

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2022
NAME OF PROVIDER OR SUPPLIER Kei-Ai Los Angeles Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 Lincoln Park Ave Los Angeles, CA 90031	

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)
<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a diagnosis of dysphagia (difficulty swallowing) was provided speech therapy services (treatment of impairments and disorders of speech, voice, communication and swallowing) timely and was provided extensive assistance and one-person physical assist while eating, per the comprehensive assessment. The facility failed to:</p> <ul style="list-style-type: none"> -Develop and implement Resident 1's person-centered care plan with interventions to address the resident's dysphagia and pocketing of food (keeping food in the cheeks or mouth instead of swallowing). -Implement interventions of extensive assist and one-person physical assist while eating, per the comprehensive assessment, including to monitor and assess for episodes of Resident 1 pocketing food. -Follow the Physician's Order dated [DATE], to provide Resident 1 with a Speech Therapy Evaluation in a timely manner (within 48 hours), on [DATE]. -Adequately assess Resident 1 for emergency services (911) on [DATE] at 5:30 pm, as Resident 1 was weak, unarousable, and had a low blood pressure of ,d+[DATE] millimeters of mercury (mm/hg, normal range ,d+[DATE] mm/hg - ,d+[DATE] mm/hg). <p>As a result, on [DATE], at around 9:30 pm, Resident 1 had a change of condition and was found with food residue lodged on the left inside of his cheek. Resident 1 was transferred by paramedics to the General Acute Care Hospital (GACH) where Resident 1 had a chest x-ray indicating Right Lower Lobe (RLL) infiltrates (abnormal substance that accumulates gradually in the cells of the lungs) likely secondary to aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident).</p> <p>Resident 1 was admitted to the GACH. On [DATE], the results of the GACH Diagnostic Radiology report indicated Resident 1 had new airspace disease (when air in the lungs is replaced by blood, fluid, pus, or other material) within the right lower lung. On [DATE] Resident 1 had died and was discharged from GACH with diagnosis of septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) secondary to aspiration pneumonia.</p> <p>Findings:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by chemical imbalances that can lead to personality changes), Type II diabetes (an impairment in the way the body regulates and uses sugar as fuel), generalized epilepsy and epileptic syndromes (having seizures [uncontrolled electrical disturbance in the brain] that come from the entire brain at once with typically no warning), dysphagia (difficulty swallowing) and dementia (loss of memory, thinking and reasoning).</p> <p>A review of Resident 1's Speech Therapy Encounter Note dated [DATE] indicated, per the resident's chart the resident had a tendency to pocket with fine chopped textures; and due to the severity of his dementia, Resident 1 was not able to follow 1-step command to clear.</p> <p>A review of Resident 1's Physical Medicine & Rehabilitation Consult dated [DATE] indicated recommendations for the resident to receive a speech language pathology evaluation and treatment as appropriate to assess for dysphagia, speech language disorder, higher cognitive function, and to improve safety awareness.</p> <p>A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated [DATE], indicated Resident 1 had severely impaired cognition (never/rarely made decisions) and fluctuating inattention. The MDS indicated Resident 1 required extensive assistance and two-person physical assistance for bed mobility and transferring; and required extensive assistance and one-person physical assistance for eating and personal hygiene. The MDS further indicated Resident 1 had complaints of difficulty or pain with swallowing; and indicated he would hold food in his mouth or cheeks after meals (pocketing food). The MDS indicated Resident 1 was on a mechanically altered therapeutic diet (food that has been altered for those who have difficulty chewing or swallowing).</p> <p>According to a review of Resident 1's Speech Therapy Treatment Encounter Note dated [DATE], Resident 1 had occasional pocketing and holding boluses (small rounded ball of food) in his buccal (cheek) cavity.</p> <p>A review of Resident 1's SBAR (Situation, Background, Assessment, Recommendations- a framework for communication between members of the health care team about a resident's condition) Summary for Providers dated [DATE] indicated Resident 1 had a habit of pocketing food.</p> <p>A review of Resident 1's Progress Note dated [DATE] at 4:53 p.m., indicated Resident 1 was noted not swallowing medications after receiving directions. The note indicated it took Resident 1 a long time to swallow and indicated Resident 1 was given a lot of direction.</p> <p>A review of Resident 1's Physician's Order dated [DATE], indicated the resident was to receive therapy evaluation and treatment as indicated for physical therapy (PT), speech therapy (ST), and occupational therapy (OT) one time only for three days.</p> <p>According to a review of Resident 1's Progress Note dated [DATE], Resident 1's medications needed to be crushed, because the resident had difficulty in swallowing.</p> <p>(continued on next page)</p>		

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F 0825 Level of Harm - Actual harm Residents Affected - Few	<p>A review of Resident 1's Physician's Order dated [DATE], indicated there was a clarification order for Speech Therapy (ST) for oropharyngeal dysphagia (swallowing problems occurring in the mouth and/or throat) every day three times a week for four weeks to include a least restrictive diet, diet modification, safe swallowing strategies and precaution, and patient and caregiver education.</p> <p>A review of the Physician's Order dated [DATE] at 5:05 p.m., indicated to monitor and document Resident 1's episodes of pocketing food. Further review of the Physician's Orders indicated there were no physician orders to monitor and document Resident 1's episodes of pocketing food prior to [DATE].</p> <p>According to a review of Resident 1's Medication Administration Record dated [DATE] to [DATE] Resident 1's episodes of pocketing food were not documented.</p> <p>A review of Resident 1's progress notes dated [DATE] at 5:15 p.m., indicated Resident 1 was arousable and the Nurse Practitioner ordered to transfer Resident 1 to the hospital for evaluation and possible Gastrostomy Tube (g-tube, a tube inserted directly through the belly for direct nutrition to the stomach) insertion. The note further indicated Resident 1 was able to open his eyes when aroused. Ambulance Service 1 was called, and Resident 1's family was made aware.</p> <p>A review of Resident 1's SBAR dated [DATE] at 5:30 p.m., indicated Resident 1 was very weak, was noted pocketing food, and was very high risk of aspiration. The ST recommended for Resident 1 to be NPO (nothing by mouth), the resident's physician was notified, and orders were received for the resident to be transferred to the hospital for evaluation and possible GT insertion. The SBAR indicated Resident 1's blood pressure was ,d+[DATE] millimeters of mercury (mm/hg, normal range ,d+[DATE] mm/hg - ,d+[DATE] mm/hg).</p> <p>A review of Resident 1's progress note dated [DATE] at 9:15 p.m., indicated Ambulance Service 1 came to transport the resident, but did not because Resident 1 was very weak and unable to be aroused. The note indicated the Ambulance Service 1 then called 911 prior to notifying the facility they were not transporting the resident. The note indicated Resident 1's family were at bedside and were aware of the situation.</p> <p>According to a review of Resident 1's progress note dated [DATE] at 9:30 p.m., the paramedics came to the facility and Resident 1 was now totally awake and the paramedics were made aware Resident 1 needed extra tactile stimuli due to severe weakness (possible dehydration) and due to pocketing food. The facility had to transfer for possible GT placement if the resident's family agreed.</p> <p>A review of the General Acute Care Hospital (GACH) Emergency Documentation dated [DATE] at 10:17 p.m. , indicated Resident 1 was being transferred from the facility to the emergency department for the concern of by mouth (PO) intolerance and possible need for GT placement.</p> <p>A review of Resident 1's GACH Diagnostic Radiology report dated [DATE] at 10:51 p.m., indicated Resident 1 had a chest x-ray (a type of imaging that uses radiation to take pictures of the inside of the body) for dysphagia and hypotension (low blood pressure). The results of the chest x-ray indicated Resident 1 had airspace disease (when air in the lungs is replaced by blood, fluid, pus, or other material) developing in the right lung base, concerning for multifocal (affecting more than one area) infection or aspiration.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Speech Therapy Treatment Encounter Note dated [DATE] at 1:46 p.m., indicated on [DATE] during a limited oral mechanical examination, the ST observed oral trace residue. The note indicated the ST successfully removed the remaining food material from Resident 1's oral cavity via a gloved finger. The note further indicated Resident 1 presented non-responsive to varied multi-sensory stimuli (e.g., auditory, thermal, verbal, and visual). The note indicated the ST attempted multiples times for approximately 15 minutes to re-alert Resident 1, however, the resident was unable to sustain alertness (e.g., eyes opened for 4 seconds). The note further indicated Resident 1 was not safe for PO (by mouth) intake. FM 1 and FM 2 verbalized request to transfer Resident 1 to the hospital. The note indicated the ST alerted the charge nurse, and the charge nurse endorsed plan to start Intravenous Fluid (IVF) and to notify Resident 1's physician. The note indicated Resident 1 was not alert, however, no increased work of breathing was noted and the resident's oral cavity clear at the end of treatment.</p> <p>According to a review of Resident 1's Medical Record the resident did not have a care plan for the resident's pocketing of food or dysphagia prior to [DATE].</p> <p>A review of Resident 1's GACH Discharge Documentation dated [DATE] indicated Resident 1 was deceased and discharged from GACH on [DATE]. The Discharge Documentation indicated Resident 1 was admitted to GACH for altered mental status concerning for aspiration pneumonia and the resident's primary discharge diagnosis was septic shock secondary (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) to aspiration pneumonia. The discharge documentation indicated on [DATE] at 6 p.m. Resident 1 became hypotensive with blood pressure in the 70's/30's and became hypoxic to the 50's.</p> <p>The documentation indicated rapid response (Medical Emergency Team that responds to immediate critical conditions) was called, the resident's blood pressure improved with intravenous fluid [IVF] and SpO2 (oxygen) improved with a nasal cannula [a device that delivers oxygen through the nose] at 6 liters (amount of oxygen delivered through the nasal cannula). The documentation further indicated Resident 1 was transferred to the Medical Intensive Care Unit and from there Resident 1 was downgraded to the Progressive Care Unit and then back to the floor where the resident's respiratory status progressively worsened, and the resident expired on [DATE].</p> <p>A review of Resident 1's Autopsy Report dated [DATE] at 9:30 a.m., indicated on [DATE] Resident 1 was brought via ambulance from the facility to GACH after being found unresponsive with unchewed food in his mouth and hypotensive in the 80s systolic. Resident 1 was alert, but not oriented (at baseline, oriented to self), and was noted to have decreased breath sounds at the bilateral lung bases, right more than left. The patient received intravenous fluid resuscitation (maintain organ perfusion (hemodynamics) and substrate (oxygen, electrolytes, among others) delivery through the administration of fluid and electrolytes) and initial doses of IV vancomycin (antibiotic medication to treat infection) and cefepime (antibiotic medication to treat infection), and the resident was admitted to the general medicine service on [DATE].</p> <p>The Report indicated on admission, a nasogastric tube (a tube placed through the nose to the stomach) was placed for Resident 1's nutrition and medication administration and the antibiotic regimen was changed to IV ceftriaxone (antibiotic medication to treat infection) and metronidazole (antibiotic medication to treat infection) given high concern for aspiration pneumonia.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On the evening of the first day of admission, ([DATE]), a rapid response was called for hypoxia with oxygen saturation 59% and hypotension (.d+[DATE], low blood pressure), at which time the resident was also hypothermic to 35 degrees Celsius (95 degrees Fahrenheit). The resident was noted to have a possible aspiration event on the evening of [DATE] after which nasogastric tube feeds were held for a time before being restarted at a trickle rate. The resident was transferred back to the medicine floor on [DATE]. On [DATE] the resident experienced a desaturation (a decrease in the level of oxygen in a resident's blood) event which was not improved despite maximal supplemental oxygen. Resident 1's family was notified of the change in clinical status and the resident was given intravenous lorazepam (medication to treat anxiety) for comfort.</p> <p>Resident 1 expired at 6:18 a.m. on [DATE]. The clinical cause of death was related to aspiration with dementia, diabetes and epilepsy contributing factors. The report indicated the autopsy cause of death was respiratory failure due to pneumonia of the resident's right lung with conditions that included aspiration. The report further indicated final anatomic diagnosis of acute pneumonia of the right lower lobe and aspiration of foreign material in the bilateral lungs.</p> <p>A review of the Certificate of Death dated [DATE] indicated Resident 1's cause of death was respiratory failure and right lung pneumonia.</p> <p>During an interview on [DATE] at 1 p.m., Family Member (FM) 2 stated on [DATE] he went to visit Resident 1 at the facility and Resident 1 was non-responsive with his eyes fluttering back. FM 2 stated he knew Resident 1's baseline because he is the resident's caregiver and he knew there was something wrong. FM 2 stated staff indicated Resident 1 was tired. FM 2 stated he found the resident had a big wad of food in his mouth. FM 2 stated this was not the first time this happened and asked staff previously to make sure someone was feeding the resident and not leaving him with food in his mouth. FM 2 stated he pulled out the wad of food in Resident 1's mouth and asked the nurse to please call someone but was brushed off. FM 2 stated he told the nurse the resident needed to go to the hospital, but the nurse told him she doesn't think it's necessary. FM 2 stated around 9:14 p.m. an ambulance came to pick up the resident but stated they would call 911 instead. FM 2 stated the resident was transferred to GACH and never recovered. FM 2 stated when an autopsy was done pieces of food were found in Resident 1's lungs.</p> <p>On [DATE] at 3:51 p.m., during an interview, Licensed Vocational Nurse (LVN) 1 stated when an order for speech therapy evaluation was received from the physician, the order was good for three days and the speech therapist should see the resident the next day, but no later than three days. LVN 1 stated if the resident had difficulty swallowing an order should be obtained from the physician to down grade the resident's diet until the swallow evaluation was done.</p> <p>During an interview on [DATE] at 4:06 p.m., ST 1 stated he remembered Resident 1. ST 1 stated FM 2 stated Resident 1 was found lying flat with food in his mouth. ST 1 stated FM 2 was cursing at the DON and holding food in his hand that he pulled from Resident 1's mouth. ST 1 stated FM 2 indicated Resident 1 had food lodged in his left cheek and had pictures of it in his cellphone. ST 1 stated he had just finished reading Resident 1's medical record on [DATE] and was about to do an evaluation. ST 1 stated Resident 1 was not alert and had residue on the inside cheek of the left side of his mouth, and it matched the food material FM 2 was holding in a napkin.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>ST 1 stated he sat the resident up, and he removed the remaining food in the resident's mouth. ST 1 stated the resident was so lethargic he was not efficient enough to take a diet by mouth. ST 1 stated he turned to the charge nurse and informed her to alert the resident's physician and the charge nurse indicated she could start IV fluid. ST 1 stated the resident was not alert enough and unable to sustain alertness ST 1 informed FM 1 and FM 2 that Resident 1 was deemed not safe to eat and expressed concerns to the resident's family and the charge nurse that the resident currently had no means to eat. ST 1 stated the charge nurse would notify the doctor. ST 1 stated when a resident receives an order for a ST evaluation, the speech therapists receive a schedule and residents are usually seen the same day.</p> <p>A review of the National Foundation of Swallowing Disorders document titled, Caregiver's guide to Dysphagia in Dementia, dated [DATE], indicated among the many problems seen in individuals with dementia, there is growing evidence and concern regarding the presence of eating and swallowing disorders in this population, also known as dysphagia. The presence of dysphagia in individuals with dementia can lead to serious consequences such as weight loss, malnutrition and dehydration; all of which can lead to other serious medical complications in older adults. It can also lead to lung-related complications such as aspiration pneumonia, which may cause the person to be hospitalized and even become life-threatening. In individuals with Alzheimer's disease (dementia), pneumonia accounts for nearly 70% of the causes of death.</p> <p>During an interview and concurrent record review on [DATE] at 11:51 a.m. with Registered Nurse (RN) 1, Resident 1's medical record was reviewed. RN 1 stated and confirmed Resident 1 had difficulty swallowing and would pocket food. RN 1 stated Resident 1 should have been monitored for pocketing food after each meal and the difficulty swallowing and pocketing food should have been care planned. RN 1 reviewed Resident 1's medical record and stated the speech therapist initiated a care plan for dysphagia on [DATE] (after the SBAR on [DATE]). RN 1 stated there was no documentation that indicated Resident 1 was monitored for pocketing of food prior to [DATE]. RN 1 stated the care plan was the guide and intervention necessary for how the resident needs to be cared for. RN 1 stated if a resident has difficulty swallowing and pockets food, and there was no care plan for the difficulty swallowing or pocketing of food, this could possibly harm the resident and put the resident at risk for choking and aspiration.</p> <p>During an interview and concurrent record review on [DATE] at 12:29 p.m., with the Director of Rehab (DOR), Resident 1's medical record was reviewed. The DOR stated Resident 1 had orders for a speech therapy evaluation dated [DATE] and was seen for evaluation on [DATE]. The DOR stated Resident 1 should have been seen earlier, on [DATE] or [DATE], and that there was a delay in Resident 1 receiving a speech therapy evaluation. The DOR stated a delay in a speech therapy evaluation could put the resident at risk for harm given the medical conditions. The DOR stated an evaluation would determine if the resident had a skilled need for an intervention, proper diet, or assistance.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:16 p.m., during an interview and concurrent record review with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated and confirmed that for Resident 1, both the difficulty swallowing, and the pocketing of food should have been care planned. The DON stated she did not see any care plan for Resident 1's difficulty swallowing or pocketing of food. The DON stated the care plan was the foundation in providing and meeting the needs of the resident. The DON stated Resident 1 should have been monitored for episodes of pocketing of food when the physician orders were received on [DATE]. The DON stated if a resident was pocketing food the resident should have been monitored after every meal because they were at a risk for choking and aspiration. The DON further stated Resident 1 had a delay in treatment for his speech therapy evaluation and the physician's orders for a speech therapy evaluation were received on [DATE], the resident should have been seen sooner than [DATE].</p> <p>During an interview on [DATE], at 12 pm, when asked why the facility staff called the ambulance vs. calling 911, the Director of Staff Development had no answer, then stated the resident was transferred via 911.</p> <p>During an interview on [DATE], at 12:20 pm, when asked should the facility staff have called 911 vs. the ambulance, the DON stated, Absolutely, based on the resident's needs.</p> <p>A review of the facility's policy and procedure titled, Care Planning Policy, dated [DATE], indicated all residents will have a comprehensive care plan to meet their individual needs that is prepared by the Interdisciplinary Team (IDT) within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments. Preliminary care plans are used until the comprehensive care plan has been completed.</p> <p>A review of the facility's policy and procedure titled, Specialized Rehab Services, dated [DATE], indicated it was the policy of the facility to ensure specialized rehab services, including physical, occupational, speech-language pathology, and respiratory therapy were provided, as required, based upon the resident's comprehensive plan of care.</p> <p>A review of the facility policy titled, Supporting Activities of Daily Living (ADLs), revised on ,d+[DATE] indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:</p> <ul style="list-style-type: none"> a. Hygiene (bathing, dressing, grooming and oral care) b. mobility (transfer and ambulation, including walking) c. elimination (toileting) d. dining (meals and snacks) e. communication (speech, language and any functional communication systems). <p>The policy indicated interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, stated goals and recognized standards of practice. The resident's response to interventions will be monitored, evaluated and revised as appropriate.</p>		