; posterior medial basal segments left lower lobe and pneumonia. The resident was placed on a ventilator and admitted to the Intensive Care Unit (ICU) in critical condition. Interview with the Emergency Department Physician (ED), on [DATE] at 11:00 AM, revealed Resident #1 was in [MEDICAL CONDITION] on [DATE] when brought to the Emergency Department. He stated when he intubated Resident #1 he identified a one and one half inch circular piece of potato that still had the peeling on it stuck in the resident's throat. He stated the potato probably acted like a ball valve and the resident may have been able to swallow some liquids. Further interview revealed the resident could not get the epiglottis to close over the trachea. He stated Resident #1 had pneumonia from aspiration and the circular potato piece he removed was intact and very firm. The ED Physician stated Resident #1 could have died from the potato piece cutting off his/her airway or could have died from the aspiration pneumonia. Interview with the Director of Nursing (DON), on [DATE] at 3:00 PM revealed she would have expected the nurse to do a respiratory assessment after the choking incidents. She revealed the ST had evaluated Resident #1 but if a wrong food item was sent out and served to the resident then obviously the resident food was not according to the resident's assessed needs and the resident should have been assessed and monitored for aspiration after each episode of choking as well as the elevated temperature. Interview with the Medical Director/Primary Physician of Resident #1, on [DATE] at

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) 11:45 AM revealed he was aware now the resident had an partially cooked potato piece lodged in his/her trachea and had developed pneumonia and was on antibiotics. Interview with the Administrator on [DATE] at 11:40 AM revealed CNA #1 had been unable to explain how a whole potato slice was found lodged in Resident #1's throat even though she said she had mashed the potatoes with a fork. She additionally stated she had never heard of leaving the peel on potatoes when preparing scalloped potatoes. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On [DATE], Resident #1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet; the facility downgraded the diet to puree on [DATE]. 2. On [DATE], the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted an assessment of Resident #1 to determine if there were any medical needs, and or ongoing assessments required that were not already being completed or any significant change in condition that required MD notification. Resident #1's assessment revealed no change in condition that required further Physician notification and noted that appropriate assessments were on-going. 3. The MDS Nurse on [DATE] reviewed Resident #1's plans of care and determined that all interventions were in place. 4. Beginning on [DATE] and completed on [DATE] the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current residents' plan of care to determine if all interventions were being followed. No further concerns were identified. 5. On [DATE], the Dietary Services Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. The Dietary Services Manager also observed the meal tray line during lunch and noted that staff was following the recipe and spreadsheet and providing the diet as ordered for Resident #1 and food was properly prepared. 6. On [DATE], the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted assessments of all current residents to determine if there were any medical needs requiring Physician notification and or ongoing assessments required that were not already being completed. Any identified residents who had a change in condition had their Physician notified with orders obtained and follow up assessments. 7. On [DATE], the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and noted that the recipe was followed, diet was correct and served per Physician order [REDACTED]. 8. On [DATE], the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse on conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. The INTERACT process is an evidence based program developed under funding from CMS to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms. A competency test was administered to validate understanding. In addition, they were educated and a competency test was given related to following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the Physician must be notified 9. On [DATE] ,the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse began re-education with all licensed nursing staff related to conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. A competency test was administered to validate understanding. No licensed staff will work after [DATE] without having completed this re-education and competency test. In addition, reeducation was provided on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. No licensed Nurse worked after [DATE] without having received this re-education and competency test. 10. Beginning [DATE], all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after [DATE] without having received this re-education and competency test. 11. On [DATE] and [DATE], the Regional Dietician reviewed all current recipes to determine if any recipe called for food products that according to the spreadsheet would not be appropriate for mechanically altered diets. No other concerns were identified. 12. On [DATE], the Regional Dietician conducted re-education with the Dietary Services Manager including competency testing related to following the recipe and serving foods per the spreadsheet for correct prescribed diet. 13. Beginning [DATE] and ongoing, the Dietary Service Manager will conduct re-education with all Dietary Staff related to following the recipe and the spreadsheet to assure diets are served per the Physician order. This re-education will include a competency test and will be conducted prior to any staff beginning work. No Dietary staff worked after [DATE] without having completed the re-education and competency test. 14. On [DATE], a contract provider verified the convection oven was working appropriately and the regular oven in which the potatoes were cooked was cooking hotter than the setting on the oven. A new stove/oven was ordered and approved on [DATE]. 15. Beginning [DATE], all dietary staff was instructed by the Dietary Service Manager to only cook on the convection oven. No staff will work after [DATE] without having had this re-education. Beginning [DATE], all dietary staff will be educated by the Dietary Service Manager that if a concern is identified with the food prepared it should be removed from the tray line and if already served dietary staff should report the concerns to the Nurse. No dietary staff will work after [DATE] without having received this education. 16. Beginning [DATE] and ongoing, all nursing staff was educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager MDS Nurse or Medical Records Nurse on notification of the nurse if meals appear to be prepared incorrectly such as overcooked, undercooked or hard to cut foods. No nursing staff will work after [DATE] without having received this education. In addition, beginning on [DATE] and on going, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after [DATE] without having received this re-education and competency test. 17. Beginning [DATE], the Director of Nursing, Assistant Director of Nursing or Unit Manager will review with the facility staff the residents' condition each shift to determine if licensed staff are notifying the Physician of significant changes in condition as well as completing ongoing assessment as needed. This will continue every shift until abatement then five (5) times per week for twelve (12)weeks thereafter. 18. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter. 19. Beginning [DATE], the Director of Nursing, Assistant Director of Nursing or Unit Manager will review all Nurses Notes daily to determine if any significant change in condition has occurred without Physician notification or any significant change in condition requiring ongoing assessment that has not occurred. This will occur daily until abatement of Immediate Jeopardy and then five (5) times per week for twelve (12) weeks. 20. Beginning [DATE], a Dietary Service Manager or a Registered Dietician will observe one meal service per day to assure staff are following the recipe, serving and using the diet spreadsheet and that food is properly prepared to meet the individual needs. This will continue until abatement of the Immediate Jeopardy and then five (5) times per week for twelve (12) weeks thereafter. 21. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee (QAPI) weekly until substantial compliance then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter. Members of the QAPI Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Services Director, Maintenance Director, Activity Director and Business Office Manager with the Medical Director participating at least quarterly and as needed. 22. On [DATE], an ad hock Quality Assurance and Performance Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Medical Director who attended via phone. In attendance was the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Medical

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Records Clerk, MDS Nurse, Social Services Director, Dietary Services Manager and Activity director. No further recommendations were made at this time. The State Survey Agency validated the corrective actions taken by the facility as follows: 1. Review of the Nursing Notes and Physician order [REDACTED].#1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet and the facility downgraded the diet to pureed on [DATE]. Observation of the lunch meal on [DATE] at 12:00 PM, revealed the resident was being fed by the Speech Therapist. The food was in pureed form, as per the resident's diet card on the tray. 2. Review of an assessment conducted by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse of Resident #1 on [DATE], revealed there were no change in condition that required further Physician notification and noted that appropriate assessments were on-going. 3. Review of documentation by the MDS Nurse, dated [DATE], revealed she reviewed Resident #1's plans of care and determined that all interventions were in place. 4. Review of documentation verified on [DATE] through [DATE] the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current resident's plans of care to determine if all interventions were being followed. The documentation revealed which residents' plans of care were reviewed by which administrative staff. 5. Review of documentation by the Dietary Manager, dated [DATE], revealed the Dietary Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. In addition, the documentation revealed she also observed the tray line and determined staff was following the recipe and spreadsheet and providing the diets as ordered. 6. Review of residents' assessments conducted on [DATE] revealed all resident assessments were completed and any residents who had an identified change in condition had their physician notified. The assessments were conducted by the DON, ADON, Unit Manager MDS Nurse and Medical Records Nurse. 7. Review of documentation dated [DATE] revealed the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and verified the recipe was followed, diet was correct and served per Physician Order, to meet the needs of the resident and properly prepared. 8. Review of documentation of re-education by the Regional Quality Manager to the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse, dated [DATE], verified they were reeducated on the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on [DATE]. 9. Review of inservice sign in sheets and competency tests, beginning [DATE], revealed all licensed staff was re-educated beginning [DATE] and competency tests were administered and passed related to the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on [DATE]. Interview with the Administrator, on [DATE] at 1:35 PM, revealed the DON provided education to the staff related to assessments, INTERACT tool for assessments and Physician notification. Staff was educated about care plan interventions ensuring their appropriateness and implementation Interview with the DON, on [DATE] at 1:30 PM, revealed she provided education on the INTERACT tool for assessments and Physician notification and had also educated staff on updating care plans according to their scope of practice. The Twenty Four Hour Report was also topic. Nursing staff was given competency tests on following the INTERACT tool and nursing judgement. CNAs required a post test as well. Interview with RN #3, on [DATE] at 12:30 PM, revealed she received education related to the INTERACT system utilized by the facility which was a tool for assessments and included why, when, who and Physician notification. The education included follow up documentation on any type of complaint or anything out of the normal for a resident. Information was to be passed on to the next shift if not resolved and follow up was to be done the next day. A post test was given which RN #3 passed. Interview with LPN #3, on [DATE] at 12:35 PM, revealed education was provided to her by the DON that resident assessments should be conducted before, during, and after any type of an event and gave examples of elevated temperature, shortness of breath, and chest pain. LPN #3 was given a post test and passed. Education was also given to her about Physician notification, follow up documentation and implementing the care plan. She stated if the care plan needed changed or could not be implemented to notify the DON. Interview with LPN #4, on [DATE] at 12:40 PM, revealed she had been educated by the DON related to the INTERACT tools for resident assessment, physician notification and documentation. The Physician was to be notified for any significant change. Assessments were to be completed, the resident monitored and reassessed. The assessments were to include the resident's vital signs as blood pressure, respiration, oxygen saturation, pulse and temperature. LPN #4 was required to pass a post test. Interview with RN #1, on [DATE] at 12:50 PM, revealed she had been provided education by the DON related to a change in condition of a resident including if the resident was having trouble swallowing. For any emergency 911 was to be called and then notify the Physician. The INTERACT tool which reflects how, what and when to notify the Physician was to be utilized, as well, as the Stop and Watch tool which anyone could fill out and give to the nurse. Any change of condition of a resident required a complete assessment, including if a resident became choked while eating. Seventy-two (72)hour documentation was required for any changes, this included the resident's vital signs and if symptoms persisted the physician should be notified again. In addition, care plan education was provided related how to access that information from the headsets worn by the CNAs. The care plan had to match the resident's needs and if not the CNAs were to notify the nurse. A post test was completed to validate understanding. Interview with RN #4, on [DATE] at 12:55 PM, revealed she had recent education by the DON related to assessments. The INTERACT tool was a step by step guide on how, what and when to do anything and Physician notification. In addition, education was provided on care plans that included information about carrying out the interventions and revising when needed. CNAs were to report any problems with the care plan and the Physician was to be notified. She stated she had to take a post test and pass. 10. Interview with CNA #5, on [DATE] at 1:00 PM, revealed education was provided on care plans related to accessing the information on the CNA headset and to always inform the nurse when something did not seem right about the information. A post test was taken and had to be passed. Interview with CNA #6, on [DATE] at 1:05 PM, revealed education was provided on care plans and she was to ensure the care plan was followed and if the care plan did not seem appropriated she was to speak with the nurse immediately. Interview with CNA #7, on [DATE] at 1:10 PM, revealed she was educated on implementation of care plans and a post test was given and she passed. Interview with CNA #8, on [DATE] at 1:15 PM, revealed she had recently been educated that she was required to be familiar with each resident's care plan an it was accessible through the head set that she wears. CNA #8 stated if she could not follow the resident'
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** Based on interview, record review and review of facility policy and Simplified Diet Manual, it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) received the appropriate therapeutic diet prepared in a form designed to meet his/her individual needs. The facility failed to follow their policy and Diet Manual regarding food prepared and served for residents that had been assessed by the facility to require a Mechanical Soft Diet. On 01/23/15, Cook #1 prepared scalloped potatoes using fresh potatoes but did not peel them. The cook baked the potatoes in the oven for one and one half hours. The potatoes were served on resident trays from the steam table to the residents in the dining room and the hall carts. Cook #1 was informed by a staff member that the potatoes were not cooked enough but she continued to serve the potatoes by picking out the thinner sliced pieces leaving the larger pieces in the pan. Cook #1 was aware the hall cart had already been dispatched to the Foxes' Drive hall where ten (10) residents would be served Mechanical Soft diets to include Resident #1. The cook took no action to to retrieve the resident trays with the scalloped potatoes on them.

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FORDSVILLE NURSING AND REHABILITATION CENTER	**313 MAIN STREET FORDSVILLE, KY 42343**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0365

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 10)
Resident #1, who required assistance with eating, was fed the scalloped potatoes by CNA #1 and became choked. The Speech Therapist (ST) was summoned and assessed the resident determining he/she needed to sit at a ninety degree angle for feeding and she provided education to the Certified Nurse Aides (CNA) to ensure the resident was sitting at a ninety degree angle for meals. Resident #1 was unable to swallow when CNA #2 attempted to feed Resident #1 the supper meal on 01/23/15. Resident #1 became choked a second time. At 8:40 PM, the resident had an elevated temperature of 99.1 degrees Fahrenheit (F) (normal 98.6 F), an audible rattle, and had coughed up a thick glob of mucus. The following morning, 01/24/15 at 7:55 AM, the resident presented with difficulty breathing, was gasping for air and his/her oxygen saturation was fluctuating in the 80s (normal 98-100) with oxygen at eight (8) liters per minute. The resident's pulse was 102 (normal 60 to 80), respirations were 30 per minute (normal 16-20), temperature of 100.8 F and blood pressure of 100/50 (normal 120/80). The resident was transported by ambulance to the hospital. The resident was diagnosed with [REDACTED]. A slice of uncooked potato the size of a silver dollar and one fourth inch thick was removed from the resident's throat during intubation. The resident was placed on a ventilator in critical condition.
Based on the above findings it was determined the facility failed to ensure food was appropriately cooked and served in a form to meet Resident #1's needs caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 02/02/15 and determined to exist on 01/23/15. An acceptable Allegation of Compliance (AoC) was received on 02/10/15 alleging the IJ was removed on 02/05/15. The State Survey Agency validated the Immediate Jeopardy was removed on 02/05/15, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance monitors the effectiveness of the system changes.
The findings include:
Review of manual, Simplified Diet Manual eleventh edition, utilized by the facility, included; The Mechanical Soft Diet is designed to permit easy chewing. The General Diet is modified in consistency and texture by cooking, grinding, chopping, mincing or mashing. The diet includes foods soft in texture such as cooked fruits and vegetables, moist ground meat and soft bread and cereal products. Foods that dissolve readily when held in the mouth such as graham crackers and some ready-to-eat cereals are also appropriate. It is most important to individualize or adjust it to the tolerance of the resident. Table 3.1 Mechanical Soft revealed: Avoid Most raw or undercooked vegetables and those with tough skins. Whole kernel corn. Fried vegetables.
Review of the spread sheet titled, Scalloped Potatoes, indicated rehydrated potatoes or fresh potatoes could be used for the recipe. The baking time was 350 AF for one and one half to two hours. There was no reference to peeling fresh potatoes if used for the recipe.
Observation of the facility kitchen conducted on 01/30/15 at 9:35 AM revealed the facility kitchen stove had a spoon wedged between the oven door and the stove frame. There were chicken nuggets cooking and tater tots on baking sheets ready to be placed into the oven.
Record review revealed the facility admitted Resident #1 on 06/26/14 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 07/03/14, revealed the facility assessed the resident's cognitive status with a Brief Interview of Mental Status score of 99, indicating the resident was not interviewable. Resident #1 required extensive assistance of one (1) person for eating. Review of Resident #1's physician's orders [REDACTED].
Review of a Nursing Note, dated 01/23/14 at 3:28 PM; and, interviews on 01/30/15 at 2:00 PM with CNA #1 and at 2:15 PM with RN #1 revealed on 01/23/15 during the lunch meal, Resident #1 became choked when CNA #1 fed the resident scalloped potatoes. The resident coughed, spitting up some of the potatoes and his/her face became red. Review of a Nursing Note, dated 01/23/15 at 8:40 PM and interview with RN #2 on 01/31/15 at 8:40 PM revealed Resident #1's temperature was 99.1 Fahrenheit (F). She stated the resident coughed up some thick mucus but was able to drink chocolate milk without difficulty and had no noted swallowing problems.
Further review of Resident #1's Nursing Notes and interview with RN #1 revealed the following morning on 01/24/15 at 7:55 AM, the resident presented with difficulty breathing, gasping for air, and his/her oxygen saturation was fluctuating in the 80s. Oxygen was administered at 8/L per minute with oxygen saturation continuing to fluctuate up and down. The resident's pulse was 102, respirations were 30 per minute, temperature was 100. The Physician was notified and the resident was transported to the hospital by ambulance.
Review of Hospital Emergency Department records, dated 01/24/15, revealed the resident suffered from Acute [MEDICAL CONDITION] with [MEDICAL CONDITION] and a slice of uncooked potato the size of a silver dollar and one-fourth inch thick was removed from the resident's throat during intubation. There was collapse/consolidation of the right lung, lower lobe; posterior medial basal segments left lower lobe and pneumonia. The resident was placed on a ventilator and admitted to the Intensive Care Unit (ICU) in critical condition.
Interview with Cook #1, on 01/30/15 at 1:00 PM, revealed on 01/23/15 she used fresh potatoes to make scalloped potatoes for the lunch meal. She stated she washed and sliced the potatoes without peeling them and cooked them for one and one half hours. Cook #1 revealed during service of the lunch meal on 01/23/15 a staff member alerted her the scalloped potatoes were not cooked enough. She stated she continued to serve the potatoes by picking out the thinner sliced pieces leaving the larger pieces in the pan. Cook #1 stated she was aware the hall cart containing resident meal trays, including Resident #1's tray, had already went out and was being delivered to residents. She revealed she did not try to retrieve the resident trays with the scalloped potatoes on them as she had not received any complaints about the scalloped potatoes from that hall. Cook #1 stated she had been trained by a former kitchen staff and had not been provided any instruction on what to do in a situation where food was discovered to be undercooked and she had used her own judgement and had decided to continue to serve the scalloped potatoes even though she was aware they were undercooked. She stated she had picked out the thinner slices leaving the thick slices in the pan.
Interview with Cook #2, on 02/01/15 at 4:00 PM, revealed she had heard someone had choked on scalloped potatoes on 01/23/15. She stated she found scalloped potatoes in the refrigerator with a note that said the potatoes were too hard and if she used them to add milk or water and cook them. She stated the potatoes were hard as she had tried to slice through them with a fork and after they were done cooking they were like mashed potatoes. She stated for a few months she had to pull food from the oven and turn it around to ensure appropriate cooking. She stated she did not know why the scalloped potatoes on 01/23/15 were so hard. Cook #2 stated she had no training by the facility on what to do if food does not turn out right. She also stated she had never prepared scalloped potatoes and would have to go by the spread sheet to know how to fix them.
Interview with Kitchen Aide #1, on 01/30/15 at 9:35 AM, revealed there were issues with the oven door having to be kept in the closed position. The facility was wedging a spoon between the oven door and the door frame. Further review revealed the staff had to turn the food multiple times for even cooking as the oven had not been heating evenly.
Interview with the Dietary Manager, on 01/30/15 at 9:45 AM, revealed the scalloped potatoes served on 01/23/15 were cooked without being peeled. She stated dehydrated potatoes had been used in the past but the facility was trying to serve more meals that were more homemade. She revealed the potatoes were served again for the supper meal on 01/23/15. Cook #1 had placed the left over potatoes in the refrigerator with a note by Cook #1 saying the potatoes needed to be cooked more. Cook #2, who prepared the supper meal on 01/23/15 served the potatoes as a substitute for that supper meal. The Dietary Manager stated the malfunctioning oven door may have kept the temperature of the oven from being accurate and could have resulted in the potatoes being undercooked .
Interview with the corporate Registered Dietician (RD), on 01/30/15 at 2:40 PM, revealed she had been made aware of the choking incident and had asked about how the scalloped potatoes were prepared. She stated she understood that Cook #1 had peeled and sliced the potatoes for the scalloped potatoes. She revealed Cook #1 was made aware the potatoes were not thoroughly cooked;so the cook took the thinner slices of potatoes out for serving and placed the thicker, bigger slices in a container and made a note for the night cook to cook further because she was concerned. The RD also stated she was concerned about the oven door falling open and said if it happened while cooking it would cause a decrease in temperature. She revealed she was aware there had been a previous problem with the springs on the oven door and it had been fixed. Additional interview with the RD on 02/02/15 at 3:10 PM revealed temperatures in the oven had not been previously monitored for accuracy. She also stated potato skins were not acceptable for Mechanical Soft Diets.
Interview with the Administrator, on 02/03/15 at 11:30 AM, revealed she was first aware on the evening of 01/23/15, that Resident #1 was admitted to the hospital with [REDACTED]. The Administrator could not explain why a whole piece of potato was fed to Resident #1. She stated and it was evident the potatoes were found uncooked and the cook had said she stopped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185354**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/12/2015**

NAME OF PROVIDER OF SUPPLIER **FORDSVILLE NURSING AND REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **313 MAIN STREET** **FORDSVILLE, KY 42343**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0365 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) serving them. She also stated she had never heard of leaving the peel on potatoes used for scalloped potatoes. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 01/24/15, Resident #1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet; the facility downgraded the diet to puree on 01/28/15. 2. On 01/30/15, the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted an assessment of Resident #1 to determine if there were any medical needs, and or ongoing assessments required that were not already being completed or any significant change in condition that required MD notification. Resident #1's assessment revealed no change in condition that required further Physician notification and noted that appropriate assessments were on-going. 3. The MDS Nurse on 01/30/15 reviewed Resident #1's plans of care and determined that all interventions were in place. 4. Beginning on 01/30/15 and completed on 02/02/15 the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse and Medical Records Nurse reviewed all current residents' plan of care to determine if all interventions were being followed. No further concerns were identified. 5. On 01/31/15, the Dietary Services Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. The Dietary Services Manager also observed the meal tray line during lunch and noted that staff was following the recipe and spreadsheet and providing the diet as ordered for Resident #1 and food was properly prepared. 6. On 01/30/15, the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse conducted assessments of all current residents to determine if there were any medical needs requiring Physician notification and or ongoing assessments required that were not already being completed. Any identified residents who had a change in condition had their Physician notified with orders obtained and follow up assessments. 7. On 01/31/15, the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and noted that the recipe was followed, diet was correct and served per Physician order [REDACTED]. 8. On 01/30/15, the Regional Quality Manager re-educated the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse on conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. The INTERACT process is an evidence based program developed under funding from CMS to prevent unnecessary acute care transfers, to provide guidance to nurses on when to notify the physician and care paths for certain common symptoms. A competency test was administered to validate understanding. In addition, they were educated and a competency test was given related to following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice that the Physician must be notified 9. On 01/30/15 ,the Director of Nursing, Assistant Director of Nursing and Unit Manager, MDS Nurse and Medical Records Nurse began re-education with all licensed nursing staff related to conducting an assessment based on resident condition to include the INTERACT process, follow up assessments as well as Physician notification for a significant change in condition referring to the INTERACT process but not to supersede nursing judgement. A competency test was administered to validate understanding. No licensed staff will work after 02/04/15 without having completed this re-education and competency test. In addition, reeducation was provided on the requirement to follow the plan of care and if the plan of care cannot be followed and an alternative is not within their scope of practice the physician must be notified. No licensed Nurse worked after 01/30/15 without having received this re-education and competency test. 10. Beginning 02/03/15, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after 02/03/15 without having received this re-education and competency test. 11. On 02/02/15 and 02/03/15, the Regional Dietician reviewed all current recipes to determine if any recipe called for food products that according to the spreadsheet would not be appropriate for mechanically altered diets. No other concerns were identified. 12. On 01/30/15, the Regional Dietician conducted re-education with the Dietary Services Manager including competency testing related to following the recipe and serving foods per the spreadsheet for correct prescribed diet. 13. Beginning 01/31/15 and ongoing, the Dietary Service Manager will conduct re-education with all Dietary Staff related to following the recipe and the spreadsheet to assure diets are served per the Physician order. This re-education will include a competency test and will be conducted prior to any staff beginning work. No Dietary staff worked after 01/31/15 without having completed the re-education and competency test. 14. On 02/03/15, a contract provider verified the convection oven was working appropriately and the regular oven in which the potatoes were cooked was cooking hotter than the setting on the oven. A new stove/oven was ordered and approved on 03/03/15. 15. Beginning 02/03/15, all dietary staff was instructed by the Dietary Service Manager to only cook on the convection oven. No staff will work after 03/03/15 without having had this re-education. Beginning 02/04/15, all dietary staff will be educated by the Dietary Service Manager that if a concern is identified with the food prepared it should be removed from the tray line and if already served dietary staff should report the concerns to the Nurse. No dietary staff will work after 02/04/15 without having received this education. 16. Beginning 01/28/15 and ongoing, all nursing staff was educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager MDS Nurse or Medical Records Nurse on notification of the nurse if meals appear to be prepared incorrectly such as overcooked, undercooked or hard to cut foods. No nursing staff will work after 02/04/15 without having received this education. In addition, beginning on 02/03/15 and on going, all Certified Nursing Assistants were re-educated with competency test related to following the plan of care and if they were unable to follow the plan of care they must report it to the Charge Nurse. No Certified Nursing Assistants will work after 02/03/15 without having received this re-education and competency test. 17. Beginning 01/31/15, the Director of Nursing, Assistant Director of Nursing or Unit Manager will review with the facility staff the residents' condition each shift to determine if licensed staff are notifying the Physician of significant changes in condition as well as completing ongoing assessment as needed. This will continue every shift until abatement then five (5) times per week for twelve (12)weeks thereafter. 18. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) residents' plans of care per week for twelve (12) weeks to evaluate if interventions are in place and being followed. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee weekly until substantial compliance then monthly thereafter. 19. Beginning 02/01/15, the Director of Nursing, Assistant Director of Nursing or Unit Manager will review all Nurses Notes daily to determine if any significant change in condition has occurred without Physician notification or any significant change in condition requiring ongoing assessment that has not occurred. This will occur daily until abatement of Immediate Jeopardy and then five (5) times per week for twelve (12) weeks. 20. Beginning 01/31/15, a Dietary Service Manager or a Registered Dietician will observe one meal service per day to assure staff are following the recipe, serving and using the diet spreadsheet and that food is properly prepared to meet the individual needs. This will continue until abatement of the Immediate Jeopardy and then five (5) times per week for twelve (12) weeks thereafter. 21. The results of these audits will be reviewed with the Quality Assurance and Improvement Committee (QAPI) weekly until substantial compliance then monthly thereafter. The QAPI committee will meet weekly or anytime concerns are identified until substantial compliance, then monthly thereafter. Members of the QAPI Committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Social Services Director, Maintenance Director, Activity Director and Business Office Manager with the Medical Director participating at least quarterly and as needed. 22. On 01/30/15, an ad hock Quality Assurance and Performance Improvement Committee was convened to review the facility's investigation and concerns. An Allegation of Compliance was developed and reviewed with the Medical Director who attended via phone. In attendance was the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Medical Records Clerk, MDS Nurse, Social Services Director, Dietary Services Manager and Activity director. No further recommendations were made at this time. The State Survey Agency validated the corrective actions taken by the facility as follows:

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FORDSVILLE NURSING AND REHABILITATION CENTER	**313 MAIN STREET FORDSVILLE, KY 42343**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0365

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 12)
1. Review of the Nursing Notes and Physician order [REDACTED].#1 was sent to the hospital and admitted for Airway Obstruction and Aspiration Pneumonia. Resident #1 returned to the facility on [DATE] on a mechanically soft diet and the facility downgraded the diet to pureed on 01/28/15. Observation of the lunch meal on 02/12/15 at 12:00 PM, revealed the resident was being fed by the Speech Therapist. The food was in pureed form, as per the resident's diet card on the tray.
2. Review of an assessment conducted by the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Nurse or Medical Records Nurse of Resident #1 on 01/30/15, revealed there were no change in condition that required further Physician notification and noted that appropriate assessments were on-going.
3. Review of documentation by the MDS Nurse, dated 01/30/15, revealed she reviewed Resident #1's plans of care and determined that all interventions were in place.
4. Review of documentation verified on 01/30/15 through 02/02/15 the DON, ADON, Unit Manager, MDS Nurse and Medical Records
Nurse reviewed all current resident's plans of care to determine if all interventions were being followed. The documentation revealed which residents' plans of care were reviewed by which administrative staff.
5. Review of documentation by the Dietary Manager, dated 01/31/15, revealed the Dietary Manager observed Resident #1's lunch meal and determined the diet served was prepared per recipe and was correct per physician's orders [REDACTED]. In addition, the documentation revealed she also observed the tray line and determined staff was following the recipe and spreadsheet and providing the diets as ordered.
6. Review of residents' assessments conducted on 01/30/15 revealed all resident assessments were completed and any residents who had an identified change in condition had their physician notified. The assessments were conducted by the DON, ADON, Unit Manager MDS Nurse and Medical Records Nurse.
7. Review of documentation dated 01/31/15 revealed the Dietary Services Manager conducted an audit of all current residents' meal trays served from the kitchen and verified the recipe was followed, diet was correct and served per Physician Order, to meet the needs of the resident and properly prepared.
8. Review of documentation of re-education by the Regional Quality Manager to the DON, ADON, Unit Manager, MDS Nurse and Medical Records Nurse, dated 01/30/15, verified they were reeducated on the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on 01/30/15.
9. Review of inservice sign in sheets and competency tests, beginning 01/30/15, revealed all licensed staff was re-educated beginning 01/30/15 and competency tests were administered and passed related to the INTERACT process, follow up assessments, Physician notification for significant change, following the plan of care, and if the plan of care cannot be followed and an alternative is not within their scope of practice the Physician must be notified. Review of the competency tests revealed each of them completed the test on 01/30/15.
Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed the DON provided education to the staff related to assessments, INTERACT tool for assessments and Physician notification. Staff was educated about care plan interventions ensuring their appropriateness and implementation
Interview with the DON, on 02/12/15 at 1:30 PM, revealed she provided education on the INTERACT tool for assessments and Physician notification and had also educated staff on updating care plans according to their scope of practice. The Twenty Four Hour Report was also topic. Nursing staff was given competency tests on following the INTERACT tool and nursing judgement. CNAs required a post test as well.
Interview with RN #3, on 02/12/15 at 12:30 PM, revealed she received education related to the INTERACT system utilized by the facility which was a tool for assessments and included why, when, who and Physician notification. The education included follow up documentation on any type of complaint or anything out of the normal for a resident. Information was to be passed on to the next shift if not resolved and follow up was to be done the next day. A post test was given which RN #3 passed.
Interview with LPN #3, on 02/12/15 at 12:35 PM, revealed education was provided to her by the DON that resident assessments should be conducted before, during, and after any type of an event and gave examples of elevated temperature, shortness of breath, and chest pain. LPN #3 was given a post test and passed. Education was also given to her about Physician notification, follow up documentation and implementing the care plan. She stated if the care plan needed changed or could not be implemented to notify the DON.
Interview with LPN #4, on 02/12/15 at 12:40 PM, revealed she had been educated by the DON related to the INTERACT tools for resident assessment, physician notification and documentation. The Physician was to be notified for any significant change. Assessments were to be completed, the resident monitored and reassessed. The assessments were to include the resident's vital signs as blood pressure, respiration, oxygen saturation, pulse and temperature. LPN #4 was required to pass a post test.
Interview with RN #1, on 02/12/15 at 12:50 PM, revealed she had been provided education by the DON related to a change in condition of a resident including if the resident was having trouble swallowing. For any emergency 911 was to be called and then notify the Physician. The INTERACT tool which reflects how, what and when to notify the Physician was to be utilized, as well, as the Stop and Watch tool which anyone could fill out and give to the nurse. Any change of condition of a resident required a complete assessment, including if a resident became choked while eating. Seventy-two (72)hour documentation was required for any changes, this included the resident's vital signs and if symptoms persisted the physician should be notified again. In addition, care plan education was provided related how to access that information from the headsets worn by the CNAs. The care plan had to match the resident's needs and if not the CNAs were to notify the nurse. A post test was completed to validate understanding.
Interview with RN #4, on 02/12/15 at 12:55 PM, revealed she had recent education by the DON related to assessments. The INTERACT tool was a step by step guide on how, what and when to do anything and Physician notification. In addition, education was provided on care plans that included information about carrying out the interventions and revising when needed. CNAs were to report any problems with the care plan and the Physician was to be notified. She stated she had to take a post test and pass.
10. Interview with CNA #5, on 02/12/15 at 1:00 PM, revealed education was provided on care plans related to accessing the information on the CNA headset and to always inform the nurse when something did not seem right about the information. A post test was taken and had to be passed.
Interview with CNA #6, on 01/12/15 at 1:05 PM, revealed education was provided on care plans and she was to ensure the care plan was followed and if the care plan did not seem appropriated she was to speak with the nurse immediately.
Interview with CNA #7, on 02/12/15 at 1:10 PM, revealed she was educated on implementation of care plans and a post test was given and she passed.
Interview with CNA #8, on 02/12/15 at 1:15 PM, revealed she had recently been educated that she was required to be familiar with each resident's care plan an it was accessible through the head set that she wears. CNA #8 stated if she could not follow the resident's care plan she was to go to the nurse for clarification. She revealed she had to take a post test and pass.
11. Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed the spread sheets and recipes were reviewed and the spread sheet for the scalloped potato recipe was revised to include peeling potatoes before cooking.
Interview with the Registered Dietician, on 02/12/15 at 11:35 AM, revealed she had revised the spread sheet and recipe for scalloped potatoes to indicate peeling the potatoes.
12. Interview with the Dietary Manager, on 02/12/15 at 11:30 AM, revealed she had received inservice from the Registered Dietician on reading and following spreadsheets and recipes. Education was provided that potato skins were not part of the Mechanical Soft Diet. She was educated on reading and calibrating thermometers and using only the left oven on the stove instead of the malfunction right side oven and the recipe and spread sheet for scalloped potatoes had been revised to instruct to peel the potatoes. One meal every day was being monitored to ensure the spread sheet and recipe as well as the tray cards were being followed.
13. Interview with the Administrator, on 02/12/15 at 1:35 PM, revealed dietary staff was educated over recipes and spread sheet, meal preparation and diets per the physician's orders [REDACTED].>Interview with the Registered Dietician, on 02/12/15 at 11:35 AM, revealed she had provided education to the dietary staff related to the spread sheets and recipes. She stated the reading of the tray cards was also covered in education as well as what to do if a food item did not turn

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NAME OF PROVIDER OF SUPPLIER **FORDSVILLE NURSING AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **313 MAIN STREET FORDSVILLE, KY 42343**	

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F 0365 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 13) out that included not serving that food item. Interview with Cook #1, on 02/12/15 at 11:40 AM, revealed she had been educated about how to set and use thermometers for checking food temperatures and about how to follow the spread sheet recipes. She stated a test was given to verify she understood the education. Interview with Dietary Aide #3, on 02/12/15 at 11:45 AM, revealed she had received education by the Dietary Manager on how to follow the spread sheets and recipes. She st