STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445139	A. Building B. Wing	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, medical record review, observation, and interview, the facility failed to ensure safety and provide individualized resident care for 1 of 12 sampled residents (Resident #1) reviewed with modified diets and/or required assistance with meals. The facility failure resulted in Immediate Jeopardy when Resident #1 was fed a regular diet instead of the ordered pureed diet (a texture modified diet in which all foods have a soft, pudding like consistency) and the Agency Certified Nursing Assistant (CNA) left the resident unattended after feeding the resident. Resident #1 was found unresponsive, a portion of a hotdog was removed with forceps by Emergency Medical Services (EMS), and Resident #1 expired in the emergency room (ER) of a local hospital. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Interim Director of Nursing (DON) were notified of the Immediate Jeopardy on [DATE] at 6:50 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-600. The facility was cited F-600 at a scope and severity of J, which is Substandard Quality of Care. The IJ was effective from [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE] at 2:26 PM and was validated onsite by the surveyors on [DATE] through observation, review of audits and meeting minutes, and staff interviews. The findings include: (continued on next page)

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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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised ,d+[DATE], revealed .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .'Neglect' means failure of the facility, its 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 .The facility will make individual determination in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment . Review of the facility's policy titled, Assistance with Meals, revised ,d+[DATE], revealed .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot assist themselves will be assisted with attention to safety, comfort and dignity . Review of the facility's undated policy titled, Consistency Modified Diets, revealed .Dysphagia [difficulty swallowing] is the impairment or loss of skills involved in swallowing foods and/or liquids .Pureed is the first consistency for solid foods that may be used after NPO [nothing by mouth] or liquid diets or for those with dysphagia. Puree consistency eliminates the need for chewing. All foods must be presented in a form that is homogenous [uniform consistency] and cohesive [sticks together] in nature, e.g. [for example] foods should have a pudding or mousse like [light spongy texture] consistency. Most foods will be pureed and/or strained to ensure a smooth cohesive quality without lumps . Review of the facility's undated meal pass protocol titled, The 5 Rights of Meal Service Administration, attached to an in-service dated [DATE], revealed .1. Right Diet 2. Right Liquids 3. Right Resident 4. Check Door Tag 5. Check Armband .Check the resident's armband with the name on the tray . Review of the facility's Breakfast, Lunch, and Dinner Meal Pass Audit dated [DATE], revealed .To ensure each Resident receive their proper meal tray, the following procedures need to take place .2. CNA deliver tray to room and verify ticket against Resident's armband . Review of the facility's CNA Job Description dated ,d+[DATE], revealed .assistance is provided to those residents who cannot feed themselves . Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Cerebral Infarction, Bipolar Disorder, Dysphagia (the impairment or loss of skills involved in swallowing foods and/or liquids), Schizophrenia, Asthma, and Anxiety Disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had no natural teeth or tooth fragments (edentulous). Review of the Physician's Orders dated [DATE], revealed .Regular diet Pureed texture, Nectar Thickened Fluids consistency . (continued on next page)

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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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed Resident #1 was assessed to have a Brief Interview of Mental Status (BIMS) score of 6, which indicated Resident #1 was severely cognitively impaired for decision making, required extensive assistance for eating, had complaints of difficulty or pain with swallowing and required a mechanically altered diet of pureed food. Review of the EMS Prehospital Patient Record dated [DATE] at 6:08 PM, revealed .U4 [unit 4] was dispatched to an emergency call. upon arrival .Pt [patient] [Resident #1] in cardiac arrest and CPR [cardiopulmonary resuscitation] in progress. Pt is 80 yo [year old] female who went into .cardiac arrest while eating and appeared to choke. First initial rhythm was asystole [no pulse, no rhythm] .A 1-inch section of hotdog was removed from obstructing the patient's airway using [NAME] forceps .Pt remained in asystole .Pt was moved to stretcher and secured. Moved to unit .Upon arrival at ER .Pt care was transferred to RN [Registered Nurse]. Shortly after transfer of care, resuscitation efforts were terminated by ER doctor . Review of the Emergency Department (ED) Physician Documentation dated [DATE] at 7:05 PM, revealed . The patient [Resident #1] presents with .arrest while eating hot dog. CPR in progress upon arrival .EMS pulled hot dog out of airway .EMS has been performing out of hospital ACLS [Advanced Cardiac Life Support] for approximately 30 minutes by the time pt arrived in ed [emergency department]. The onset was unknown .Medical Decision Making: Primary concern for respiratory arrest given reported history of choking on hot dog and then becoming nonresponsive at nursing home. EMS removed some hot dog from airway during intubation .EMS reports rhythm was asystole initially and transiently PEA [pulseless electrical activity]. CPR continued on arrival, prolonged downtime > [greater than] 30 minutes, further resus [resuscitation] efforts deemed futile and pt pronounced [dead] in ed. time of death 18:55 [6:55 PM] . Review of the facility's investigation dated [DATE], revealed .On [DATE], during the dinner meal pass, [Named CNA #20, an Agency CNA] .grab [grabbed] a tray that had the letter F and the letter B on the tray card. The tray she picked [with a regular diet instead of ordered puree diet] had another resident [picture] with a hat on, causing it to look similar to Ms. [Named Resident #1] picture; both Resident [Resident #1 and Resident #2, which was the resident's tray she selected to deliver to Resident #1] had hats on in their pictures [pictures of the residents are located on the bottom of the tray card] .[Named CNA #20] failed to carefully validate the tray she selected belonged to the resident in question. Additionally, she failed to utilize the identifier process [the resident wristband] to correctly identify resident [Resident #1] before giving Ms. [Named Resident #1] another resident's tray .After giving the wrong tray, [Named CNA #20] exited the resident's room to take a tray to another resident. Leaving the resident alone to eat should not have occurred, as resident [Resident #1] required assistance eating .[CNA #20 called for assistance when she reentered the room about ,d+[DATE] minutes later] Upon entering the room, the RN noted that Resident [Resident #1] was not responding to verbal commands and was not making any sounds .Floor staff were told to call 911 and bring the crash cart to the resident's room Paramedics arrived at the resident's room at 18:07 [6:07 PM] and exited the facility with the resident at 18:35 [6:35 PM] .At 20:00 [8:00 PM] the facility received notification the Resident [Resident #1] has [had] expired at the hospital . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure, Dysphagia, Esophagitis with Bleeding, Pneumonia due to Coronavirus 2019, and Wheezing. (continued on next page)

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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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physician's Orders dated [DATE], revealed, .NAS [No Added Salt] diet Regular texture, Thin Liquids consistency .Skilled ST [Speech Therapy] services 5 to 7 times a week for 30 days to increase functional communication, memory, and problem solving skills, and for planning of LRD [least restrictive diet] with Dysphagia Management . Review of the admission MDS assessment dated [DATE], revealed Resident #2 was assessed to have a BIMS score of 6, which indicated the resident had severe cognitive impairment for decision making. Resident #2 needed extensive assistance for eating and her nutritional approach was for a therapeutic [low salt] diet. Observation of Resident #1 and Resident #2's pictures on their individual meal card on [DATE] at 10:30 AM, revealed a picture quality that was not clear, both were African American women with elongated faces and both were wearing a hat. Resident #1's first name started with the letter F. Resident #2's last name started with the letter F and both residents resided in a B bed in different rooms. Observation in the resident's room on [DATE] at 12:03 PM, revealed CNA #4 failed to check Resident #2's armband and verify the picture on the meal card during the lunch meal tray pass. Resident #2 had no armband and stated, I never had one. CNA #4 did not look for the armband. During a telephone interview on [DATE] at 5:21 PM, Agency CNA #20 confirmed her witness statement and stated, .I pulled the last tray out I thought was hers [Resident #1]. I looked at the picture thought was [Named Resident #1] but it was [Named Resident #2] .I glanced down at the picture and saw name and took tray in room thought the tray already there was the noon tray [lunch] from earlier .I did not open the tray. I didn't even touch the tray .I fed her with the spoon two bites of coleslaw and pinched off with my fingers two bites of hotdog. I put that in her mouth, and she chewed on it. She made a face and said don't want no more. I left and went across the hall. I left her sitting up in bed. I was gone for about five to seven minutes. I came back and saw she was pale in color and just looking at me. I yelled for [Named CNA #19]. I performed the Heimlich maneuver [process for dislodging something lodged in a person's windpipe] and some coleslaw came out and goldish color fluids .The nurse came in and took over .I thought it [dinner tray] was [Named Resident #1], I saw clearly a F and thought it was [Named Resident #1] .[Resident #1's first name started with the letter F, Resident #2's last name started with the letter F, and both residents resided in a B bed] . During an interview on [DATE] at 1:24 PM, the Administrator was asked when she received notification of the event involving Resident #1. The Administrator stated, .I was at home. I received notification she [Resident #1] received an incorrect tray and was transported to the hospital .The CNA [Agency CNA #20] didn't properly identify the meal tray with the resident .She left the room, then went back in the room, and then called for help . During an interview on [DATE] at 3:30 PM, the Interim DON stated, .The pictures [on the meal card] are grainy .I didn't realize how many of our residents wore hats in their pictures and so many of them [residents] look alike .We need to see if dietary system can print the pictures clearer like they are in [Named Electronic Healthcare Software] . The nursing home utilized temporary staffing agencies for the provision of CNAs, and did not have processes in place to provide orientation, medical or care plan information to the temporary staff regarding the individual resident's needs on the unit they were assigned. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Refer to F 689. The surveyors verified the removal Plan by: 1. On [DATE], a tray audit was completed by the Dietary Manager to ensure that residents are receiving the correct consistencies on the resident's trays compared to the resident's diet slips with no discrepancies identified. The surveyors reviewed the audits and observed delivery of meal trays. 2. On [DATE], Care plans, Kardexes and the facility Electronic Healthcare System that the CNAs use for electronic documentation, were reviewed by the Unit Managers for the appropriate level of assistance required for eating and of the 127 residents reviewed there were no issues identified . The surveyors reviewed the Care Plans, Kardexes, interviewed the Unit Managers, and observed the delivery of the meal trays. 3. On [DATE], the agency orientation packet was reviewed, and a checklist of all items covered including the updated guidance of the five rights of meal administration was added by the DON. The surveyors reviewed the orientation packets. 4. On [DATE], resident pictures were reviewed by Unit Managers and all were present in the facility Electronic Healthcare System. The Unit Managers will check daily in the facility Electronic Healthcare System to ensure pictures are present for the new admissions. The surveyors reviewed the pictures and interviewed the Unit Managers. 5. Meal tray audits will be completed by the Floor/Charge Licensed Practical Nurse (LPN)/RN or their designee for resident tray passes at each meal. Any discrepancies will be addressed and resolved immediately by the nursing staff and dietary manager/designee reviewing the physician orders in the facility Electronic Healthcare System, dietary communication slips and dietary tray card system to identify where the breakdown occurred. The surveyors reviewed the audits and interviewed nurses on all shifts. 6. Beginning on [DATE], managers will oversee the meal tray delivery process at each meal to ensure the right tray, right person, right assistance is provided and will be ongoing. The surveyors observed the delivery of the meal trays and interviewed the managers. 7. On [DATE], door name tags and armbands were audited for the 127 residents by the Wound Care Nurse with no discrepancies identified in the facility on that day. The surveyors reviewed the audits. 8. Audits of wristbands and door name plates will be completed daily Monday-Friday by Medical Records/designee and Saturday and Sunday by the Manager on Duty to ensure compliance. Concerns identified will be corrected immediately. The surveyors reviewed the audits and interviewed Medical Records and managers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On [DATE], an agency orientation checklist was created by the DON and provided to each unit to begin using immediately ([DATE]) for all agency staff on their first shift which includes all above policies and procedures. The Staffing Development Coordinator (SDC)/Unit Managers will ensure orientation packet is completed prior to start of first shift in facility. This process is overseen daily with each new agency staff by DON/designee beginning [DATE] and is ongoing. Monitoring of agency staff performance will be conducted by Charge Nurses, Unit Managers, and other nursing management team members each shift and any issues with performance will be addressed and corrected immediately by the same with input from DON. Overall responsibility of performance of the agency staff will be the DON. The surveyors reviewed the orientation packet and interviewed staff on all shifts. 10. On [DATE], audits of wristbands and door name plates were completed by Medical Records with no additional concerns identified. The surveyors reviewed the audits. 11. Beginning [DATE], direct meal tray observations will be conducted by Nurse Managers, Charge Nurses and other Nursing Managers will provide direct observation of meal tray at each meal to ensure facility and agency staff are following the process for delivery of the meal trays to ensure the right tray with the right meal is being provided to the correct residents and this will be ongoing. The surveyors observed meal tray passes and interviewed nursing staff. 12. On [DATE], the DON began re-education of all nursing staff regarding the resident identifiers to be used prior to delivering a meal tray. These include a combination of any two of the following: resident photo; name on door; name on wristband; verbalization of resident (by asking resident to state their name); and/or asking facility staff to identify the resident. No staff will be allowed to work until educated on the above by Charge Nurses, Nurse Managers, DON. The surveyors reviewed the education, the in-service sign in sheets, and interviewed staff on all shifts. 13. On [DATE], the dietary tray cards were altered by Information Technology (IT) to make the room number font the same size as the resident name font. The surveyors reviewed the dietary tray cards. The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on policy review, job description review, medical record review, observation, and interview, the facility failed to ensure staff provided the ordered modified diet and provided the needed assistance with meals, failed to ensure necessary safe individualized resident care was provided, and failed to ensure nursing staff followed the facility process for identifying residents during delivery of meal trays for 9 of 12 sampled residents (Resident #1, #2, #5, #7, #8, #9, #10, #11, #12) reviewed that required modified diets and/or required assistance with meals. The facility's failure resulted in Immediate Jeopardy when Resident #1 was fed a regular diet instead of the prescribed pureed diet (a texture modified diet in which all foods have a soft, pudding like consistency) and the Agency Certified Nursing Assistant (CNA) left the resident unattended after feeding the resident. Resident #1 was found unresponsive and a portion of a hotdog was removed with forceps from the resident by Emergency Medical Services (EMS) attendants. Resident #1 expired in the emergency room (ER) of a local hospital. The facility's failures resulted in Immediate Jeopardy for Resident #2, #5, #7, #8, #9, #10, #11, and #12 when these residents required modified diets and/or assistance with meals and staff did not follow the process for identifying residents during the delivery of the meal trays. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Interim Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on [DATE] at 6:50 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-689. The facility was cited F-689 at a scope and severity of K which is Substandard Quality of Care. The Immediate Jeopardy was effective from [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE] at 2:26 PM. The corrective actions were validated onsite by the surveyors on [DATE] through observation, review of audits and meeting minutes, and staff interviews. The findings include: Review of the facility's policy titled, Assistance with Meals, revised ,d+[DATE], revealed .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot assist themselves will be assisted with attention to safety, comfort and dignity . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the undated facility's policy titled, Consistency Modified Diets, revealed .Dysphagia [difficulty swallowing] is the impairment or loss of skills involved in swallowing foods and/or liquids .Pureed is the first consistency for solid foods that may be used after NPO [nothing by mouth] or liquid diets or for those with dysphagia. Puree consistency eliminates the need for chewing. All foods must be presented in a form that is homogenous [uniform consistency] and cohesive in nature, e.g. [for example] foods should have a pudding or mousse [light spongy texture] like consistency. Most foods will be pureed and/or strained to ensure a smooth cohesive quality without lumps . Review of the CNA job description dated ,d+[DATE], revealed .Perform direct resident care duties under the supervision of licensed nursing personnel .Essential Duties & Responsibilities .assistance is provided to those residents who cannot feed themselves . Review of the facility's Breakfast, Lunch, and Dinner Meal Pass Audit, dated [DATE], revealed .To ensure each Resident receive their proper meal tray, the following procedures need to take place .2. CNA deliver tray to room and verify ticket against Resident's armband . Review of the undated facility's meal pass protocol titled, The 5 Rights of Meal Service Administration, attached to an in-service dated [DATE], revealed, .1. Right diet. 2. Right liquid. 3. Right resident. 4. Check door tag. 5. Check arm band .6. Check resident's armband with the name on the tray . Review of employee personnel files revealed that CNA #4, #6, and #13 and Agency CNA #19 and #20 had no documentation of a competency evaluation for the employees, no documentation of the employee's skills, or orientation of the employees to the facility processes and protocols related to the individual care of residents needing assistance with activities of daily living which included eating and modified diets. There was no documentation the CNAs or the Agency CNAs were determined to be competent to provide care for the residents in the facility. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of Cerebral Infarction, Bipolar Disorder, Dysphagia (the impairment of loss of skills involved in swallowing foods and/or liquids), Schizophrenia, Asthma and Anxiety Disorder. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had no natural teeth or tooth fragments (edentulous). Review of the Physician's Orders dated [DATE], revealed .Regular diet Pureed texture, Nectar Thickened Fluids consistency . Review of the quarterly MDS assessment dated [DATE], revealed Resident #1 was assessed to have a Brief Interview of Mental Status (BIMS) score of 6, which indicated Resident #1 was severely cognitively impaired for decision making, required extensive assistance for eating, had complaints of difficulty or pain with swallowing, and required a mechanically altered diet of pureed food. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's investigation dated [DATE], revealed .On [DATE], during the dinner meal pass, [Named CNA #20, an Agency CNA] .grab [grabbed] a tray that had the letter F and the letter B on the tray card. The tray she picked [with a regular diet instead of ordered puree diet] had another resident [picture] with a hat on, causing it to look similar to Ms. [Named Resident #1] picture; both Resident [Resident #1 and Resident #2, which was the resident's tray she selected to deliver to Resident #1] had hats on in their pictures [pictures of the residents are located on the bottom of the tray card] .[Named CNA #20] failed to carefully validate the tray she selected belonged to the resident in question. Additionally, she failed to utilize the identifier process [the resident wristband] to correctly identify resident [Resident #1] before giving Ms. [Named Resident #1] another resident's tray .After giving the wrong tray, [Named CNA #20] exited the resident's room to take a tray to another resident. Leaving the resident alone to eat should not have occurred, as resident [Resident #1] required assistance eating .[CNA #20 called for assistance when she reentered the room about ,d+[DATE] minutes later] Upon entering the room, the RN [Registered Nurse] noted that Resident [Resident #1] was not responding to verbal commands and was not making any sounds . Floor staff were told to call 911 and bring the crash cart to the resident's room Paramedics arrived at the resident's room at 18:07 [6:07 PM] and exited the facility with the resident at 18:35 [6:35 PM] .At 20:00 [8:00 PM] the facility received notification the Resident [Resident #1] has [had] expired at the hospital . Review of the EMS Prehospital Patient Record dated [DATE] at 6:08 PM, revealed .U4 [unit 4] was dispatched to an emergency call. upon arrival .Pt [patient] [Resident #1] in cardiac arrest and CPR [cardiopulmonary resuscitation] in progress. Pt is 80 yo [year old] female who went into .cardiac arrest while eating and appeared to choke. First initial rhythm was asystole [no pulse, no rhythm] .A 1-inch section of hotdog was removed from obstructing the patient's airway using [NAME] forceps .Pt remained in asystole .Pt was moved to stretcher and secured. Moved to unit .Upon arrival at ER .Pt care was transferred to RN. Shortly after transfer of care, resuscitation efforts were terminated by ER doctor . Review of the ED [Emergency Department] Physician Documentation dated [DATE] at 7:05 PM, revealed . The patient [Resident #1] presents with .arrest while eating hot dog. CPR in progress upon arrival .EMS pulled hot dog out of airway .EMS has been performing out of hospital ACLS [Advanced Cardiac Life Support] for approximately 30 minutes by the time pt [patient] arrived in ed [emergency department]. The onset was unknown .Medical Decision Making: Primary concern for respiratory arrest given reported history of choking on hot dog and then becoming nonresponsive at nursing home. EMS removed some hot dog from airway during intubation .EMS reports rhythm was asystole initially and transiently PEA [pulseless electrical activity]. CPR continued on arrival, prolonged downtime > [greater than] 30 minutes, further resus [resuscitation] efforts deemed futile and pt pronounced [dead] in ed. time of death 18:55 [6:55 PM] . Review of the medical record, revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Acute Respiratory Failure, Dysphagia, Esophagitis with Bleeding, Pneumonia due to Coronavirus 2019, and Wheezing. Review of the Physician's Orders dated [DATE], revealed the following orders .NAS [No Added Salt] diet Regular texture, Thin Liquids consistency .Skilled ST [Speech Therapy] services 5 to 7 times a week for 30 days to increase functional communication, memory, and problem solving skills, and for planning of LRD [least restrictive diet] with Dysphagia Management . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the admission MDS assessment dated [DATE], revealed Resident #2 was assessed to have a BIMS score of 6, which indicated the resident had severe cognitive impairment for decision making, needed extensive assistance for eating, and her nutritional approach was for a low salt therapeutic diet. Observation of Resident #1 and Resident #2's pictures on their individual meal card on [DATE] at 10:30 AM, revealed a picture quality that was not clear, both African American women had elongated faces and both were wearing hats. Resident #1's first name started with the letter F. Resident #2's last name started with the letter F and both residents resided in a B bed in different rooms. Observation in the resident's room on [DATE] at 12:03 PM, revealed CNA #4 delivered the lunch tray to Resident #2 and failed to check the resident's armband or verify the picture on the meal card. Resident #2 had no armband and stated, I never had one. CNA #4 did not look for the armband. Observations on the 2nd, 3rd, and 4th floors on [DATE] and [DATE] during delivery of the lunch trays revealed there was no monitoring of the tray delivery to the residents. There was no monitoring at the bedside to determine facility staff identified the residents and delivered the correct meal trays to the correct residents. During a telephone interview on [DATE] at 5:21 PM, CNA #20 confirmed her witness statement. She stated, . I pulled the last tray out I thought was hers [Resident #1]. I looked at the picture thought was [Named Resident #1] but it was [Named Resident #2] .I glanced down at the picture and saw name and took tray in room thought the tray already there was the noon tray [lunch] from earlier .I did not open the tray. I didn't even touch the tray .I fed her with the spoon two bites of coleslaw and pinched off with my fingers two bites of hotdog. I put that in her mouth, and she chewed on it. She made a face and said don't want no more. I left and went across the hall. I left her sitting up in bed. I was gone for about five to seven minutes. I came back and saw she was pale in color and just looking at me. I yelled for [Named CNA #19]. I performed the Heimlich maneuver [process for dislodging something lodged in a person's windpipe] and some coleslaw came out and goldish color fluids .The nurse came in and took over .I thought it [dinner tray] was [Named Resident #1], I saw clearly a F and thought it was [Named Resident #1] .[Resident #1's first name started with the letter F. Resident #2's last name started with the letter F and both residents resided in the B bed in different rooms] . During an interview on [DATE] at 1:24 PM, the Administrator was asked when she received notification of the event involving Resident #1. The Administrator stated, .I was at home. I received notification she [Resident #1] received an incorrect tray and was transported to the hospital .the CNA [CNA #20] didn't properly identify the meal tray with the resident .She left the room, then went back into the room, and then called for help . During an interview on [DATE] at 3:30 PM, the Interim DON stated, .The pictures [on the meal card] are grainy .I didn't realize how many of our residents wore hats in their pictures and so many of them [residents] look alike .We need to see if the dietary system can print the pictures clearer like they are in [Named Electronic Healthcare Software] . Review of the medical record, revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Dysphagia, Hemiplegia and Hemiparesis Affecting Left Dominant Side, Neurologic Neglect Syndrome, and Dysarthria. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Physician's Orders dated [DATE], revealed .diet Mechanical Soft texture, Nectar Thickened Fluids consistency . Review of the annual MDS assessment dated [DATE], revealed Resident #5 was assessed to have a BIMS score of 0, which indicated the resident had severe cognitive impairment for decision making, needed supervision when eating, and the resident's nutritional approach was for a mechanically altered diet with nectar thick liquids. Observation in the resident's room on [DATE] at 12:03 PM, revealed CNA #7 failed to identify the resident by checking Resident #5's armband and the picture on the meal card. Review of the medical record, revealed Resident #7 was admitted to the facility on [DATE] with diagnoses of Dysphagia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Alcohol Abuse, Heart Failure, and a Foot Ulcer. Review of the quarterly MDS assessment dated [DATE], revealed Resident #7 was assessed to have a BIMS score of 15 which indicated the resident had no cognitive impairment for daily decision-making tasks and needed supervision when eating. Observation in the resident's room on [DATE] at 12:20 PM, revealed CNA #6 failed to identify the resident by checking Resident #7's armband and the picture on the meal card. Review of the medical record, revealed Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Convulsions, Cerebral Infarction, Dysphagia, Aphasia, Osteoarthritis, and Dementia with Behaviors. Review of the quarterly MDS assessment dated [DATE], revealed Resident #8 was assessed to have a BIMS score of 14 which indicated the resident had no cognitive impairment for daily decision-making tasks, needed set up help only when eating, complained of difficulty or pain with swallowing, and received a mechanical altered diet. Observation and interview in the resident's room on [DATE] at 12:19 PM, revealed CNA #21 failed to identify Resident #8 by checking the resident's armband and the picture on the meal card during delivery of the lunch tray. When CNA #21 was asked if the armband had been checked, she stated, yes. The surveyor and CNA #21 walked back into the room and CNA #21 stated, .maybe I didn't .I lied .I did not look for an armband . Resident #8 did not have an armband. Review of the medical record, revealed Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Diabetes Mellitus Type 2, Chronic Obstructive Pulmonary Disease, Heart Failure, Epilepsy, Parkinson's Disease, Dementia without Behaviors and was Bipolar. Review of the quarterly MDS assessment dated [DATE], revealed Resident #9 was assessed to have a BIMS score of 0 which indicated the resident had severe cognitive impairment for daily decision-making tasks, needed supervision and tray set up when eating, complained of difficulty or pain when swallowing, and received a mechanical altered diet of pureed food. Observation in the resident's room on [DATE] at 11:53 AM, revealed CNA #13 failed to verify Resident #9's picture on the meal card with his armband during delivery of the lunch tray. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record, revealed Resident #10 was admitted to the facility on [DATE] with diagnoses of Cerebral Infarction, Dysphagia, and Hemiplegia/Hemiparesis on the right side. Review of the quarterly MDS assessment dated [DATE], revealed Resident #10 was assessed to have a BIMS score of 9 which indicated the resident had moderate cognitive impairment for daily decision-making tasks, needed extensive assistance when eating, complained of difficulty or pain with swallowing, and received a mechanically altered diet of pureed food. Observation in the resident's room on [DATE] at 12:09 PM, revealed RN #5 failed to verify Resident #10's identity by checking the picture on the meal card and checking Resident #10's armband. Review of the medical record, revealed Resident #11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Supraventricular Tachycardia, Dementia without Behaviors, Dysphagia, and Osteoarthritis. Review of Resident #11's Physician's Orders dated [DATE], revealed a diet that was mechanical soft with thin liquids, was vegetarian and abstained from the consumption of meat. Review of the quarterly MDS assessment dated [DATE], revealed Resident #11 was assessed to have a BIMS score of 9 which indicated the resident had moderate cognitive impairment for daily decision-making tasks, needed extensive assistance when eating, complained of difficulty or pain with swallowing, and required a mechanically altered diet of soft foods. Observation in the resident's room on [DATE] at 11:57 AM, revealed CNA #4 failed to verify the picture on the meal card with Resident #11's armband. CNA #4 placed the tray on the over bed table and prepared the resident's tray for dining. RN #1 entered the room and stated, .She [Resident #11] is vegetarian check that taco to see if meat . CNA #4 took the spoon and lifted the lettuce. She stated, .It is ground beef . Review of Resident #11's meal card revealed the resident was to receive large portions of mechanical soft fortified foods. There was no documentation the resident was to receive a vegetarian diet and was not to receive beef or pork. During an interview on [DATE] at 1:01 PM, the Dietary Manager (DM) confirmed Resident #11 received a regular diet with beef, the meal card and diet listing documented an incorrect diet and did not match the Physician's Order for a vegetarian diet. She stated, .Yes, this can happen again .the resident gets the wrong diet and cause problems for them . She stated, .We removed hotdogs and smoked sausage on [DATE] from the Always Available Menu . Observation on the 2nd, 3rd, and 4th floors on [DATE]-[DATE], revealed a posted sign that documented . Always Available Menu (Lunch & Dinner) that included chicken tenders, hot dogs, French fries, and hamburgers. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses of Atrial Fibrillation, Malignant Neoplasm of the Breast, Hypertension, and a Colostomy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE], revealed Resident #12 was assessed to have a BIMS score of 15 which indicated the resident had no cognitive impairment for daily decision-making tasks, needed supervision when eating, and received a mechanical altered diet with no added salt (NAS). Observation in the resident's room on [DATE] at 12:01 PM, revealed Graduate Practical Nurse (GPN) #1 failed to check Resident #12's armband and verify the picture on the meal card during delivery of the lunch meal tray. During an interview on [DATE] at 12:23 PM, CNA #6 who had been employed for one month was asked how she identified a resident. CNA #6 stated, A log at the front desk with name and room number. I haven't seen it . When asked if she received training in orientation about the facility's process for identifying residents during delivery of the meal trays, CNA #6 stated, No ma'am. CNA #6 confirmed she was unaware of a resident Kardex which included individualized resident care directives. During an interview on [DATE] at 12:30 PM, CNA #7 who had been employed for 2 weeks was asked how she identified a resident. CNA #7 stated, The name on the door. When asked if during orientation she received training on the facility process for identifying residents during delivery of the meal trays. CNA #7 stated, I know there is a name on the door. CNA #7 confirmed she was not aware of a resident Kardex which included individualized resident care directives and that each resident had an armband. During an interview on [DATE] at 11:01 AM, Licensed Practical Nurse (LPN) #3 was asked if the facility had an orientation program for agency staff. LPN #3 stated, .We don't have anything in writing, It is all verbal . They [staff] are supposed to look at armbands every day when they pass meds [medications] and meal trays . With agency [agency staff] when they come we make walking rounds, give a census sheet and shown the Kardex. The computer gives more information . When asked if each resident had an armband, LPN #3 stated, Residents take them off all the time . During an interview on [DATE] at 11:56 AM, CNA #10 was asked if she received orientation from the facility before providing resident care. CNA #10 stated, .No, they [facility] didn't give me nothing about that here . During an interview on [DATE] at 1:01 PM, the Interim DON stated, .We had no policy for identification and meal pass .After the incident [on [DATE]] we put into place the breakfast, lunch and dinner meal pass process and audit .The staff deliver the tray to the room and verify the meal card against the resident's armband . When asked if every resident had an armband, she stated, .they should . During an interview on [DATE] at 1:01 PM, the Administrator stated, .There is no routine or QA [quality assurance] to audit armband compliance . During an interview on [DATE] at 1:20 PM, the Administrator was asked how the staff identified residents. She stated, .I have to have confidence the audit tool that was done on the 8th [[DATE]] is correct .I would have to assume that she identified the resident. I would have faith that she did it correctly . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on [DATE] at 5:21 PM, CNA #20 stated, .No one told me how to get information about the resident. They just put us on the floor. We had no training. They didn't teach us about any Kardex book. [Named Nursing Facility] didn't tell me anything . During a telephone interview on [DATE] at 11:30 AM, CNA #19 was asked if she received information about the facility or assignments prior to working with the residents. CNA #19 stated, .No information about this facility or assignment. You just show up. Nothing about a Kardex . During an interview on [DATE] at 12:06 PM, CNA #2 confirmed she was not told about the resident's information in the Kardex binder. CNA #2 stated, .I ain't seen that. I don't know about a book or binder . During an interview on [DATE] at 1:24 PM, the Administrator was asked if the facility had an orientation program for contract staff. The Administrator stated, .The DON was the point of contact for the agency staffing . When asked if she was involved in the orientation of newly hired employees and contract staff, the Administrator stated, No, not right now. During an interview on [DATE] at 1:24 PM, the Administrator was asked if the facility audits included comparing the armband with the meal ticket to identify the correct resident and she stated, .No, it does not . The Administrator was asked where on the audit tool did the nurse or person that was auditing the meal delivery document the CNA or staff member observed had identified the correct resident before serving the tray. She stated, .It's not . The Administrator was asked what audit tool or data gathering documentation of observations at the bedside was used to verify the meal card picture, name of the resident, and armband were checked to assure the meal tray was delivered to the correct resident. She stated .There is no documentation. We are auditing that .I would have to have faith they did what was [they were] supposed to do . During an interview on [DATE] at 2:37 PM, the Interim DON stated she had received the contract employee files from the staffing agency. When asked if the files contained the education and competency of each CNA, the DON shook her head no. The Interim DON confirmed the facility had no employee personnel files and no contract personnel files to reflect facility orientation and competency determination. During an interview on [DATE] at 1:17 PM, LPN #2 was asked if there was a book or binder with resident information and resident care directives for the staff to access. LPN #2 stated, .Don't ask me. I'm agency. I don't know . During an interview on [DATE] at 1:35 PM, the Interim DON confirmed there were no facility employee files or contract employee files that documented any orientation or competency checks. The Administrator and Interim DON were unable to present any employee personnel files or contract personnel files that contained competency assessments. During an interview on [DATE] at 2:25 PM CNA #10 stated, .There is no sheet in the Kardex book for [Named Resident #3]. During an interview on [DATE] at 2:27 PM, LPN #1 confirmed there was no Visual/Kardex Report for Resident #3 in the Kardex. She stated, I need to update this whole thing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyors verified the Removal Plan by: 1. On [DATE], a tray audit was completed by the Dietary Manager to ensure that residents are receiving the correct consistencies on the resident's trays compared to the resident's diet slips with no discrepancies identified. The surveyors confirmed this through review of the tray audit and interview with the Dietary Manager. 2. Hotdogs were removed from the menu on [DATE] by the Dietary Manager. The surveyors confirmed this through review of the menus and interview with the Dietary Manager. 3. On [DATE], the Care Plans, Kardexes and the electronic healthcare systems (the system the CNAs use for electronic documentation) of 127 residents were reviewed for appropriate level of assistance for eating by the Unit Managers and no concerns were identified. The surveyors confirmed this through observation, record review, and interviews with the Unit Managers. 4. The agency orientation packet was reviewed, and a checklist of all items covered including the updated guidance of the five rights of meal administration added on [DATE] by the DON were reviewed. The surveyors confirmed this through review of the orientation packed and checklist, and interview with the Interim DON. 5. Resident pictures were reviewed on [DATE] by Unit Managers and all were present in the electronic healthcare systems. Unit Managers will check daily in the electronic healthcare system to ensure pictures are present on new admissions in the system. The surveyors confirmed this through interviews with the Unit Managers. 6. Residents with hats or other accessories, which included facial coverings, that are not worn daily in the center, new pictures will be taken to display the usual appearance so the resident will be more correctly identified. The surveyors confirmed this through review of the pictures and interviews with staff on all shifts. 7. Meal tray audits will be completed by the Floor/Charge LPN/RN or their designee for resident tray passes at each meal. Any discrepancies will be addressed and resolved immediately by nursing staff and the dietary manager/designee, reviewing physician orders in the electronic healthcare system, dietary communication slips, and dietary tray card system to identify where the breakdown occurred. The surveyors confirmed this through observations of the delivery of the meal trays, record reviews and interviews with staff on all shifts. 8. Beginning on [DATE], managers will oversee meal tray delivery process at each meal to ensure the right tray, the right person, the right assistance is provided and is ongoing. Diets or assistance provided that is found to be in error are corrected immediately. Incorrect meal trays are removed from the cart immediately and reviewed to determine how the discrepancy occurred. This is completed by the nursing staff and dietary manager at time of the occurrence. Assistance needed is audited by the floor nurse with oversight by the nursing managers to ensure the correct level of assistance needed is provided and any discrepancies identified are corrected immediately and reviewed by the nursing manager to determine the breakdown and it is resolved immediately. The surveyors confirmed this through observation of the delivery of the meal trays and interviews with managers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9. Door name tags and armbands were audited on [DATE] by the Wound Care Nurse for all 127 residents with no discrepancies identified. The surveyors confirmed this through observation and interviews on all shifts. 10. Audits of wristbands and door name plates were completed on [DATE] by Medical Records with no additional issues identified. The surveyors confirmed this through observations and interviews on all shifts. 11. Audits of wristbands and door name plates will be completed daily Monday-Friday by Medical Records/designee and Saturday and Sunday by the Manager on Duty to ensure compliance. Issues identified will be corrected immediately. The surveyors confirmed this through review of the audits and interviews with Medical Records and managers. 12. All nursing staff were in-serviced by the Staff Development Coordinator (SDC) on the following policies and procedures between [DATE]-[DATE]. The policies and procedures were Assistance with Meals, Therapeutic Diets, Abuse, Neglect and Exploitation, The Five Rights of Meal Administration guidelines that was developed by the Unit Managers and reviewed by the Administrator on [DATE]. Any staff not in-serviced by [DATE] for any reason will not be allowed to work until education is received. The surveyors confirmed this through review of sign in sheets, employee rosters and interviews on all shifts. 13. An agency orientation checklist was created on [DATE] by the DON and provided to each unit to begin using immediately for all agency staff on their first shift which included all of the above policies and procedures. The SDC/Unit Managers will ensure the orientation packet is completed prior to the start of the first shift in the facility. This process is overseen daily with each new agency staff by the DON or designee beginning [DATE] and is ongoing. Monitoring of agency staff performance will be conducted by the Charge Nurses, Unit managers and other nursing management team members each shift and any issues with performance will be addressed and corrected immediately by the same with input from the DON. Overall responsibility of performance of agency staff will be the DON. The surveyors confirmed this through review of the checklist and interview with the Interim DON. 14. Direct meal tray observations will be conducted by the Nurse Managers, Charge Nurses and other Nursing Managers. They will provide direct observation of the meal trays at each meal to ensure facility and agency staff are following the process for meal delivery to ensure the right tray with the right meal is being provided to the right residents begin[TRUNCATED]

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, employee job description, facility employee file review, agency employee file review, medical record review, and interview, the facility failed to ensure the Certified Nursing Assistants (CNAs) had the competencies and skill sets necessary to assure safety and provide individualized care for 9 of 12 sampled residents (Resident #1, #2, #5, #7, #8, #9, #10, #11, and #12) reviewed with modified and therapeutic diet orders and/or required assistance with meals. The facility's failure to ensure the CNAs had the specific knowledge, skill sets, and orientation necessary to provide the resident's individual needs resulted in Immediate Jeopardy when Resident #1 was fed a regular diet instead of the ordered pureed diet (a texture modified diet in which all foods have a soft, pudding like consistency) and CNA #20 (an Agency CNA) left the resident unattended after feeding the resident a regular diet. Resident #1 was found unresponsive and a portion of a hotdog was removed with forceps by Emergency Medical Services (EMS) attendants. Resident #1 expired in the emergency room (ER) of a local hospital. The facility's failures resulted in Immediate Jeopardy for Resident #2, #5, #7, 8, #9, #10, #11, and #12 when these residents required modified diets and/or assistance with meals and staff did not follow the process for identifying residents during delivery of the meal trays. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on [DATE] at 6:50 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-726. The Immediate Jeopardy was effective from [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE] at 2:26 PM, and was validated onsite by the surveyors on [DATE] through medical record reviews, observations, review of education provided, audits, and staff interviews. The findings include: Review of the facility's policy titled, Assistance with Meals, revised ,d+[DATE], revealed .Resident shall receive assistance with meals in a manner that meets the individual needs of each resident .Residents who cannot assist themselves will be assisted with attention to safety, comfort and dignity .All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Administrator job description dated ,d+[DATE], revealed .Lead and direct the overall operations of the facility .management duties including, but not limited to, hiring, training and developing, coaching and counseling .Monitor each department's activities, communicate policies, evaluate performance . Oversee regular rounds to monitor delivery of nursing care .and ensure resident needs are being addressed . Manage turnover and solidify current and future staffing through development of recruiting sources, and through appropriate selection, orientation, training, and staff education and development . Review of the CNA job description dated ,d+[DATE], revealed .Perform direct resident care duties under the supervision of licensed nursing personnel .Essential Duties & Responsibilities .assistance is provided to those residents who cannot feed themselves . Review of employee personnel files revealed that CNA #4, #6, and #13 and Agency CNA #19 and #20 had no documentation of a competency evaluation for the employees, no documentation of the employee's skills, or orientation of the employees to the facility processes and protocols related to the individual care of residents needing assistance with activities of daily living which included eating and modified diets. There was no documentation the CNAs or the Agency CNAs were determined to be competent to provide care for the residents in the facility. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Cerebral Infarction, Bipolar Disorder, Dysphagia (the impairment or loss of skills involved in swallowing foods and/or liquids), Schizophrenia, Asthma, and Anxiety Disorder. Review of the Physician's Orders dated [DATE], revealed .Regular diet Pureed texture, Nectar Thickened Fluids consistency . Review of the quarterly MDS assessment dated [DATE], revealed Resident #1 needed extensive assistance for eating and had complaints of difficulty or pain with swallowing and required a mechanically altered diet of pureed food. Review of the EMS Prehospital Patient Record dated [DATE] at 6:08 PM, revealed .U4 [unit 4] was dispatched to an emergency call. upon arrival .Pt [patient] [Resident #1] in cardiac arrest and CPR [cardiopulmonary resuscitation] in progress. Pt is 80 yo [year old] female who went into .cardiac arrest while eating and appeared to choke. First initial rhythm was asystole [no pulse, no rhythm] .A 1-inch section of hotdog was removed from obstructing the patient's airway using [NAME] forceps .Pt remained in asystole .Pt was moved to stretcher and secured. Moved to unit .Upon arrival at ER [emergency room] .Pt care was transferred to RN [Registered Nurse]. Shortly after transfer of care, resuscitation efforts were terminated by ER doctor . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Emergency Department (ED) Physician Documentation dated [DATE] at 7:05 PM, revealed . The patient [Resident #1] presents with .arrest while eating hot dog. CPR in progress upon arrival .EMS pulled hot dog out of airway .EMS has been performing out of hospital ACLS [Advanced Cardiac Life Support] for approximately 30 minutes by the time pt arrived in ed [emergency department]. The onset was unknown .Medical Decision Making: Primary concern for respiratory arrest given reported history of choking on hot dog and then becoming nonresponsive at nursing home. EMS removed some hot dog from airway during intubation .EMS reports rhythm was asystole initially and transiently PEA [pulseless electrical activity]. CPR continued on arrival, prolonged downtime > [greater than] 30 minutes, further resus [resuscitation] efforts deemed futile and pt pronounced [dead] in ed. time of death 18:55 [6:55 PM] . Review of the facility's investigation dated [DATE], revealed .On [DATE], during the dinner meal pass, [Named CNA #20, an Agency CNA] .grab [grabbed] a tray that had the letter F and the letter B on the tray card. The tray she picked [with a regular diet instead of ordered puree diet] had another resident [picture] with a hat on, causing it to look similar to Ms. [Named Resident #1] picture; both Resident [Resident #1 and Resident #2, which was the resident's tray she selected to deliver to Resident #1] had hats on in their pictures [pictures of the residents are located on the bottom of the tray card] .[Named CNA #20] failed to carefully validate the tray she selected belonged to the resident in question. Additionally, she failed to utilize the identifier process [the resident wristband] to correctly identify resident [Resident #1] before giving Ms. [Named Resident #1] another resident's tray .After giving the wrong tray, [Named CNA #20] exited the resident's room to take a tray to another resident. Leaving the resident alone to eat should not have occurred, as resident [Resident #1] required assistance eating .[CNA #20 called for assistance when she reentered the room about ,d+[DATE] minutes later] Upon entering the room, the RN noted that Resident [Resident #1] was not responding to verbal commands and was not making any sounds .Floor staff were told to call 911 and bring the crash cart to the resident's room Paramedics arrived at the resident's room at 18:07 [6:07 PM] and exited the facility with the resident at 18:35 [6:35 PM] .At 20:00 [8:00 PM] the facility received notification the Resident [Resident #1] has [had] expired at the hospital . Observation of Resident #1 and Resident #2's picture on their individual meal cards on [DATE] at 10:30 AM, revealed a picture quality that was not clear, both African American women had elongated faces and both were wearing a hat. Resident #1's first name started with the letter F. Resident #2's last name started with the letter F and both residents resided in a B bed in different rooms. During a telephone interview on [DATE] at 5:21 PM, CNA #20 confirmed her witness statement. She stated, . I pulled the last tray out I thought was hers [Resident #1]. I looked at the picture thought was [Named Resident #1] but it was [Named Resident #2] .I glanced down at the picture and saw name and took tray in room thought the tray already there was the noon tray [lunch] from earlier .I did not open the tray. I didn't even touch the tray .I fed her with the spoon two bites of coleslaw and pinched off with my fingers two bites of hotdog. I put that in her mouth, and she chewed on it. She made a face and said don't want no more. I left and went across the hall. I left her sitting up in bed. I was gone for about five to seven minutes. I came back and saw she was pale in color and just looking at me. I yelled for [Named CNA #19]. I performed the Heimlich maneuver [process for dislodging something lodged in a person's windpipe] and some coleslaw came out and goldish color fluids .The nurse came in and took over .I thought it [dinner tray] was [Named Resident #1], I saw clearly a F and thought it was [Named Resident #1] .[Resident #1's first name started with the letter F. Resident #2's last name started with the letter F and both residents resided in the B bed in different rooms] . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Minimum Data Set (MDS) assessments and Physician's Orders for Resident #2, #5, #7, #8, #9, #10, #11, and #12 revealed these residents had modified/therapeutic diets and/or needed assistance with eating. Observation in the resident's room on [DATE] at 11:53 AM, revealed CNA #13 failed to verify Resident #9's picture on the meal card to his armband during delivery of the lunch meal tray. Observation in the resident's room on [DATE] at 12:01 PM, revealed Graduate Practical Nurse (GPN) #1 failed to check Resident #12's arm band and verify the picture on the meal card during delivery of the lunch meal tray. Observation in the resident's room on [DATE] at 12:03 PM, revealed CNA #4 failed to check Resident #2's armband and verify the picture on the meal card during delivery of the the lunch meal tray. Resident #2 had no armband and stated, I never had one. CNA #4 did not look for the armband. Observation in the resident's room on [DATE] at 12:03 PM, revealed CNA #7 failed to check Resident #5's armband and verify the picture on the meal card during delivery of the lunch meal tray. Observation in th resident's room on [DATE] at 12:09 PM, revealed RN #5 failed to verify the picture on the meal card with Resident #10's armband during delivery of the lunch meal tray. Observations in the resident's room on [DATE] at 12:20 PM, revealed CNA #6 failed to check Resident #7's armband and verify the picture on the meal card during delivery of the lunch meal tray. Observation in the resident's room on [DATE] at 11:57 AM, revealed CNA #4 failed to verify the picture on the meal card with Resident #11's armband during delivery of the lunch meal tray. CNA #4 placed the tray on the over bed table and prepared to set up the tray. RN #1 entered the room and stated, .She [Resident #11] is vegetarian. Check that taco to see if meat . CNA #4 took the spoon and lifted the lettuce. She stated, .It is ground beef . Review of Resident #11's meal card revealed a diet of fortified foods, mechanical soft large portions, and no documentation of a vegetarian diet or that the resident was not to have beef or pork. During an interview on [DATE] at 1:01 PM, the Dietary Manager confirmed Resident #11 received a regular diet with beef, the meal card and diet listing documented an incorrect diet and did not match the Physician's Order for a vegetarian diet. She stated, .Yes, this can happen again .the resident gets the wrong diet and cause problems for them . She stated, .We removed hotdogs and smoked sausage on [DATE] from the Always Available Menu . Observation and interview in the resident's room on [DATE] at 12:19 PM, revealed CNA #21 failed to check Resident #8's armband and verify the picture on the meal card during delivery of the lunch meal tray. When CNA #21 was asked if she checked the armband she stated, yes. The surveyor and CNA #21 walked back into room and CNA #21 stated, .maybe I didn't .I lied .I did not look for an armband . Resident #8 did not have an armband. Observations on the 2nd, 3rd, and 4th floors on [DATE]-[DATE], revealed a posted sign that documented Always Available Menu (Lunch & Dinner) that included chicken tenders, hot dogs, French fries, and hamburgers. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:23 PM, CNA #6 who had been employed for one month, was asked how she identified a resident. CNA #6 stated, A log at the front desk with name and room number. I haven't seen it . When asked if she received training in orientation about the facility's process for identifying residents during meal pass, CNA #6 stated, No ma'am. CNA #6 confirmed she was not aware of a resident Kardex which included individualized resident care directives. During an interview on [DATE] at 12:30 PM, CNA #7 who had been employed for 2 weeks, was asked how she identified a resident. CNA #7 stated, The name on the door. When asked if she received training in orientation about the facility process for identifying residents during delivery of the meal trays. CNA #7 stated, I know there is a name on the door. CNA #7 confirmed she was not aware of a resident Kardex which included individualized resident care directives and each resident having an armband. During an interview on [DATE] at 11:01 AM, Licensed Practical Nurse (LPN) #3 was asked if the facility had an orientation program for agency staff. LPN #3 stated, .We don't have anything in writing, It is all verbal . They [staff] are supposed to look at armbands every day when they pass meds [medications] and meal trays . With agency [agency staff] when they come we make walking rounds, given a census sheet and shown the Kardex. The computer gives more information . When asked if each resident had an armband, LPN #3 stated, Residents take them off all the time . During an interview on [DATE] at 11:56 AM, CNA #10 was asked if she received orientation from the facility before providing resident care. CNA #10 stated, .No, they [facility] didn't give me nothing about that here . During an interview on [DATE] at 1:01 PM the Interim DON was asked if the facilty had a policy for the identification of the resident to be certain the correct resident received the correct diet/medication and the DON stated, .We had no policy for identification and meal pass .After the incident [on [DATE]] we put into place the breakfast, lunch and dinner meal pass process and audit .The staff deliver the tray to the room and verify the meal card against the resident's armband . When asked if every resident had an armband, she stated, .they should . During an interview on [DATE] at 1:20 PM, when the Administrator was asked how the staff identified the residents, she stated, .I have to have confidence the audit tool that was done on the 8th [[DATE]] is correct .I would have to assume that she identified the resident. I would have faith that she did it correctly . During a telephone interview on [DATE] at 5:21 PM, CNA #20 stated, .No one told me how to get information about the resident. They just put us on the floor. We had no training. They didn't teach us about any Kardex book. [Named Nursing Facility] didn't tell me anything. During a telephone interview on [DATE] at 11:30 AM, CNA #19 was asked if she received information about the facility or assignments prior to working with the residents. CNA #19 stated, .No information about this facility or assignment. You just show up. Nothing about a Kardex . During an interview on [DATE] at 12:06 PM, CNA #2 confirmed she was not told about the resident's information in the Kardex binder. CNA #2 stated, .I ain't seen that. I don't know about a book or binder. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:24 PM, the Administrator was asked if the facility had an orientation program for contract staff. The Administrator stated, .The DON is the point of contact for the agency staffing . When asked if she was involved in the orientation of newly hired employees and agency staff, the Administrator stated, No, not right now. The Administrator was asked the number of nursing positions that the facility currently had and the Administrator stated .Off the top of my head the facility has 4 RNs, 12 LPNs, and 16 CNAs . The Administrator was asked how she was made aware of how things were progressing in the facility and she stated that information was directed to the DON. She was also asked if the audit instrument included staff identification of the armband and the Administrator stated No, it does not . During an interview on [DATE] at 2:37 PM, the Interim DON stated she had received the contract employee files from the staffing agency. When asked if the files contained the education and competency of each CNA, the Interim DON shook her head no. The Interim DON confirmed the facility had no employee personnel files and no contract personnel files for facility orientation and competency determination. During an interview on [DATE] at 1:17 PM, LPN #2 was asked if there was a book or binder with resident information for the staff to use with resident care directives. LPN #2 stated, .Don't ask me. I'm agency. I don't know. During an interview on [DATE] at 1:35 PM, the Interim DON confirmed there were no facility employee files or contract employee files for orientation or competency checks. During an interview on [DATE] at 2:25 PM, CNA #10 stated, .There is no sheet in the Kardex book for [Named Resident #3]. During an interview on [DATE] at 2:27 PM, LPN #1 confirmed there was no Visual/Kardex Report for Resident #3 in the book [Kardex]. She stated, I need to update this whole thing. The Administrator and Interim DON were unable to present any employee personnel files or contract personnel files that contained competency assessments. Refer to F-689 The surveyors verified the removal Plan by: 1. On [DATE], a tray audit was completed by the Dietary Manager to ensure that residents are receiving the correct consistencies on the resident's trays compared to the resident's diet slips with no discrepancies identified. The surveyors reviewed the audits. 2. On [DATE], hotdogs were removed from the menu by the Dietary Manager. The surveyors made observations, reviewed the menus, and interviewed staff on all shifts. 3. On [DATE], Care plans, Kardexes and (named electronic healthcare software system used by CNAs for electronic documentation) were reviewed for appropriate level of assistance for eating by Unit Managers and of the 127 residents reviewed no concerns were identified. The surveyors made observations, reviewed the Care Plans and Kardexes, and interviewed the Unit Managers. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	13. Between [DATE]-[DATE], all nursing staff were in-serviced by the Staff Development Coordinator on the following policies and procedures: Assistance with Meals, Therapeutic Diets, Abuse, Neglect and Exploitation, The Five Rights of Meal Administration guidelines (developed by the Unit Managers and reviewed by Administrator on [DATE]). Any staff not in-serviced by [DATE] for any reason will not be allowed to work until education was received. The surveyors reviewed the sign in sheets, education, and interviewed staff on all shifts. 14. On [DATE], agency orientation checklist was created by the DON and provided to each unit to begin using immediately ([DATE]) for all agency staff on their first shift which includes all the above policies and procedures. Staff Development Coordinator/Unit Managers will ensure orientation packet is completed prior to start of the first shift in facility. This process is overseen daily with each new agency staff by the DON/designee beginning [DATE] and is ongoing. Monitoring of agency staff performance will be conducted by the Charge Nurses, Unit Managers, and other nursing management team members each shift and any issues with performance will be addressed and corrected immediately with input from the DON. Overall responsibility of performance of agency staff will be the DON. The surveyors reviewed the orientation packet and interviewed staff on all shifts. 15. Beginning [DATE], Nurse Managers, Charge Nurses and other Nursing Managers will direct meal tray observations and will provide direct observation of meal tray delivery at each meal to ensure facility and agency staff are following the process for meal delivery to ensure the right tray with the right meal is being provided to the residents and this is ongoing. The surveyors observed delivery of the meal trays and interviewed the Charge Nurses and Nurse Managers. 16. The dietary tray cards were altered by Information Technology to make the room number font the same size as the resident name font. The surveyors observed the dietary tray cards. 17. On [DATE], training was conducted for the Dietary Manager, Registered Dietitian and Dietary Supervisor by (named dietary software) on the tray card system that dietary uses, and included instructions for updating/editing profiles, preferences, and dietary orders to ensure consistency. The surveyors reviewed the education and interviewed dietary staff. Noncompliance at F-726 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, job description review, record review, medical record review, observation, and interview, facility Administration failed to administer the facility in a manner to provide oversight, to monitor and provide a safe environment related to identification of residents when delivering the meal trays, and failed to ensure nursing staff had the knowledge and skill sets necessary to assure safety and provide individualized resident care for 9 of 12 sampled residents (Resident #1, #2, #5, #7, #8, #9, #10, #11, and #12) reviewed that required modified or therapeutic diets and/or required assistance with meals. These failures resulted in Immediate Jeopardy when Resident #1 was fed a regular diet instead of the pureed (a texture modified diet in which all foods have a soft, pudding like consistency) diet that was ordered and an Agency Certified Nursing Assistant (CNA) left the resident unattended after feeding the resident a piece of a hotdog. Resident #1 was found unresponsive, a portion of a hotdog was removed from the resident's airway with forceps by the Emergency Medical Services (EMS) attendants, and Resident #1 expired in the emergency room (ER) at a local hospital. The facility's failures resulted in Immediate Jeopardy for Resident #2, #5, #7, #8, #9, #10, #11, and #12 when these residents required modified diets and/or assistance with meals and staff did not follow the process for identifying residents during delivery of the meal trays. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on [DATE] at 6:50 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-600, F-689, F-726, F-835, and F-867. The facility was cited F-600 at a scope and severity of J, and F-689 at a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy was effective from [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE] at 2:26 PM, and was validated onsite by the surveyors on [DATE] through medical record review, observation, review of education provided to staff members, audits, and staff interviews. The findings include: Review of the facility's policy titled, Administration of Facility, dated [DATE], revealed .This facility will provide policies and systems to ensure that it is administered in a manner that will focus on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident .The facility will employ professionals necessary to carry out the provisions of requirements . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Administrator Job Description dated ,d+[DATE] revealed .Lead and direct the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives . Essential Duties & [Symbol for and] Responsibilities: .management duties including, but not limited to, hiring, training and developing, coaching and counseling, and terminating department staff, as deemed necessary . Lead the facility management staff and consultants in developing and working from the business plan that focuses on all aspects of facility operations, including setting priorities and job assignments .Monitor each department's activities, communicate policies, evaluate performance, provide feedback and assist, observe, coach, and discipline as needed .Oversee regular rounds to monitor delivery of nursing care .and ensure resident needs are being addressed .Responsible for the QA [Quality Assurance] program .Manage turnover and solidify current and future staffing through development of recruiting sources, and through appropriate selection, orientation, training, staff education and development .Consult with department managers concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services . The DON job description was requested on two separate occasions but was not submitted to the surveyors as requested. The facility's policy titled, Abuse, Neglect and Exploitation, revised ,d+[DATE] revealed .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .The facility will make individual determination in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment .The facility will provide ongoing oversight and supervision of staff in order to assure that it's policies are implemented as written .The facility will make individual determination in consideration of current staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment, and equipment . Review of employee personnel files revealed that CNA #4, #6, and #13 and Agency CNA #19 and #20 had no documentation of a competency evaluation for the employees, no documentation of the employee's skills, or orientation of the employees to the facility processes and protocols related to the individual care of residents needing assistance with activities of daily living which included eating and modified diets. There was no documentation the CNAs or the Agency CNAs were determined to be competent to provide care for the residents in the facility. Review of the EMS Prehospital Patient Record dated [DATE], Emergency Department (ED) Physician Documentation dated [DATE], and the facility's investigation revealed CNA #20, an Agency CNA, served Resident #1 another resident's supper tray, which was a regular diet instead of the ordered pureed diet. Resident #1 was found unresponsive, a portion of a hotdog was removed from the resident's airway with forceps by the Emergency Medical Services (EMS) attendants, and Resident #1 expired in the ER of a local hospital. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations were made on [DATE] and [DATE] during meal tray delivery that revealed staff did not verify residents were the right residents to the meal card pictures of the residents, did not identify residents with their armbands nor did staff ensure all residents had arm bands for identification purposes and staff did not ensure residents received the correct physician ordered meals. These residents observed were residents which required assistance with eating and/or modified/therapeutic diets. During an interview on [DATE] at 1:01 PM, the Interim DON stated, .We had no policy for identification and meal pass .After the incident [on [DATE]] we put into place the breakfast, lunch and dinner meal pass process and audit .The staff deliver the tray to the room and verify the meal card against the resident's arm band . When asked if every resident had an armband, the DON stated, .They should . During an interview on [DATE] at 1:20 PM, the Administrator was asked how staff identified residents. She stated, .I have to have confidence the audit tool that was done on the 8th [[DATE]] is correct .I would have to assume that she [Unit Manager] identified the resident. I would have faith that she did it correctly . During an interview on [DATE] at 1:24 PM, the Administrator was asked when she received notification of the event involving Resident #1. The Administrator stated, .I was at home. I received notification she [Resident #1] received an incorrect tray and was transported to the hospital .the CNA [Agency CNA #20] didn't properly identify the meal tray with the resident .She left the room, then went back into the room, then called for help . The Administrator was asked if the facility had an orientation program for contract staff. The Administrator stated, .The DON was the point of contact for the agency staffing . When asked if she was involved in the orientation of newly hired employees and contract staff, the Administrator stated, No, not right now. When the Administrator was asked what her role in the QAPI program was, she stated, Had always been overseen by the DON .QA [quality assurance] reports were kept in the DON's office in a binder. When the Administrator was asked if the facility's audit included the identifier of the arm band, she stated, .No, it does not . The Administrator was asked where the facility documented the collection of the data and observations of the staff verifying the meal card picture with the name of the resident and the armband when delivering the resident's meal tray to be certain the correct resident receives the correct tray. The Administrator stated . There is no documentation we are auditing that .I would have to have faith they [staff] did what [they] was supposed to do . During an interview on [DATE] at 2:37 PM, the Interim DON stated she had received the contract employee files from the staffing agency. When asked if the files contained the education and competency of each CNA, the Interim DON shook her head no. During an interview on [DATE] at 3:30 PM, the Interim DON stated, .The pictures [on the meal card] are grainy .I didn't realize how many of our residents wore hats in their pictures and so many of them [residents] look alike .We need to see if dietary system can print the pictures clearer like they are in [Named Electronic Healthcare Software] . During an interview on [DATE] at 1:35 PM, the Interim DON confirmed there were no contract employee files validating any orientation or competency checks in the facility or at the agency. (continued on next page)

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	445139	A. Building B. Wing	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Midtown Center for Health and Rehabilitation	141 N McLean Blvd Memphis, TN 38104

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator and the Interim DON were unable to present any employee personnel files or contract personnel files that contained the employee's competency determination. The facility did not have any Agency employee personnel files. Refer to F-689 and F-726 The surveyors verified the removal Plan by: 1. On [DATE], the Regional Director of Operations (RDO) educated the Administrator on the role of the Administrator, the job description, the tools and resources available to effectively administer nursing facility operations. The surveyors confirmed this through interviews with the RDO and the Administrator. 2. On [DATE], the Regional Director of Clinical Services educated the Administrator on the Accident Policy. The surveyors confirmed this by review of the education provided, interview with the Regional Director of Clinical Services and the Administrator. 3. On [DATE], the Administrator was educated by the RDO and the Regional Director of Clinical Services on the full orientation agenda/education required by all staff, both agency and full-time staff, prior to working at the facility. The surveyors confirmed this by reviewing the education provided, interview with the Regional Director of Clinical Services and the Administrator. 4. The Administrator was educated on Quality Assessment and Performance Improvement (QAPI) as it relates to self-identifying, monitoring and correcting in-house process issues. This included bringing identified issues to the committee for review, revision, and monitoring. The surveyors confirmed this through review of the education provided and interview with the Administrator. 5. Beginning [DATE], direct meal tray observations will be conducted by the Nurse Managers, Charge Nurses and other Nursing Managers. They will conduct direct observations of meal trays at each meal to ensure facility and agency staff are following the process for meal delivery to ensure the right tray with the right meal is being provided to the right resident and this is ongoing. The surveyors confirmed this through observation and interview. 6. The Administrator and/or designee will review results of the direct meal tray observations daily beginning [DATE] and this will be ongoing. The results will be presented to the QAPI committee for review, monitoring and discussion. The surveyors confirmed this through interview with the Administrator and review of the audit tool. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. An agency orientation checklist was created on [DATE] by the DON and was provided to each unit for them to begin using immediately. This will be completed for all agency staff on their first shift and will include all the above policies and procedures. The Staff Development (SDC)/Unit Managers will ensure the orientation packet is completed prior to the start of the first shift in the facility. This process is overseen daily with each new agency staff person by the DON or designee beginning [DATE] and will be ongoing. Monitoring of agency staff performance will be conducted by Charge Nurses, Unit managers and other Nursing Management team members each shift. Any concerns with the agency staff member performance will be addressed and corrected immediately by the same facility staff person with input from the DON. The DON will have the overall responsibility of evaluating the performance of agency staff. The surveyors confirmed this through interview with the Staff Development (SDC)/Unit Managers and the Interim DON. 8. The RDO and Area Director of Clinical Services provide oversight of facility administration with a weekly 1:1 interaction reviewing the completed audits and QA findings. The plan of correction will be reviewed weekly to ensure all the audits are completed and concerns are identified for 4 weeks and/or until substantial compliance is achieved. The QAPI meetings will be conducted monthly and attended by the RDO and Area Director of Clinical Services for a period of three months to ensure compliance is sustained. The surveyors confirmed this through interview with the RDO, Area Director of Clinical Services, and the Administrator. The facility's noncompliance at F-835 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on policy review, job description review, record review, medical record review, observation, and interview, the Quality Assurance Performance Improvement (QAPI) committee failed to ensure systems and processes were in place and consistently followed by staff to address quality concerns related to safe individualized resident care when the staff failed to provide the ordered modified diet meal, failed to provide assistance with meals, and failed to ensure nursing staff followed the facility process for identifying residents during the delivery of the meal trays. The facility failed to ensure the QAPI committee reviewed and validated systemic problems and determined a system was in place to ensure nursing staff had the knowledge and skills necessary to assure safety and provide individualized care for 9 of 12 sampled residents (Resident #1, #2, #5, #7, #8, #9, #10, #11, and #12) reviewed that required modified and therapeutic diets and/or required assistance with meals. The facility's failures resulted in Immediate Jeopardy when Resident #1, a cognitively impaired resident who required assistance eating, was fed a regular diet instead of the ordered pureed (a texture modified diet in which all foods have a soft, pudding like consistency) diet and the resident was left unattended after feeding the resident bites of solid food. Resident #1 was found unresponsive, a portion of a hotdog was removed with forceps by Emergency Medical Services (EMS) attendants, and Resident #1 expired in the emergency room (ER). The facility's failures resulted in Immediate Jeopardy for Resident #2, #5, #7, #8, #9, #10, #11, and #12 when these residents required modified diets and/or assistance with meals and staff did not follow the process for identifying residents during delivery of the meal trays. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Interim Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) on [DATE] at 6:50 PM, in the Chapel. The facility was cited Immediate Jeopardy at F-600, F-689, F-726, F-835, and F-867. The facility was cited F-600 at a scope and severity of J, and F-689 at a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy was effective from [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] at 2:26 PM. The corrective actions were validated onsite by the surveyors on [DATE] through observation, review of audits and meeting minutes, and staff interviews. The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy titled, Quality Assurance Performance Improvement Plan, revised [DATE], revealed .The purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents .To do this, all employees will participate in ongoing QAPI efforts which support our mission by enhancing quality of life by nurturing individuality and independence . The QAPI program at [Named Management Company] will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents), by ensuring our data collection tools and monitoring systems are in place and are consistent for a proactive analysis .The governing body assures adequate resources exist to conduct QAPI efforts .[Named Management Company] company's facilities governing body is ultimately responsible for overseeing the QAPI Committee. The president has direct oversight responsibility for all functions of the QAPI Committee and reports directly to the governing body. The QAPI Committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction .Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance. It also includes tracking, investigating, and monitoring adverse events/medical errors every time they occur, and action plans implemented through the Plan Do Study Act (PDSA) and Root Cause Analysis to prevent recurrences .The QAPI team at [Named Management Company] facilities will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements . [Named Management Company] facilities use a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change . Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised ,d+[DATE], revealed .It is the policy of this facility to provide protection for the health, welfare and rights of each resident .'Neglect' means failure of the facility, its 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 .The facility will develop and implement written policies and procedures that: .d. establish coordination with the QAPI program .The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written . Review of the Administrator job description dated ,d+[DATE], revealed .Lead and direct the overall operations of the facility in accordance with customer needs . with focus on maintaining excellent care for the residents .Oversee regular rounds to monitor delivery of nursing care .and ensure resident needs are being addressed .Responsible for the QA [Quality Assurance] program .Consult with department managers concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services . Review of the EMS Prehospital Patient Record dated [DATE], Emergency Department (ED) Physician Documentation dated [DATE], and the facility's investigation revealed CNA #20, an Agency CNA, served Resident #1 another resident's supper tray, which was a regular diet instead of the ordered pureed diet. Resident #1 was found unresponsive, a portion of a hotdog was removed from the resident's airway with forceps by the Emergency Medical Services (EMS) attendants, and Resident #1 expired in the hospital ER. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations were made on [DATE] and [DATE] during meal tray delivery that revealed staff did not verify residents were the right residents by comparing the meal card pictures of the residents, did not identify residents with their armbands nor did staff ensure all residents had arm bands for identification purposes and staff did not ensure residents received the correct physician ordered meals. These residents observed were residents which required assistance with eating and/or modified/therapeutic diets. During an interview on [DATE] at 1:01 PM, the Administrator stated, .There is no routine or QA [Quality Assurance] to audit armband compliance . During an interview on [DATE] at 1:24 PM the Administrator was asked what her role in the QAPI program was and she stated, Had always been overseen by the DON .QA [quality assurance] reports were kept in the DON's office in a binder. When the Administrator was asked if the facility's audit included the identifier of the arm band, she stated, .No, it does not . The Administrator was asked where the facility documented the collection of the data and observations of the staff verifying the meal card picture with the name of the resident and the armband when delivering the resident's meal tray to be certain the correct resident receives the correct tray. The Administrator stated .There is no documentation we are auditing that .I would have to have faith they [staff] did what [they] was supposed to do . During a telephone interview on [DATE] at 3:00 PM, when asked if the facility had identified the root cause of the incident of Resident #3 when she was served the incorrect ordered meal, the Chief Operating Officer stated, .isolated freaky accident . Refer to F-600, F-689, and F-726. The surveyors verified the Removal Plan by: 1. On [DATE] an Ad Hoc (as needed) QAPI meeting was conducted with the Administrator, DON, Unit Managers, Regional Director of Operations, and Area Director of Clinical Services to discuss this event. The surveyors reviewed the minutes and interviewed the QAPI members. 2. On [DATE], the Administrator was educated on QAPI as it relates to self-identifying, monitoring and correcting in-house process issues, to include bringing identified issues to the committee for review, revision, and monitoring. The surveyors confirmed this by reviewing the education review and an interview with the Administrator. 3. On [DATE], the Nursing Home Administrator and Interim DON were educated by the Area Director of Clinical Services regarding the QAPI process to include systems review and Performance Improvement Process. Results of audits will be brought to the QAPI committee meetings and will be reviewed and discussed with the members of QAPI, which include the Administrator, DON, Unit Managers, Medical Director, Social Services, Activities Director, Maintenance, and the Dietary Managers. The surveyors reviewed the education and interviewed the Administrator and Interim DON. The facility's noncompliance at F-867 continues at a scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.