| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105965 | A. Building<br>B. Wing | 04/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Capri Health and Rehabilitation Center | 1450 East Venice Avenue<br>Venice, FL 34292 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on review of the clinical record, review of facility policy and procedures and staff and family interviews, the facility failed to protect the resident's right to be free from neglect.<br><br>The facility failed to provide the necessary services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. They failed to provide the correct diet and required assistance for one (Resident #43) of 3 sampled residents with dysphagia (difficulty swallowing).<br><br>Resident #43 had a physician's order for a soft and bite sized diet, and required extensive assistance with meals.<br><br>On [DATE] Resident #43 did not receive the necessary assistance during meals. Staff was not aware Resident #43 required extensive assistance with meals. The SLP (Speech-Language Patholigist) changed the resident's diet from a soft, small bites diet to a regular diet without an assessment and physician's order. The resident was served a regular diet. Resident #43 was found unresponsive. Staff performed CPR (Cardiopulmonary Resuscitation) called 911 and suctioned a whole Brussels sprout out of the resident's throat. EMS (Emergency medical services) took over CPR. CPR was not successful and Resident #43 was pronounced dead on [DATE] at approximately 8:50 p.m. The ME (Medical Examiner) advised the facility medical director that the cause of the resident's death was accidental death by choking.<br><br>The facility's failure to provide the services necessary to prevent neglect placed other residents with similar conditions at a likelihood of serious illness and/or death.<br><br>On [DATE] it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on [DATE] at 8:30 a.m.<br><br>Immediate Jeopardy was identified on [DATE]. It began on [DATE] and was removed on [DATE]. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of [DATE] and verified by interview, observation and record review on [DATE].<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Capri Health and Rehabilitation Center | 1450 East Venice Avenue<br>Venice, FL 34292 |

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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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Cross reference to F609, F689 and F692.<br><br>The findings included:<br><br>The facility policy Patient Protection, Abuse, Neglect, Mistreatment, and Misappropriation Prevention (dated, d+[DATE]) defined neglect as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.<br><br>Review of the clinical record revealed Resident #43 had an admitted [DATE] with diagnoses including dementia, anxiety, and oropharyngeal dysphagia (difficulty swallowing).<br><br>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) v.1.17.2 with an assessment reference date (ARD) of [DATE] documented Resident #43 required supervision with eating meals.<br><br>The MDS noted Resident #65's cognitive skills for daily decision making were intact.<br><br>A Significant Change MDS v.1.17.2 with an ARD of [DATE] documented Resident #43 required extensive assistance of 1 person with eating her meals. The MDS noted Resident #43's cognitive skills were mildly impaired.<br><br>Review of the Speech Language Pathologist (SLP) note dated [DATE] documented skilled interventions addressing swallowing dysfunction included therapeutic trial feedings with soft and bite sized consistency to increase safety. Patient with significant improvement with soft and bite sized consistency.<br><br>Review of the clinical record showed the diet communication form dated [DATE] documented a soft and bite sized diet.<br><br>On [DATE] the SLP wrote on a posted note to change Resident #43's diet to a regular diet and gave the posted note to the Certified Dietary Manager (CDM).<br><br>On [DATE] the CDM changed Resident #43's diet from soft and bite sized to a regular textured diet without a physician order.<br><br>On [DATE] at 6:30 p.m., Certified Nursing Assistant (CNA) Staff A delivered the evening meal to Resident #43 who was in her bed. The meal served was chicken and dumplings with whole Brussels sprouts. The CNA set up the meal tray and left Resident #43 unattended.<br><br>On [DATE] at 7:45 p.m., CNA Staff A went to Resident #43's room to pick up her meal tray. The CNA reported Resident #43 was sitting upright in bed with the meal tray in front of her on the over the bed table. The CNA asked the resident if she was finished eating and the resident nodded her head yes. The CNA removed the tray and exited the room.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] between 8:15 p.m., and 8:20 p.m., CNA Staff A returned to Resident #43's room to assist the resident to get ready for bed and found her unresponsive. Licensed Practical Nurse (LPN) Staff B was notified and assessed the resident who was pulseless and not breathing. The LPN initiated CPR and contacted 911.<br><br>EMS arrived and pronounced Resident #43 dead at 8:51 p.m.<br><br>On [DATE] at 10:03 a.m., in an interview the SLP said Resident #43 was on a regular diet and it took a very long time for her to eat meals, up to 3 hours at each meal. She was safe, she would chew her food for a while, and she had no dentures. The SLP worked with Resident #43 because she was losing weight and changed her diet to soft with bite sized small pieces on [DATE]. The family requested regular food so she told the kitchen she could have the regular diet on [DATE]. She did not write a doctor's order, she wrote the diet change on a sticky note and gave it to the CDM. The SLP confirmed she did not evaluate Resident #43 before changing her diet to a regular diet. The SLP said I made a lot of mistakes. She said she should have assessed the resident, and should have obtained a physician order. I did not follow the policy for upgrading the diet.<br><br>On [DATE] at 4:10 p.m., in an interview, CNA Staff A said Resident #43 was a total care resident with everything but could feed herself. Staff A said on [DATE] she set the food tray up and put her in a sitting position in bed for the meal. I put the tray on the table and put the table in front of her. She had regular food and I helped her to cut it. CNA Staff A said I don't know when the diet was changed, she was always on a regular diet. No one at the facility spoke with me about her or how much help she needed. I left the room after I gave her the food at 6:30 p.m. I checked on her at 7:45 p.m., because she eats slow. I gave her time to eat. Resident #43 was not eating, and Staff A asked her if she was done. She shook her head yes and I took the tray from her. I don't know if she had food in her mouth, I did not look. Staff A said Resident #43 never told me if she had any problem chewing or swallowing. The nurse will tell you if something is new, they will let you know. No one told me the diet was changed and the resident needed assistance to eat. CNA Staff A said she went back to Resident #43's room to get her ready for bed between 8:25 p.m., and 8:30 p.m. I laid her head down and she looked like she was not breathing. I called my coworker, and she said no she is not breathing, and she called the nurse. The nurse came right away, and called a Code Blue, then started CPR. The nurse checked the mouth, nothing was in there, but she was not breathing so they started CPR. The Respiratory Therapist (RT) came and suctioned her and the Brussels sprout came out.<br><br>On [DATE] at 2:06 p.m., in an interview, the Respiratory Therapist said I was four rooms down and heard the page for Code Blue and responded. They were bringing the code cart in and the nurse was doing chest compressions. I was getting the Ambu bag (a handheld device used to provide pressure ventilation to patients who are not breathing). I noticed when I used it, she was not ventilating, I saw no chest rise. I noticed something green at the back of her mouth, it appeared to be a Brussels sprout and it was whole. I used the suction machine to remove the Brussels sprout, it was bigger than a marble but smaller than a golf ball. Resident #43 did not cough when the food was removed. I was ventilating her when EMS arrived. Resident #43 was unresponsive when I arrived. No one attempted to do the Heimlich maneuver on her, nursing was doing chest compressions. The Brussels sprout was right there at the back of her throat. She did not cough or anything when I removed the food.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 8:45 a.m., in an interview, the MDS Coordinator Registered Nurse Staff C said Resident #43 had a weight loss and a decline in her activities of daily living (ADL's). I reviewed the CNA documentation and noticed Resident #43 had a change in her ADL's. Resident #43 went from supervision with meals to different levels of assistance documented in the CNA charting. I initiated a significant change MDS on [DATE].<br><br>I did not observe Resident #43, and I did not speak with the CNA's regarding her care needs. The management team was notified by email there was a change with Resident #43. The MDS Coordinator said extensive assist means the CNA's are actually feeding the resident. Staff #43 said she did not speak with the resident or the CNA's. I don't know how the information is passed on to the CNA's when there is a change in the resident's status.<br><br>On [DATE] at 11:08 a.m., in an interview, LPN Staff B said she was familiar with Resident #43. She ate really slow in bed and kept the tray for hours and would not let us take it. She had some dementia and was resistive at times. We made sure the head of the bed was up. She just needed her containers opened for her. She had finger food, and did not use utensils. I was not aware she had dysphagia until I checked her diet. LPN Staff B said Resident #43's diet was regular texture, there were whole Brussels sprouts served. LPN Staff B said she was not aware Resident #43 required extensive, or any assistance with meals. The LPN said if a resident was on an altered diet, there must be someone with them and if they have dysphagia, someone needs to be at the meals. I supervised that night to the point that I walked past the room and looked in at her. LPN Staff B said I know what a small bite sized diet looks like. It looks like toddler food. It is cut and chopped but the Brussels sprouts she had that night were whole. She said she checked her mouth and saw she had food in the back of her throat. The RT suctioned her and removed a whole Brussels sprout. No one told me Resident #43 required assistance with meals. It was not communicated.<br><br>On [DATE] at 3:14 p.m., in an interview, the Director of Nursing (DON) said he received a phone call from LPN Staff B on [DATE]. LPN Staff B said Resident #43 had coded and 911 was at the facility. CPR was provided. I interviewed the staff and had them make witness statements. The DON said I don't know why the significant change MDS was done. We talk about things in the daily morning Eagle Room meeting, but I don't recall what the change was. I know the spouse wanted Resident #43 on regular foods and I think that is why SLP wrote the note. I guess she felt the resident was safe. Resident #43 could feed herself. She required no assistance from staff, I was not aware the MDS said otherwise. She took a long time to eat. The diet was changed by the SLP who is no longer employed at the facility. The SLP put the change for the diet on a sticky note. The previous CDM made the change in the computer, that is not process. A physician order is necessary to change the diet. The SLP gave the sticky note to the kitchen and the CDM made the changes. The policy is a recommendation for a diet change goes to the Registered Nurse Practitioner or Physician for an order for diet change, then it is changed in the computer system. The CDM should not have made the change based on what was written on the sticky note. Resident #43 was never assessed for swallowing difficulty per the SLP. I did not look at the speech therapy notes, I only went by what the SLP told me. The DON said he determined the root cause of Resident #43's death. At the time, we thought she just passed. I had no knowledge of the Medical Examiner (ME) taking the case. They did not tell us they were going to do that. The Medical Director called the ME's office and was informed Resident #43 died from accidental death by choking.<br><br>On [DATE] at 10:47 a.m., in an interview, the Administrator said Resident #43's diet was changed to a regular diet on [DATE] because of the information on a sticky note the SLP provided to the CDM.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The root cause after the investigation was the SLP did not complete an evaluation, and did not receive an order from the physician to upgrade the diet. The Administrator said there was no diet order to change Resident #43's diet to a regular diet.<br><br>On [DATE] at 10:00 a.m., in an interview, the spouse of Resident #43 said he received a phone call from the facility. They said she was not breathing and they were doing CPR. I got to the facility, and I was with her. I never asked for her diet to be changed, and they never asked me if I wanted it changed. In my opinion, they left her alone and did not check on her for over an hour, that is what happened. The facility told me she passed, they did not say she choked. The medical examiner called me and told me about her choking, I guess that is why he took the case. I always cut her food up in real small pieces for her. I was there every day except the days she had physician appointments outside of the facility. She had gone to an appointment on that day . The food was always regular, and must cut up into tiny pieces, I did that for her. The facility did not check on her for a long period of time when she was eating that night, that is what I and my family think. She would fall asleep during meals. She was always so tired. The facility knew she was falling asleep at meals and that is why it took her so long to eat. I think they did not check on her, she fell asleep with food in her mouth and choked. Like I told the facility, I think she fell asleep and choked. I wish they would have checked on her, maybe she would be here. That is the concern for myself and my family, why did they not check on her?<br><br>The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of [DATE] and verified by interview, observation, and record review on [DATE] included the following:<br><br>On [DATE] all resident diet orders in the electronic medical record (EMR) were compared to the tray card, the most recent orders and speech therapy evaluations.<br><br>On [DATE] all residents with dyshagia or on a mechanically altered diet were ordered Speech Therapy evaluations.<br><br>On [DATE] all resident care plans and kardex's were audited for diet orders.<br><br>On [DATE] licensed and unlicensed clinical staff re-educated on the use of the Kardex.<br><br>On [DATE] all therapy staff were educated on the process of rehabilitation screening and evaluations.<br><br>On [DATE] dietary staff were educated on the proper process when receiving or changing diet orders.<br><br>On [DATE] through [DATE] all staff received education on abuse, neglect. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on record review, facility policy and procedure, and staff interviews, the facility failed to report the allegation of neglect within 24 hours to the State Agency. The facility also failed to report the results of the investigation to the State Agency within 5 days for one (Resident #43) of 3 reports reviewed.<br><br>Cross reference to F600<br><br>The findings included:<br><br>The facility policy Patient Protection, Abuse, Neglect, Mistreatment, and Misappropriation Prevention (dated , d+[DATE]) defined neglect as the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.<br><br>In response to allegations of abuse, neglect, exploitation or mistreatment, the facility must: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source or misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.<br><br>Review of the clinical record revealed Resident #43 had an admitted [DATE] with diagnoses including dementia, anxiety, and dysphagia (difficulty swallowing).<br><br>Review of the physician orders documented Resident #43 was on a regular textured diet.<br><br>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) v.1.17.1 with an assessment reference date (ARD) of [DATE] documented Resident #43 required supervision with eating meals.<br><br>The MDS noted Resident #65's cognitive skills for daily decision making were intact.<br><br>A Significant Change MDS v.1.17.1 with an ARD of [DATE] documented Resident #43 required extensive assistance of one person with eating her meals.<br><br>Review of the Speech Language Patholigist (SLP) note dated [DATE] documented skilled interventions addressing swallowing dysfunction included therapeutic trial feedings with soft and bite sized consistency to increase safety. Patient with significant improvement with soft and bite sized consistency.<br><br>Review of the clinical record showed the diet communication form dated [DATE] documented a soft and bite sized diet.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] the SLP wrote on a posted note to change Resident #43's diet to a regular diet without a physician order and gave the posted note to the Certified Dietary Manager (CDM).<br><br>On [DATE] the CDM changed Resident #43's diet from soft and bite sized to a regular textured diet without a physician order.<br><br>On [DATE] at 6:30 p.m., Certified Nursing Assistant (CNA) Staff A delivered the evening meal to Resident #43 who was in her bed. The meal served was chicken and dumplings with whole Brussels sprouts. The CNA set up the meal tray and left Resident #43 unattended.<br><br>On [DATE] at 7:45 p.m., CNA Staff A entered Resident #43's room to pick up her meal tray. The CNA reported Resident #43 was sitting upright in bed with the meal tray in front of her on the over the bed table. The CNA asked the resident if she was finished eating and the resident nodded her head yes. The CNA removed the tray and exited the room.<br><br>On [DATE] between 8:15 p.m., and 8:20 p.m., CNA Staff A returned to Resident #43's room to assist the resident to get ready for bed and found her unresponsive. Licensed Practical Nurse (LPN) Staff B was notified and assessed the resident who was pulseless and not breathing. The LPN initiated CPR and contacted 911.<br><br>EMS arrived and pronounced Resident #43 dead at 8:51 p.m.<br><br>On [DATE] at 2:06 p.m., in an interview the Respiratory Therapist said I was four rooms down and heard the page for Code Blue and responded. They were bringing the code cart in and the nurse was doing chest compressions. I was getting the Ambu bag (a handheld device used to provide pressure ventilation to patients who are not breathing). I noticed when I used it, she was not ventilating, I saw no chest rise. I noticed something green at the back of her mouth, it appeared to be a Brussels sprout and it was whole. I used the suction machine to remove the Brussels sprout, it was bigger than a marble but smaller than a golf ball. I was ventilating her. EMS arrived and took over CPR. Resident #43 was unresponsive when I arrived.<br><br>On [DATE] at 9:30 a.m., the Administrator confirmed she did not file a report with the State agency as required. At the time we did not know what had happened to Resident #43. We thought it was a heart attack or age-related death. We found out she had accidentally choked around [DATE] when we received the Medical Examiner report. It was not abuse, she choked. She was receiving the correct diet at the time. I did not know I was required to file both a state and federal report. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on record review, facility policy and procedures, and staff and family interviews, the facility failed to implement processes to communicate a change in condition and ensure adequate supervision and assistance to prevent the choking death for one (Resident #43) of 3 residents reviewed with dysphagia (difficulty swallowing).<br><br>On [DATE] it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on [DATE] at 8:30 a.m.<br><br>Immediate Jeopardy was identified on [DATE]. It began on [DATE] and was removed on [DATE]. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of [DATE] and verified by interview, observation and record review on [DATE].<br><br>Cross reference F600, F609, and F692<br><br>The findings included:<br><br>Review of the clinical record revealed Resident #43 had an admitted [DATE] with diagnoses including dementia, anxiety, and dysphagia (difficulty swallowing).<br><br>Review of the Physician orders documented resident #43 was on a regular textured diet.<br><br>A Significant Change Minimum Data Set (MDS) with an ARD of [DATE] documented Resident #43 required extensive assistance of one person with eating her meals.<br><br>Review of the Speech Language Pathologist (SLP) note dated [DATE] documented skilled interventions addressing swallowing dysfunction included therapeutic trial feedings with soft and bite sized consistency to increase safety. Patient with significant improvement with soft and bite sized consistency regular diet (normal food cut into smaller pieces).<br><br>Review of the clinical record showed the diet communication form dated [DATE] documented a soft and bite sized diet.<br><br>On [DATE] the SLP wrote on a posted note to change Resident #43's diet to a regular diet without a physician order, and gave the posted note to the Certified Dietary Manager (CDM).<br><br>On [DATE] the CDM changed Resident #43's diet from soft and bite sized to a regular textured diet without a physician order.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 6:30 p.m., Certified Nursing Assistant (CNA) Staff A delivered the evening meal to Resident #43 who was in her bed. The meal served was chicken and dumplings and whole Brussels sprouts. The CNA set up the meal tray and left Resident #43 unattended.<br><br>On [DATE] at 7:45 p.m., CNA Staff A went to Resident #43's room to pick up her meal tray. The CNA reported Resident #43 was sitting upright in bed with the meal tray in front of her on the over the bed table. The CNA asked the resident if she was finished eating and the resident nodded her head yes. The CNA removed the tray and exited the room.<br><br>On [DATE] between 8:15 p.m., and 8:20 p.m., CNA Staff A said she returned to Resident #43's room to assist the resident to get ready for bed and found her unresponsive. Licensed Practical Nurse (LPN) Staff B was notified and assessed the resident who was pulseless and not breathing. The LPN initiated CPR and contacted 911. EMS arrived and pronounced Resident #43 dead at 8:51 p.m.<br><br>On [DATE] at 10:03 a.m., in an interview the SLP said Resident #43 was on a regular diet and it took up to 3 hours for her to eat meals. I worked with Resident #43 because she was losing weight. I changed her diet to soft with bite sized small pieces on [DATE]. The family requested regular food so I told the kitchen she could have the regular diet on [DATE]. I did not write a doctor's order, I wrote the diet change on a sticky note and gave it to the CDM. The SLP confirmed she did not evaluate Resident #43 before changing her diet to a regular diet. The SLP said I made a lot of mistakes. I should have assessed the resident and should have written the physician order. I did not follow the policy for upgrading the diet.<br><br>On [DATE] at 4:10 p.m., in an interview CNA Staff A said, Resident #43 could feed herself. On [DATE] I set the food tray up and put her in a sitting position in bed for the meal. She had regular food and I helped her to cut it. CNA Staff A said I don't know when the diet was changed. She was always on a regular diet, I never saw anything but a regular diet for her. No one at the facility told me how much help she needed. Once I gave her the food at 6:30 p.m., I left the room. At 7:45 p.m., I checked on her because she eats slow. I gave her time to eat. Resident #43 was not eating, I asked her if she was done, and she shook her head yes and I took the tray from her. I never noticed any food in her mouth, I did not look. Resident #43 never told me if she had any problem chewing or swallowing. The nurse will tell you if something is new, they will let you know. No one told me the diet was changed, and the resident now needed assistance to eat. CNA Staff A said she went back to Resident #43's room between 8:25 p.m., and 8:30 p.m., to get her ready for bed. I laid her head down and she looked like she was not breathing. I called my coworker, and she said no she is not breathing, and she called the nurse. The nurse came right away, called a Code Blue, and she started CPR. The nurse checked the mouth, and nothing was in there but she was not breathing, so they started CPR. The Respiratory Therapist (RT) came and suctioned her and the BrusselS sprout came out, it looked like a green ball.<br><br>(continued on next page) |

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|---|---|---|---|
| | 105965 | A. Building<br>B. Wing | 04/07/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Capri Health and Rehabilitation Center | 1450 East Venice Avenue<br>Venice, FL 34292 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE] at 2:06 p.m., in an interview the Respiratory Therapist (RT) said I heard the page for Code Blue and responded. Resident #43 was unresponsive when I arrived. Staff were bringing the code cart in and the nurse was doing chest compressions. I noticed when I used the Ambu bag (a handheld device used to provide pressure ventilation to patients who are not breathing) she was not ventilating, I saw no chest rise. I noticed something green at the back of her mouth. I used the suction machine to remove a Brussels sprout. It was bigger than a marble but smaller than a golf ball. Resident #43 did not cough when the food was removed. I was ventilating her when EMS arrived. No one attempted to do the Heimlich maneuver on her, nursing was doing chest compressions. The Brussels sprout was right there at the back of her throat.<br><br>On [DATE] at 8:45 a.m., in an interview the MDS Coordinator Registered Nurse Staff C said Resident #43 had a weight loss and a decline in her activities of daily living (ADL's). I reviewed the CNA documentation and noticed Resident #43 had a change in her ADL's. I reviewed the CNA documentation and noticed she had days when she required more assistance than others. I initiated a significant change MDS on [DATE]. I did not observe Resident #43, and I did not speak with the CNA's regarding her need for assistance with meals. The management team was notified by e mail there was a change. The MSD Coordinator said extensive assist means the CNA's are actually feeding the resident. I don't know how the information is passed on to the CNA's when there is a change in the resident's status.<br><br>On [DATE] at 11:08 a.m., in an interview, LPN Staff B said she was familiar with Resident #43. She just needed her containers opened for her. She had finger food and did not use utensils. LPN Staff B said she was not aware that Resident #43 required extensive assistance with meals. Staff B said if a resident was on an altered diet, there must be someone with them. If they have dysphagia, someone needs to be with them during meals. I supervised that night to the point that I walked past the room and looked in at her. LPN Staff B said I know what a small bite sized diet looks like it looks like toddler food, it is cut and chopped. The Brussels sprouts she had that night were whole. I checked her mouth and I said she had food in the back of her throat, they brought the suction machine. The RT suctioned her and removed a whole Brussesl sprout. The CNA never told me Resident #43 required assistance with meals. It was not communicated when she went from a regular diet to bite sized soft diet, and back to a regular diet. I wish the unit managers would tell us if there any changes.<br><br>On [DATE] at 3:14 p.m., in an interview the Director of Nursing (DON) said I received a phone call from LPN Staff B on [DATE]. She said the Resident #43 had coded and 911 was at the facility, CPR was provided. I interviewed the staff and had them write witness statements. I don't know why the significant change MDS was done for resident #43. We talk about things in the daily morning Eagle Room meeting, but I don't recall what the change was. I know the spouse wanted Resident #43 on regular foods and I think that is why SLP wrote the note. I guess she felt the resident was safe. Resident #43 required no assistance from staff, I was not aware the MDS said otherwise. The SLP put the change for the diet on a sticky note. The previous CDM made the change in the computer, that is not process. A physician order is necessary to change the diet. The SLP gave the sticky note to the kitchen and the CDM made the changes. The policy is the recommendation for a diet change goes to the Registered Nurse Practitioner or Physician for a diet change order, and then it is changed in the computer system. Resident #43 was never seen for swallowing difficulty per the SLP. I did not look at the therapy notes, I only went by what the SLP told me. The DON said he determined the root cause of Resident #43's death was she just passed. The Medical Director called the Medical Examiners office and was informed Resident #43 died from accidental death by choking.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of [DATE] and verified by interview, observation, and record review on [DATE] included the following:<br><br>On [DATE] all resident diet orders in the electronic medical record (EMR) were compared to the tray card, the most recent orders and speech therapy evaluations.<br><br>On [DATE] all residents with dyshagia or on a mechanically altered diet were ordered Speech Therapy evaluations.<br><br>On [DATE] all resident care plans and kardex's were audited for diet orders.<br><br>On [DATE] licensed and unlicensed clinical staff re-educated on the use of the Kardex.<br><br>On [DATE] all therapy staff were educated on the process of rehabilitation screening and evaluations.<br><br>On [DATE] dietary staff were educated on the proper process when receiving or changing diet orders.<br><br>On [DATE] all staff were re-educated on how to communicate a change in the resident's condition.<br><br>The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of [DATE] and verified by interview, observation and record review on [DATE]. |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155<br><br>Based on record review, facility policy and procedures, and staff and family interviews, the facility ensure residents receive a therapeudic diet when there is a nutritional problem. The facility failed to provide food in the appropriate texture, and size to prevent accidental choking death for one (Resident #43) of 3 residents reviewed with dysphagia (difficulty swallowing).<br><br>On 4/6/23 it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on 4/6/23 at 8:30 a.m.<br><br>Immediate Jeopardy was identified on 4/6/23. It began on 3/20/23 and was removed on 4/7/23. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of 4/6/23 and verified by interview, observation and record review on 4/7/23.<br><br>Cross reference F600, and F689.<br><br>The findings included:<br><br>The facility policy Participation in Treatment Decisions Related to Diet Orders initiated 4/2022, specified The facility is responsible to inform the patient of the right to participate in their treatment. It is also the facility's responsibility to talk with the patient or patients decision maker and provide information pertaining to the risks and benefits of choice.In most cases involving diet restrictions where the consistency or texture of food and drinks is altered, recommendations are preceded by an evaluation by the rehab professional that identifies or demonstrates swallowing difficulties. The patient's physician is ultimately responsible to provide orders for diet consistencies or nutritional restrictions to the diet as well as educating and having discussions with the patient and patient decision-maker and documenting conversations in the medical record. The physician then issues orders as appropriate.<br><br>The facility policy Soft and Bite Sized Diet specified, The diet consists of foods that are soft, tender and moist with pieces no bigger than 15 millimeters (mm) with no thin liquids leaking or dripping from the food. Vegetables are cooked soft and chopped into pieces no bigger than 15 mm x 15 mm.<br><br>Review of the clinical record revealed Resident #43 had an admitted [DATE] with diagnoses including dementia, anxiety, and oropharyngeal dysphagia (difficulty swallowing).<br><br>Review of the Physician orders documented Resident #43 was on a regular textured diet.<br><br>The Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) v.1.17.1 with an assessment reference date (ARD) of 12/8/22 documented Resident #43 required supervision with eating meals.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A Significant Change MDS v.1.17.1 with an ARD of 3/10/23 documented Resident #43 required extensive assistance of one person with eating her meals.<br><br>Review of the Speech Language Pathologist (SLP) note dated 2/17/23 documented skilled interventions addressing swallow dysfunction included therapeutic trial feedings with soft and bite sized consistency to increase safety. Patient with significant improvement with soft and bite sized consistency.<br><br>Review of the clinical record showed the diet communication form dated 2/16/23 documented a soft and bite sized diet was ordered by the physician.<br><br>On 3/20/23 the SLP wrote on a posted note to change Resident #43's diet to a regular diet and gave the posted note to the Certified Dietary Manager (CDM).<br><br>On 3/20/23 the CDM changed Resident #43's diet from soft and bite sized to a regular textured diet without a physician order.<br><br>On 4/4/23 at 10:03 a.m., in an interview the SLP said Resident #43 was on a regular diet and it took a very long time for her to eat meals. I worked with Resident #43 because she was losing weight and I changed her diet to soft with bite sized small pieces on 2/14/23. The family requested regular food so I told the kitchen she could have the regular diet on 3/20/23. I did not write a doctor's order, I wrote the diet change on a sticky note and gave it to the CDM. A soft and bite sized diet was a regular diet, it would be normal food cut into smaller pieces. The SLP confirmed she did not evaluate Resident #43 before changing her diet to a regular diet. The SLP said I made a lot of mistakes, I should have assessed the resident and should have received a physician order. I did not follow the policy for upgrading the diet.<br><br>On 4/5/23 at 10:47 a.m., in an interview the Administrator said Resident #43's diet was changed to regular on 3/20/23 because of the sticky note the SLP provided to the CDM.<br><br>The root cause after the investigation was the SLP, did not complete an evaluation and did not receive an order from the physician to upgrade the diet. The Administrator said there was no diet order to change Resident #43's diet to a regular diet.<br><br>On 4/6/23 it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on 4/6/23 at 8:30 a.m.<br><br>Immediate Jeopardy was identified on 4/6/23. It began on 3/20/23 and was removed on 4/7/23. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of 4/6/23 and verified by interview, observation and record review on 4/7/23.<br><br>The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of 4/6/23 and verified by interview, observation, and record review on 4/7/23 included the following:<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 3/26/23 all resident diet orders in the electronic medical record (EMR) were compared to the tray card, the most recent orders and speech therapy evaluations.<br><br>On 3/26/23 all residents with dyshagia or on a mechanically altered diet were ordered Speech Therapy evaluations.<br><br>On 4/6/23 all resident care plans and kardex's were audited for diet orders.<br><br>On 4/6/23 licensed and unlicensed clinical staff re-educated on the use of the Kardex.<br><br>On 3/30/23 all therapy staff were educated on the process of rehabilitation screening and evaluations.<br><br>On 4/3/23 dietary staff were educated on the proper process when receiving or changing diet orders.<br><br>On 4/6/23 all staff were re-educated on how to communicate a change in the resident's condition.<br><br>The Immediate Jeopardy was removed as a result of the facility's corrective actions implemented as of 4/6/23 and verified by interview, observation and record review on 4/7/23. |