STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. BUILDING ______ B. WING _____	**11/10/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY MANOR	**625 N MAIN ST BOERNE, TX 78006**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to failed to develop and implement policies and procedures that prohibited the neglect of 1 of 5 residents (#1) whose care was reviewed for neglect in that: The facility failed to feed Resident #1 when he should have been fed and was served cut up pieces of sausage instead of ground meat. As a result, Resident #1 choked on pieces of meat and died due to asphyxiation. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as pattern until all residents were assessed and staff was in-serviced. This deficient practice placed 39 residents with swallowing disorders and requiring mechanically altered food at risk for choking and aspiration of food due to not being served the appropriate form of food and not being fed. The findings were: Review of Resident #1's undated admission face sheet revealed the resident was admitted to the facility on [DATE] with a medical history of [REDACTED]. Review of initial admission orders [REDACTED]. Review of the attending physician's history and physical dated [DATE] revealed that Resident #1 was a poor historian due to cognitive and psychiatric impairment as a result of a middle cerebral artery aneurysm rupture in 1992 and was admitted to the facility from the local state hospital after being treated for [REDACTED].#1 became agitated and aggressive and was difficult to understand due to hypophonic voice (soft speech, especially resulting from a lack of coordination in the vocal musculature and a common presentation in [MEDICAL CONDITION]). Review of the initial MDS dated [DATE] revealed the resident had a swallow disorder and required limited assistance. The resident's diet was mechanically altered. The most recent MDS dated [DATE] assessed Resident #1 having difficulty focusing attention and being easily distracted; and having disorganized thinking and incoherent (rambling or irrelevant conversation). Eating in section G (Functional Status) required 1 person's physical assistance. Section K, Swallowing/Nutritional Status did not assess for swallowing disorder. Review of a nutritional assessment dated [DATE] revealed Resident #1 required a regular/liberalized diet type, dysphagia advanced diet texture. (Dysphagia Advanced Diet is defined by the facility's diet manual dated 2015 as foods that are difficult to chew and/or swallow are modified in any of the following ways: chopped, ground, shredded. The nutritional assessment also documented that Resident #1 exhibited combative behavior by pushing plates off the tables during meals; and needed assistance with meals. Resident #1 was ordered food to be served on plastic plates due to throwing them. Review of the facility's dining room rounds tracking log, dated [DATE], documented that Resident #1 required total assistance with eating. Review of nursing notes dated [DATE] revealed documentation that Resident #1 was totally dependent for eating as the resident would attempt to feed himself, but was unable to put food safely in his mouth at one time. A second note dated [DATE] documented the resident was totally dependent (on staff) for eating. Review of a care plan dated [DATE] revealed that Resident #1 required extensive assist of 1 for eating. Extensive assistance included encouraging the resident to take small sips and bites; to encourage the resident to chew and swallow each bite; and to monitor the resident for signs/symptoms of aspiration such as coughing, watery eyes, and choking and/or moist sounding voice. There was no documentation in the care plan instructing staff to prevent the resident from grabbing at food and putting food into his mouth. Review of a speech therapist evaluation dated [DATE] revealed that Resident #1 had a mild oropharyngeal dysphagia (difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process) and severe cognitive-communication deficit which impacted on his overall swallowing function, safety, understanding, verbal expression of his basic wants/needs, safety awareness, self-monitoring, reasoning, judgment, orientation, problem solving and executive function for toleration of least restrictive diet. The recommended strategies were: 100% closely supervised feedings with nursing assistance, upright positioning during meals, small bites/sips and additional dry swallows as indicated. Resident #1 required assistance with feeding secondary to impulsivity and executive function deficit, which impairs his ability to recall and use trained safety precautions for swallowing. Review of the attending physician's progress report dated [DATE] revealed that the resident was recovering from pneumonia and required nurses to anticipate the resident's needs. The attending physician documented that Resident #1resident had not had any recent choking episodes. Review of the menu for the evening meal on [DATE] revealed residents were served sausage, pepper and onions, parsley potato, seasoned spinach and dinner roll. According to a facility dietary manual dated [DATE] on the preparation of dysphagia advance diet, Sausage, Pepper and Onion, Ground, the sausage was to be ground as follows: transfer sausage to food processor, chop to rice size pieces. Transfer back to pan, stir. Review of an incident report dated [DATE] revealed that at 6:00 p.m., Resident #1 was sitting at a table with 2 other residents in the assisted dining room. The report described Resident #1 as needing extensive assistance for impulse control and supervision due to grabbing food. Resident #1 was unsupervised waiting to be served and began choking. Staff performed [MEDICATION NAME] and called 911. The resident was transported to the ER and died and was pronounced at 6:50 p.m. Review of an emergency provider report dated [DATE] revealed that Resident #1 had a [MEDICAL CONDITION] after choking on a piece of meat at the nursing home. Per EMS, pt. was found unresponsive after choking at 1800 today. EMS pulled out a lot of food out of our pt. as they intubated him. They do not know if someone performed the [MEDICATION NAME] maneuver. They were doing CPR when EMS got there. The provider report also assessed the resident with: Symmetric dilated pupils and face is cyanotic; and ET tube present with food debris in tube. The emergency physician determined that: Primary impression: Aspiration into airway. and Secondary impression: [MEDICAL CONDITION]. Time of death called at 1855. Review of Resident #1's tray card dated [DATE] revealed the resident was to be served dysphagia advance (textured) meals on a lip plate. During an interview on [DATE] at 12:05 p.m., the Food Service Manager stated that although she was not in the building on [DATE], she interviewed the cooks preparing the evening meal and they reported that Resident #1's tray was not served and was still on the last cart (#7), when the resident began to choke. The Food Service Manager stated that Resident #1 was probably served some other resident's tray. The Food Service Manager also stated that 24 residents within the facility were served dysphagia advance diets, including her father, who was a resident in the facility.

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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TOWN AND COUNTRY MANOR	**625 N MAIN ST BOERNE, TX 78006**

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1)

During an interview on [DATE] at 2:30 p.m., RN N, Weekend Supervisor, stated that when she was called to the assisted dining room at 6:00 p.m. on [DATE], Resident #1 was already on the floor. She stated that she started CPR. When asked if she was in the dining room, RN N stated that she was outside in the parking lot speaking to her ex-husband. RN N stated that she observed a tray of food on the table where Resident #1 had been sitting, but did not recall what type of food was on the plate. She stated that CNA J, agency staff, was sitting at the table also. RN N stated that when she reported Resident #1 had choked to the resident's daughter, the daughter asked how this could happen because her father (Resident #1) was always fed and was not allowed to feed himself. RN N stated that she didn't know that and assumed the resident fed himself, because he had a plate with a rim.

During an interview on [DATE] at 2:50 p.m., CNA G stated that Resident #1 was always fed by staff and that his tray was left on the cart and served last. CNA G stated that she was assisting in the dining room and that CNAs H and I were passing out trays, because CNA J didn't know the residents.

During an interview on [DATE] at 3:00 p.m., CNA H stated that he worked the evening shift on [DATE] and was passing out trays to the residents. He reported that he had told CNA J twice to not allow Resident #1 to feed himself. CNA H stated that he placed the tray of food in front of Resident #1 and left the table to feed other residents. He stated that he had his back to Resident #1's table and did not see if Resident #1 fed himself, or if he had been fed.

During an interview on [DATE] at 3:25 p.m., CNA I stated that she worked the evening shift on [DATE] and reported that all the facility staff knew that Resident #1 had to be fed, because the resident grabbed food off of other's plates and pushed food into his mouth. She stated that the incident was preventable.

During an interview on [DATE] at 5:30 p.m., CNA K stated that other CNAs took turns feeding Resident #1 and that the resident was always served last, because of his behaviors. She stated that all the CNAs had an electronic notepad that described the care to be given to all the residents. During the interview, CNA K demonstrated the notepad and accessed the care plan of another resident that was fed. There were several choices regarding eating. CNA K stated that the resident required extensive assistance which he understood that the resident was to be fed.

During an interview on ,[DATE] at 5:20 p.m., CNA L stated that Resident #1 was not allowed to feed himself. When asked how he knew the resident required to be fed, he stated that everyone knew the resident had to be fed and had fed him many times. He stated that Resident #1's tray was always kept out of reach so the resident could not grab the food.

During an interview on [DATE] at 6:00 p.m., Medication Aide M stated that he had worked in the facility for [AGE] years and had fed Resident #1 on many occasions. He stated that the resident was not allowed to feed himself as he would grab food and push the food into his mouth.

During an interview on [DATE] at 6:11 p.m., CNA J stated that he worked for a staffing agency and worked in the facility on [DATE] from 4:00 p.m. to 12:00 midnight. He stated that he was assigned to the hall in which Resident #1 had resided and understood that the resident required total care. CNA J stated that after providing incontinent care to Resident #1, he pushed the resident to the dining room in his wheelchair. CNA J stated that he was assigned to simultaneously feed 2 other residents (#2 and 3) and was seated between them, when Resident #1 was served his tray by CNA H. Resident #1 was sitting in his wheelchair across from him at the square table. He stated that CNA H placed the tray of food in front of Resident #1 and told him that he had to feed Resident #1. CNA J stated that he questioned the instructions and stated that he could not feed Resident #1 and the other 2 residents. CNA H then stated that Resident #1 could feed himself but was sloppy. CNA J stated that he was busy feeding the other 2 residents and did not see Resident #1 feed himself. He then noticed that Resident #1 had turned his wheelchair around and was propelling away from the table. CNA J stated that he observed LVN N speaking to the resident and asking if he was all right. CNA J stated that he suggested that maybe LVN N should sweep the resident's mouth for food. At that time, LVN N turned to CNA J and instructed him to call 911 at the nurses' station.

During an interview on [DATE] at 2:25 p.m., the attending physician reported that he had been asked by the city's medical examiner how to categorize Resident #1's death, natural or accidental. The physician stated that he informed the medical examiner that due to the choking, the death was accidental. The physician stated that Resident #1 could not protect himself (from choking) due to his mental capacity.

During an interview on [DATE] at 1:15 p.m., LVN S stated that she had worked the evening shift on [DATE] and was passing out trays to residents on the West Wing. She stated that she had observed the Weekend Supervisor standing in the parking lot outside of the building speaking with her ex-husband and little son. When she reentered the assisted feeding dining room, she noticed activity at a table and someone shouted to get the weekend supervisor. At that moment the supervisor appeared through another door and began to perform CPR. LVN S stated that she also assisted with compressions and while standing next to the table that Resident #1 sat at she noticed that the plate had cut up pieces of sausage and potatoes. She stated that when a mouth sweep was performed on the resident, pieces of meat were extracted. She stated that the meat was not ground and that they were pulling out chunks of meat. She stated that she had small children and cut pieces of meat in the same way so they could chew the meat.

Review of the facility's health care guideline, dated [DATE], Dementia Care Dining Guidelines, resident with dementia included the following guidelines:

a. Assessments need to address nutritional problems and resident characteristics such as poor dental health, swallowing difficulties or distractibility during meals that may affect food and fluid consumption (e.g., refer to dietitian for residents who are at high risk for nutritional problems; refer residents with swallowing difficulties to speech therapy for dysphagia evaluation).

b. Staff sits on the side of the resident, make eye contact and speak with residents when assisting with meals.

c. Residents are given enough time to open their mouth, chew and swallow. Drinks are offered regularly to moisten the mouth, wash food down and provide hydration.

d. Staff is aware of resident's eating and nutritional issues.

Review of the facility's policy for Meal Service in Dining Service date [DATE], revealed that staff were to:

a. Check items on the tray against diet care for accuracy.

b. Assure correct meal is served to the patient.

c. Assist patient with eating and provide assistance/supervision based on patient's current level of self-performance in eating.

Review of the facility ' s abuse, neglect and exploitation prohibition policy dated [DATE] specified that neglect was defined as failure to provide goods and services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation or resident property, will include: identifying, correcting and intervening in situations in which abuse, neglect and/or misappropriation of patient property is more likely to occur.

The Administrator was notified on [DATE] at 2:37 p.m. of an Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the Administrator on [DATE] and included the following steps to be taken by the facility:

a. On [DATE], the Center Nurse Executive (DON) revised the orientation onboarding guide for direct care agency staff which included orientation on Resident Rights, Abuse, Safety, Reports, Documentation, Skin Management and Meal Service to include feeding assistance, upright positioning, alternating food and fluids, multiple swallow and signs and symptoms of choking. All agency direct care staff could not begin their shift until the orientation was completed.

b. On [DATE], the facility began in-servicing direct care nursing staff regarding the [MEDICATION NAME] maneuver and included signs and symptoms of choking. In-services also included the supervision of residents requiring assistance with meals and proper feeding techniques as specified by the speech therapy department. In-services were also conducted on how to redirect residents with behavioral disorders at meal time.

c. On [DATE], the direct care staff were in-serviced on how to utilize the Kardex too (electric notepad) to communicate resident care plans. Staff was instructed on how to translate the codes which indicated specific instructions such as feeding and/or supervision.

d. On [DATE], care plans of residents with dysphagia and swallowing issues were updated to include specific instructions specified by the Speech Therapy Department. Any resident presenting with swallowing difficulty was to be referred to the department for evaluation immediately and any and all recommendations would be reviewed by the Center Nurse Executive.

e. On [DATE], nursing meal supervisors were in-serviced on the use of the Meal Supervision Tool in order to familiarize supervisors with the individual needs of each resident and to have them ensure that care plans were being implemented for

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
each resident. The tool was to be utilized twice a day for 30 days and then during random observations. The Center Nurse Executive was to report the use of the tool and findings to the monthly Quality Assurance Committee, which included the Medical Director and Administrator.
Verification of the Plan of Removal was as follows:
Observations and interviews of both facility and agency direct care staff conducted on [DATE], confirmed that the in-services had been conducted. All employed staff members, with the exception of 3 weekend staff members, were in-serviced either during their shifts, or prior to starting their shifts.
Observations during the evening meal on [DATE] confirmed that residents with dysphasia advance diets were being served the appropriately altered meal items. Observations during the dispersing of food items by the cooks during the evening meal confirmed that the chicken being served had undergone a grounding process prior to being served.
On [DATE] at 7:30 p.m., the Administrator was informed that the IJ was removed. However, the facility remained out of compliance with a severity of actual harm with a scope identified as pattern.
The facility reported that 39 residents had swallowing disorders.

F 0226

Level of harm - Immediate jeopardy

Residents Affected - Some

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview and record review, the facility failed to implement the facility's policies and procedures that prohibited the neglect of 1 of 5 residents (#1) whose care was reviewed for neglect in that:
The facility failed to feed Resident #1 when he should have been fed and was served cut up pieces of sausage instead of ground meat. As a result, Resident #1 choked on pieces of meat and died due to asphyxiation.
This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as pattern until all residents were assessed and staff was in-serviced.
This deficient practice placed 39 residents with swallowing disorders and requiring mechanically altered food at risk for choking and aspiration of food due to not being served the appropriate form of food and not being fed.
The findings were:
1. Review of the facility's abuse, neglect and exploitation prohibition policy dated [DATE] specified that neglect was defined as failure to provide goods and services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation or resident property, will include: identifying, correcting and intervening in situations in which abuse, neglect and/or misappropriation of patient property is more likely to occur.
Review of the facility's health care guideline, dated [DATE], Dementia Care Dining Guidelines, resident with dementia included the following guidelines:
a. Assessments need to address nutritional problems and resident characteristics such as poor dental health, swallowing difficulties or distractibility during meals that may affect food and fluid consumption (e.g., refer to dietitian for residents who are at high risk for nutritional problems; refer residents with swallowing difficulties to speech therapy for dysphagia evaluation).
b. Staff sits on the side of the resident, make eye contact and speak with residents when assisting with meals.
c. Residents are given enough time to open their mouth, chew and swallow. Drinks are offered regularly to moisten the mouth, wash food down and provide hydration.
d. Staff is aware of resident's eating and nutritional issues.
Review of the facility's policy for Meal Service in Dining Service date [DATE], revealed that staff were to:
a. Check items on the tray against diet care for accuracy.
b. Assure correct meal is served to the patient.
c. Assist patient with eating and provide assistance/supervision based on patient's current level of self-performance in eating.
2. Review of Resident #1's undated admission face sheet revealed the resident was admitted to the facility on [DATE] with a medical history of [REDACTED].
Review of initial admission orders [REDACTED].
Review of the attending physician's history and physical dated [DATE] revealed that Resident #1 was a poor historian due to cognitive and psychiatric impairment as a result of a middle cerebral artery aneurysm rupture in 1992 and was admitted to the facility from the local state hospital after being treated for [REDACTED].#1 became agitated and aggressive and was difficult to understand due to hypophonic voice (soft speech, especially resulting from a lack of coordination in the vocal musculature and a common presentation in [MEDICAL CONDITION]).
Review of the initial MDS dated [DATE] revealed the resident had a swallow disorder and required limited assistance. The resident's diet was mechanically altered. The most recent MDS dated [DATE] assessed Resident #1 having difficulty focusing attention and being easily distracted; and having disorganized thinking and incoherent (rambling or irrelevant conversation). Eating in section G (Functional Status) required 1 person's physical assistance. Section K, Swallowing/Nutritional Status did not assess for swallowing disorder.
Review of a nutritional assessment dated [DATE] revealed Resident #1 required a regular/liberalized diet type, dysphagia advanced diet texture. (Dysphagia Advanced Diet is defined by the facility's diet manual dated 2015 as foods that are difficult to chew and/or swallow are modified in any of the following ways: chopped, ground, shredded. The nutritional assessment also documented that Resident #1 exhibited combative behavior by pushing plates off the tables during meals; and needed assistance with meals. Resident #1 was ordered food to be served on plastic plates due to throwing them.
Review of the facility's dining room rounds tracking log, dated [DATE], documented that Resident #1 required total assistance with eating.
Review of nursing notes dated [DATE] revealed documentation that Resident #1 was totally dependent for eating as the resident would attempt to feed himself, but was unable to put food safely in his mouth at one time. A second note dated [DATE] documented the resident was totally dependent (on staff) for eating.
Review of a care plan dated [DATE] revealed that Resident #1 required extensive assist of 1 for eating. Extensive assistance included encouraging the resident to take small sips and bites; to encourage the resident to chew and swallow each bite; and to monitor the resident for signs/symptoms of aspiration such as coughing, watery eyes, and choking and/or moist sounding voice. There was no documentation in the care plan instructing staff to prevent the resident from grabbing at food and putting food into his mouth.
Review of a speech therapist evaluation dated [DATE] revealed that Resident #1 had a mild oropharyngeal dysphagia (difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process) and severe cognitive-communication deficit which impacted on his overall swallowing function, safety, understanding, verbal expression of his basic wants/needs, safety awareness, self-monitoring, reasoning, judgment, orientation, problem solving and executive function for toleration of least restrictive diet. The recommended strategies were: 100% closely supervised feedings with nursing assistance, upright positioning during meals, small bites/sips and additional dry swallows as indicated. Resident #1 required assistance with feeding secondary to impulsivity and executive function deficit, which impairs his ability to recall and use trained safety precautions for swallowing.
Review of the attending physician's progress report dated [DATE] revealed that the resident was recovering from pneumonia and required nurses to anticipate the resident's needs. The attending physician documented that Resident #1resident had not had any recent choking episodes.
Review of the menu for the evening meal on [DATE] revealed residents were served sausage, pepper and onions, parsley potato, seasoned spinach and dinner roll. According to a facility dietary manual dated [DATE] on the preparation of dysphagia advance diet, Sausage, Pepper and Onion, Ground, the sausage was to be ground as follows: transfer sausage to food processor, chop to rice size pieces. Transfer back to pan, stir.
Review of an incident report dated [DATE] revealed that at 6:00 p.m., Resident #1 was sitting at a table with 2 other

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F 0226

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
residents in the assisted dining room. The report described Resident #1 as needing extensive assistance for impulse control and supervision due to grabbing food. Resident #1 was unsupervised waiting to be served and began choking. Staff performed [MEDICATION NAME] and called 911. The resident was transported to the ER and died and was pronounced at 6:50 p.m.
Review of an emergency provider report dated [DATE] revealed that Resident #1 had a [MEDICAL CONDITION] after choking on a piece of meat at the nursing home. Per EMS, pt. was found unresponsive after choking at 1800 today. EMS pulled out a lot of food out of our pt. as they intubated him. They do not know if someone performed the [MEDICATION NAME] maneuver. They were
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Review of Resident #1's tray card dated [DATE] revealed the resident was to be served dysphagia advance (textured) meals on a lip plate.
During an interview on [DATE] at 12:05 p.m., the Food Service Manager stated that although she was not in the building on [DATE], she interviewed the cooks preparing the evening meal and they reported that Resident #1's tray was not served and was still on the last cart (#7), when the resident began to choke. The Food Service Manager stated that Resident #1 was probably served some other resident's tray. The Food Service Manager also stated that 24 residents within the facility were served dysphagia advance diets, including her father, who was a resident in the facility.
During an interview on [DATE] at 2:30 p.m., RN N, Weekend Supervisor, stated that when she was called to the assisted dining room at 6:00 p.m. on [DATE], Resident #1 was already on the floor. She stated that she started CPR. When asked if she was in the dining room, RN N stated that she was outside in the parking lot speaking to her ex-husband. RN N stated that she observed a tray of food on the table where Resident #1 had been sitting, but did not recall what type of food was on the plate. She stated that CNA J, agency staff, was sitting at the table also. RN N stated that when she reported Resident #1 had choked to the resident's daughter, the daughter asked how this could happen because her father (Resident #1) was always fed and was not allowed to feed himself. RN N stated that she didn't know that and assumed the resident fed himself, because he had a plate with a rim.
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During an interview on ,[DATE] at 5:20 p.m., CNA L stated that Resident #1 was not allowed to feed himself. When asked how he knew the resident required to be fed, he stated that everyone knew the resident had to be fed and had fed him many times. He stated that Resident #1's tray was always kept out of reach so the resident could not grab the food.
During an interview on [DATE] at 6:00 p.m., Medication Aide M stated that he had worked in the facility for [AGE] years and had fed Resident #1 on many occasions. He stated that the resident was not allowed to feed himself as he would grab food and push the food into his mouth.
During an interview on [DATE] at 6:11 p.m., CNA J stated that he worked for a staffing agency and worked in the facility on [DATE] from 4:00 p.m. to 12:00 midnight. He stated that he was assigned to the hall in which Resident #1 had resided and understood that the resident required total care. CNA J stated that after providing incontinent care to Resident #1, he pushed the resident to the dining room in his wheelchair. CNA J stated that he was assigned to simultaneously feed 2 other residents (#2 and 3) and was seated between them, when Resident #1 was served his tray by CNA H. Resident #1 was sitting in his wheelchair across from him at the square table. He stated that CNA H placed the tray of food in front of Resident #1 and told him that he had to feed Resident #1. CNA J stated that he questioned the instructions and stated that he could not feed Resident #1 and the other 2 residents. CNA H then stated that Resident #1 could feed himself but was sloppy. CNA J stated that he was busy feeding the other 2 residents and did not see Resident #1 feed himself. He then noticed that Resident #1 had turned his wheelchair around and was propelling away from the table. CNA J stated that he observed LVN N speaking to the resident and asking if he was all right. CNA J stated that he suggested that maybe LVN N should sweep the resident's mouth for food. At that time, LVN N turned to CNA J and instructed him to call 911 at the nurses' station.
During an interview on [DATE] at 2:25 p.m., the attending physician reported that he had been asked by the city's medical examiner how to categorize Resident #1's death, natural or accidental. The physician stated that he informed the medical examiner that due to the choking, the death was accidental. The physician stated that Resident #1 could not protect himself (from choking) due to his mental capacity.
During an interview on [DATE] at 1:15 p.m., LVN S stated that she had worked the evening shift on [DATE] and was passing out trays to residents on the West Wing. She stated that she had observed the Weekend Supervisor standing in the parking lot outside of the building speaking with her ex-husband and little son. When she reentered the assisted feeding dining room, she noticed activity at a table and someone shouted to get the weekend supervisor. At that moment the supervisor appeared through another door and began to perform CPR. LVN S stated that she also assisted with compressions and while standing next to the table that Resident #1 sat at she noticed that the plate had cut up pieces of sausage and potatoes. She stated that when a mouth sweep was performed on the resident, pieces of meat were extracted. She stated that the meat was not ground and that they were pulling out chunks of meat. She stated that she had small children and cut pieces of meat in the same way so they could chew the meat.
The Administrator was notified on [DATE] at 2:37 p.m. of an Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the Administrator on [DATE] and included the following steps to be taken by the facility:
a. On [DATE], the Center Nurse Executive (DON) revised the orientation onboarding guide for direct care agency staff which included orientation on Resident Rights, Abuse, Safety, Reports, Documentation, Skin Management and Meal Service to include feeding assistance, upright positioning, alternating food and fluids, multiple swallow and signs and symptoms of choking. All agency direct care staff could not begin their shift until the orientation was completed.
b. On [DATE], the facility began in-servicing direct care nursing staff regarding the [MEDICATION NAME] maneuver and included signs and symptoms of choking. In-services also included the supervision of residents requiring assistance with meals and proper feeding techniques as specified by the speech therapy department. In-services were also conducted on how to redirect residents with behavioral disorders at meal time.
c. On [DATE], the direct care staff were in-serviced on how to utilize the Kardex too (electric notepad) to communicate resident care plans. Staff was instructed on how to translate the codes which indicated specific instructions such as feeding and/or supervision.
d. On [DATE], care plans of residents with dysphagia and swallowing issues were updated to include specific instructions specified by the Speech Therapy Department. Any resident presenting with swallowing difficulty was to be referred to the department for evaluation immediately and any and all recommendations would be reviewed by the Center Nurse Executive.
e. On [DATE], nursing meal supervisors were in-serviced on the use of the Meal Supervision Tool in order to familiarize supervisors with the individual needs of each resident and to have them ensure that care plans were being implemented for each resident. The tool was to be utilized twice a day for 30 days and then during random observations. The Center Nurse Executive was to report the use of the tool and findings to the monthly Quality Assurance Committee, which included the Medical Director and Administrator.
Verification of the Plan of Removal was as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **455796**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/10/2016**

NAME OF PROVIDER OF SUPPLIER **TOWN AND COUNTRY MANOR**	STREET ADDRESS, CITY, STATE, ZIP **625 N MAIN ST BOERNE, TX 78006**

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 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) Observations and interviews of both facility and agency direct care staff conducted on [DATE], confirmed that the in-services had been conducted. All employed staff members, with the exception of 3 weekend staff members, were in-serviced either during their shifts, or prior to starting their shifts. Observations during the evening meal on [DATE] confirmed that residents with dysphasia advance diets were being served the appropriately altered meal items. Observations during the dispersing of food items by the cooks during the evening meal confirmed that the chicken being served had undergone a grounding process prior to being served. On [DATE] at 7:30 p.m., the Administrator was informed that the IJ was removed. However, the facility remained out of compliance with a severity of actual harm with a scope identified as pattern. The facility reported that 39 residents had swallowing disorders.
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents for 1of 5 residents (#1) who were reviewed for accidents in that: The facility failed to feed Resident #1 when he should have been fed and was served cut up pieces of sausage instead of ground meat. As a result, Resident #1 choked on pieces of meat and died due to asphyxiation. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as pattern until all residents were assessed and staff was in-serviced. This deficient practice placed 39 residents with swallowing disorders and requiring mechanically altered food at risk for choking and aspiration of food due to not being served the appropriate form of food and not being fed. The findings were: Review of Resident #1's undated admission face sheet revealed the resident was admitted to the facility on [DATE] with a medical history of [REDACTED]. Review of initial admission orders [REDACTED]. Review of the attending physician's history and physical dated [DATE] revealed that Resident #1 was a poor historian due to cognitive and psychiatric impairment as a result of a middle cerebral artery aneurysm rupture in 1992 and was admitted to the facility from the local state hospital after being treated for [REDACTED].#1 became agitated and aggressive and was difficult to understand due to hypophonic voice (soft speech, especially resulting from a lack of coordination in the vocal musculature and a common presentation in Parkinson's disease). Review of the initial MDS dated [DATE] revealed the resident had a swallow disorder and required limited assistance. The resident's diet was mechanically altered. The most recent MDS dated [DATE] assessed Resident #1 having difficulty focusing attention and being easily distracted; and having disorganized thinking and incoherent (rambling or irrelevant conversation). Eating in section G (Functional Status) required 1 person's physical assistance. Section K, Swallowing/Nutritional Status did not assess for swallowing disorder. Review of a nutritional assessment dated [DATE] revealed Resident #1 required a regular/liberalized diet type, dysphagia advanced diet texture. (Dysphagia Advanced Diet is defined by the facility's diet manual dated 2015 as foods that are difficult to chew and/or swallow are modified in any of the following ways: chopped, ground, shredded. The nutritional assessment also documented that Resident #1 exhibited combative behavior by pushing plates off the tables during meals; and needed assistance with meals. Resident #1 was ordered food to be served on plastic plates due to throwing them. Review of the facility's dining room rounds tracking log, dated [DATE], documented that Resident #1 required total assistance with eating. Review of nursing notes dated [DATE] revealed documentation that Resident #1 was totally dependent for eating as the resident would attempt to feed himself, but was unable to put food safely in his mouth at one time. A second note dated [DATE] documented the resident was totally dependent (on staff) for eating. Review of a care plan dated [DATE] revealed that Resident #1 required extensive assist of 1 for eating. Extensive assistance included encouraging the resident to take small sips and bites; to encourage the resident to chew and swallow each bite; and to monitor the resident for signs/symptoms of aspiration such as coughing, watery eyes, and choking and/or moist sounding voice. There was no documentation in the care plan instructing staff to prevent the resident from grabbing at food and putting food into his mouth. Review of a speech therapist evaluation dated [DATE] revealed that Resident #1 had a mild oropharyngeal dysphagia (difficulty transferring food from the mouth into the pharynx and esophagus to initiate the involuntary swallowing process) and severe cognitive-communication deficit which impacted on his overall swallowing function, safety, understanding, verbal expression of his basic wants/needs, safety awareness, self-monitoring, reasoning, judgment, orientation, problem solving and executive function for toleration of least restrictive diet. The recommended strategies were: 100% closely supervised feedings with nursing assistance, upright positioning during meals, small bites/sips and additional dry swallows as indicated. Resident #1 required assistance with feeding secondary to impulsivity and executive function deficit, which impairs his ability to recall and use trained safety precautions for swallowing. Review of the attending physician's progress report dated [DATE] revealed that the resident was recovering from pneumonia and required nurses to anticipate the resident's needs. The attending physician documented that Resident #1resident had not had any recent choking episodes. Review of the menu for the evening meal on [DATE] revealed residents were served sausage, pepper and onions, parsley potato, seasoned spinach and dinner roll. According to a facility dietary manual dated [DATE] on the preparation of dysphagia advance diet, Sausage, Pepper and Onion, Ground, the sausage was to be ground as follows: transfer sausage to food processor, chop to rice size pieces. Transfer back to pan, stir. Review of an incident report dated [DATE] revealed that at 6:00 p.m., Resident #1 was sitting at a table with 2 other residents in the assisted dining room. The report described Resident #1 as needing extensive assistance for impulse control and supervision due to grabbing food. Resident #1 was unsupervised waiting to be served and began choking. Staff performed Heimlich and called 911. The resident was transported to the ER and died and was pronounced at 6:50 p.m. Review of an emergency provider report dated [DATE] revealed that Resident #1 had a cardiac arrest after choking on a piece of meat at the nursing home. Per EMS, pt. was found unresponsive after choking at 1800 today. EMS pulled out a lot of food out of our pt. as they intubated him. They do not know if someone performed the Heimlich maneuver. They were doing CPR when EMS got there. The provider report also assessed the resident with: Symmetric dilated pupils and face is cyanotic; and ET tube present with food debris in tube. The emergency physician determined that: Primary impression: Aspiration into airway. and Secondary impression: cardiac arrest. Time of death called at 1855. Review of Resident #1's tray card dated [DATE] revealed the resident was to be served dysphagia advance (textured) meals on a lip plate. During an interview on [DATE] at 12:05 p.m., the Food Service Manager stated that although she was not in the building on [DATE], she interviewed the cooks preparing the evening meal and they reported that Resident #1's tray was not served and was still on the last cart (#7), when the resident began to choke. The Food Service Manager stated that Resident #1 was probably served some other resident's tray. The Food Service Manager also stated that 24 residents within the facility were served dysphagia advance diets, including her father, who was a resident in the facility. During an interview on [DATE] at 2:30 p.m., RN N, Weekend Supervisor, stated that when she was called to the assisted dining room at 6:00 p.m. on [DATE], Resident #1 was already on the floor. She stated that she started CPR. When asked if she was in the dining room, RN N stated that she was outside in the parking lot speaking to her ex-husband. RN N stated that she observed a tray of food on the table where Resident #1 had been sitting, but did not recall what type of food was on the plate. She stated that CNA J, agency staff, was sitting at the table also. RN N stated that when she reported Resident #1 had choked to the resident's daughter, the daughter asked how this could happen because her father (Resident #1) was always fed and was not allowed to feed himself. RN N stated that she didn't know that and assumed the resident fed himself, because he had a plate with a rim.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY MANOR	**625 N MAIN ST BOERNE, TX 78006**

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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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) During an interview on [DATE] at 2:50 p.m., CNA G stated that Resident #1 was always fed by staff and that his tray was left on the cart and served last. CNA G stated that she was assisting in the dining room and that CNAs H and I were passing out trays, because CNA J didn't know the residents. During an interview on [DATE] at 3:00 p.m., CNA H stated that he worked the evening shift on [DATE] and was passing out trays to the residents. He reported that he had told CNA J twice to not allow Resident #1 to feed himself. CNA H stated that he placed the tray of food in front of Resident #1 and left the table to feed other residents. He stated that he had his back to Resident #1's table and did not see if Resident #1 fed himself, or if he had been fed. During an interview on [DATE] at 3:25 p.m., CNA I stated that she worked the evening shift on [DATE] and reported that all the facility staff knew that Resident #1 had to be fed, because the resident grabbed food off of other's plates and pushed food into his mouth. She stated that the incident was preventable. During an interview on [DATE] at 5:30 p.m., CNA K stated that other CNAs took turns feeding Resident #1 and that the resident was always served last, because of his behaviors. She stated that all the CNAs had an electronic notepad that described the care to be given to all the residents. During the interview, CNA K demonstrated the notepad and accessed the care plan of another resident that was fed. There were several choices regarding eating. CNA K stated that the resident required extensive assistance which he understood that the resident was to be fed. During an interview on ,[DATE] at 5:20 p.m., CNA L stated that Resident #1 was not allowed to feed himself. When asked how he knew the resident required to be fed, he stated that everyone knew the resident had to be fed and had fed him many times. He stated that Resident #1's tray was always kept out of reach so the resident could not grab the food. During an interview on [DATE] at 6:00 p.m., Medication Aide M stated that he had worked in the facility for [AGE] years and had fed Resident #1 on many occasions. He stated that the resident was not allowed to feed himself as he would grab food and push the food into his mouth. During an interview on [DATE] at 6:11 p.m., CNA J stated that he worked for a staffing agency and worked in the facility on [DATE] from 4:00 p.m. to 12:00 midnight. He stated that he was assigned to the hall in which Resident #1 had resided and understood that the resident required total care. CNA J stated that after providing incontinent care to Resident #1, he pushed the resident to the dining room in his wheelchair. CNA J stated that he was assigned to simultaneously feed 2 other residents (#2 and 3) and was seated between them, when Resident #1 was served his tray by CNA H. Resident #1 was sitting in his wheelchair across from him at the square table. He stated that CNA H placed the tray of food in front of Resident #1 and told him that he had to feed Resident #1. CNA J stated that he questioned the instructions and stated that he could not feed Resident #1 and the other 2 residents. CNA H then stated that Resident #1 could feed himself but was sloppy. CNA J stated that he was busy feeding the other 2 residents and did not see Resident #1 feed himself. He then noticed that Resident #1 had turned his wheelchair around and was propelling away from the table. CNA J stated that he observed LVN N speaking to the resident and asking if he was all right. CNA J stated that he suggested that maybe LVN N should sweep the resident's mouth for food. At that time, LVN N turned to CNA J and instructed him to call 911 at the nurses' station. During an interview on [DATE] at 2:25 p.m., the attending physician reported that he had been asked by the city's medical examiner how to categorize Resident #1's death, natural or accidental. The physician stated that he informed the medical examiner that due to the choking, the death was accidental. The physician stated that Resident #1 could not protect himself (from choking) due to his mental capacity. During an interview on [DATE] at 1:15 p.m., LVN S stated that she had worked the evening shift on [DATE] and was passing out trays to residents on the West Wing. She stated that she had observed the Weekend Supervisor standing in the parking lot outside of the building speaking with her ex-husband and little son. When she reentered the assisted feeding dining room, she noticed activity at a table and someone shouted to get the weekend supervisor. At that moment the supervisor appeared through another door and began to perform CPR. LVN S stated that she also assisted with compressions and while standing next to the table that Resident #1 sat at she noticed that the plate had cut up pieces of sausage and potatoes. She stated that when a mouth sweep was performed on the resident, pieces of meat were extracted. She stated that the meat was not ground and that they were pulling out chunks of meat. She stated that she had small children and cut pieces of meat in the same way so they could chew the meat. Review of the facility's health care guideline, dated [DATE], Dementia Care Dining Guidelines, resident with dementia included the following guidelines: a. Assessments need to address nutritional problems and resident characteristics such as poor dental health, swallowing difficulties or distractibility during meals that may affect food and fluid consumption (e.g., refer to dietitian for residents who are at high risk for nutritional problems; refer residents with swallowing difficulties to speech therapy for dysphagia evaluation). b. Staff sits on the side of the resident, make eye contact and speak with residents when assisting with meals. c. Residents are given enough time to open their mouth, chew and swallow. Drinks are offered regularly to moisten the mouth, wash food down and provide hydration. d. Staff is aware of resident's eating and nutritional issues. Review of the facility's policy for Meal Service in Dining Service date [DATE], revealed that staff were to: a. Check items on the tray against diet care for accuracy. b. Assure correct meal is served to the patient. c. Assist patient with eating and provide assistance/supervision based on patient's current level of self-performance in eating. The Administrator was notified on [DATE] at 2:37 p.m. of an Immediate Jeopardy for the above failures and a Plan of Removal was requested. The facility's Plan of Removal was provided by the Administrator on [DATE] and included the following steps to be taken by the facility: a. On [DATE], the Center Nurse Executive (DON) revised the orientation onboarding guide for direct care agency staff which included orientation on Resident Rights, Abuse, Safety, Reports, Documentation, Skin Management and Meal Service to include feeding assistance, upright positioning, alternating food and fluids, multiple swallow and signs and symptoms of choking. All agency direct care staff could not begin their shift until the orientation was completed. b. On [DATE], the facility began in-servicing direct care nursing staff regarding the Heimlich maneuver and included signs and symptoms of choking. In-services also included the supervision of residents requiring assistance with meals and proper feeding techniques as specified by the speech therapy department. In-services were also conducted on how to redirect residents with behavioral disorders at meal time. c. On [DATE], the direct care staff were in-serviced on how to utilize the Kardex too (electric notepad) to communicate resident care plans. Staff was instructed on how to translate the codes which indicated specific instructions such as feeding and/or supervision. d. On [DATE], care plans of residents with dysphagia and swallowing issues were updated to include specific instructions specified by the Speech Therapy Department. Any resident presenting with swallowing difficulty was to be referred to the department for evaluation immediately and any and all recommendations would be reviewed by the Center Nurse Executive. e. On [DATE], nursing meal supervisors were in-serviced on the use of the Meal Supervision Tool in order to familiarize supervisors with the individual needs of each resident and to have them ensure that care plans were being implemented for each resident. The tool was to be utilized twice a day for 30 days and then during random observations. The Center Nurse Executive was to report the use of the tool and findings to the monthly Quality Assurance Committee, which included the Medical Director and Administrator. Verification of the Plan of Removal was as follows: Observations and interviews of both facility and agency direct care staff conducted on [DATE], confirmed that the in-services had been conducted. All employed staff members, with the exception of 3 weekend staff members, were in-serviced either during their shifts, or prior to starting their shifts. Observations during the evening meal on [DATE] confirmed that residents with dysphasia advance diets were being served the appropriately altered meal items. Observations during the dispersing of food items by the cooks during the evening meal confirmed that the chicken being served had undergone a grounding process prior to being served. On [DATE] at 7:30 p.m., the Administrator was informed that the IJ was removed. However, the facility remained out of compliance with a severity of actual harm with a scope identified as pattern. The facility reported that 39 residents had swallowing disorders.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6)