STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185220	A. BUILDING _____ B. WING _____	**05/31/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF NICHOLASVILLE	**100 SPARKS AVENUE NICHOLASVILLE, KY 40356**

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 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the American Nurse's Association, Principles of Nursing Documentation, dated [DATE], and review of the Clinical Nursing Skills Technique eighth (8th) edition, dated [DATE], revealed it was determined the facility failed to ensure services provided meet professional standards of quality for one (1) of four (4) sampled Residents (Resident #1). Interviews with staff revealed Registered Nurse (RN) #1, documented a Departmental Note in Resident #1's medical record on [DATE], under the name of Licensed Practical Nurse (LPN) #1, instead of starting a new entry under her own name. The findings include: Review of the American Nurse's Association, Principles of Nursing Documentation, dated [DATE], revealed entries into organization documents or the health record (including but not limited to provider orders) must be authenticated; meaning, the information was truthful, the author was identified, and nothing had been added or inserted; and must be dated and time-stamped by the person who created the entry. Interview on [DATE] at 4:52 PM, with the Director of Nursing (DON), revealed the facility did not have a policy related to documentation, and used the Clinical Nursing Skills Technique eight (8th) edition, dated [DATE], for their resource for documentation. Review of this resource under Perry and Potter, titled Documentation and informatics, revealed a section titled, use of the electronic record, which stated the following: sign on to the electronic health record using only the password, never share passwords, keep passwords private, and sign off when leaving the computer. Further review under the section titled legal guidelines, revealed chart only for yourself, you are accountable for information that you enter into a chart, never chart for someone else. Further review revealed the exception would be if a caregiver had left the unit for the day and called with information that needed to be documented, which would include the name of the source of information in the entry, and that the information was provided via telephone. Review of Resident #1's Departmental Notes, dated [DATE], signed by Licensed Practical Nurse (LPN) #1, revealed Resident #1 was found unresponsive setting in his/her chair at approximately 11:45 AM, and staff alerted said nurse and other staff members of resident's condition. Per the Note, prior to being found in this condition staff stated that he/she was sitting in his/her chair watching TV. There was ice cream that was opened on his/her bedside table that appeared to have some missing. Further review, revealed the resident was still seated in his/her wheelchair at the time with no success for several thrusts. Continued review of the Note, revealed the Registered Nurse (RN) instructed staff to transfer the resident to bed, and once the resident was in the bed, a mouth sweep was done by RN with no results. Per the Note, the resident took approximately three (3) agonal respirations (gasping irregular respirations) once he/she was transferred to the bed, and the resident's pulse check was performed by the RN with no pulse felt. According to the Note, the resident had a Do Not Resuscitate (DNR) Advanced Directive, so Cardiopulmonary Resuscitation (CPR) was not initiated. Further review, revealed the nurses then immediately auscultated heart rate (HR) and respirations for approximately two (2) minutes with no heart beat or respirations heard, and the RN called time of death (TID) TOD at 11:57 AM. Continued review of the Note, revealed the Power of Attorney (POA) was called at 12:03 PM, and a message was left to return the call. The Note revealed the POA was notified several different times during the span of the initial call, until the funeral home was called, and the Funeral Home was notified at 12:45 PM. Per the Note, the Coroner's Office was notified of the resident's passing at 12:30 PM. According to the Note, Post mortem care was completed by staff, the funeral home representative arrived at the facility at 1:47 PM, and the resident's body was released. Interview on [DATE] at 2:23 PM, with LPN #1, revealed she called RN #1 to inquire how to spell, [MEDICATION NAME] Maneuver, and RN #1 told her not to finish writing the Nurse's Note until she came to Unit B. LPN #1 revealed RN #1 came to the unit, and started telling her how to write the Note, then took over writing the Note herself. LPN #1 stated her Note was re-written by RN #1. She revealed the first line of the Note, and up to the part of the Note that stated, Prior to being found, was the only part of the note that was written by her, which was two (2) lines. Further interview, revealed the remainder of the Note was written by RN #1. LPN #1 stated RN #1 did not start a new Note when she came to the unit, and wrote the Note under LPN #1's name. Additional interview on [DATE] at 4:19 PM, with LPN #1, revealed she did not ask RN #1 to write the nurse, and stated she was capable of writing her own Note because she was assigned to Resident #1. LPN #1 stated she should have signed out and insisted RN #1 write the Note under her own name. Further interview with LPN #1, revealed this was very unprofessional for both of them, and there was no way of proving she did not write the Note. Interview on [DATE] at 11:40 AM, with RN #1, revealed LPN #1 called her over to review her note and when she looked at the Note there was some discrepancies. She revealed she responded to the emergency call received regarding Resident #1 and was able to chart with knowledge of what transpired with the resident. She revealed she did have LPN #1 to move over and she wrote the Note herself. She stated, it was faster than telling her what to write. Additional interview with RN #1 revealed she should have started her own Note and it was not the professional thing to do, charting under another nurse's name. Continued interview on [DATE] at 4:52 PM, with the DON revealed she expected nurses to chart under their own name and never to chart under another nurse's entry. The DON stated that's nursing 101. Additional interview with the DON revealed this was highly unprofessional and created a Note which could not be authenticated as the words of the nurse who signed the entry. Interview with the Administrator, on [DATE] at 5:02 PM, revealed it was her expectation that nurses chart and be responsible for their own Notes in the medical record. She further revealed it was improper and unprofessional to document in the medical record under someone elses signature.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Centers for the Medicare and Medicaid Resident Assessment Instrument (RAI) Version 3.0 Manual, dated [DATE], it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for one (1) of four (4) sampled residents (Resident #1). Resident #1's Comprehensive Plan of Care, reviewed [DATE], revealed the resident was at risk for altered nutritional status related to receiving a mechanically altered pureed diet for a [DIAGNOSES REDACTED]. However, on [DATE] at approximately 11:30 AM, Resident #1 received fish that was not properly pureed and the resident was left alone in his/her room

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) unsupervised. At approximately 11:45 AM to 11:55 AM, Resident #1 was found to be unresponsive and cyanotic and staff performed the [MEDICATION NAME] Maneuver without success. Resident #1 expired on [DATE] at 11:57 AM. The facility's failure to ensure each resident's written care plan interventions were implemented has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. The facility provided an acceptable credible Allegation of Compliance (AOC) on [DATE], with the facility alleging removal of the Immediate Jeopardy on [DATE]. Based on the validation of the AOC, on [DATE], the State Agency verified the deficient practice was corrected on [DATE], prior to the initiation of the investigation on [DATE]; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Interview with the Director of Nursing (DON) on [DATE] at 12:50 PM, revealed the facility had no policy related to following the care plan, and utilized the RAI Manual. Review of the Centers for the Medicare and Medicaid Resident Assessment Instrument (RAI) Version 3.0 Manual, dated [DATE], chapter four (4.7), revealed, the Comprehensive Care Plan was an interdisciplinary communication tool, and must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Further review, revealed the services provided or arranged must be consistent with each resident's written plan of care. Review of Resident #1's clinical record, revealed the facility admitted the resident on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), indicating the resident was severely cognitive impaired. Further review of the MDS, revealed the facility assessed Resident #1 as requiring supervision with meals (oversight, encouragement, or cueing) with the support of one (1) person physical assist, and as receiving a mechanically altered diet. Review of the Comprehensive Plan of Care, dated [DATE], revealed Resident #1 was at risk for altered nutritional status related to receiving a mechanically altered diet-pureed (cooked food that has been blended to the consistency of a soft creamy paste or thick liquid), for a [DIAGNOSES REDACTED]. The goal revealed the resident's weight would remain stable with no signs and symptoms of dehydration. There were several Care Plan interventions including: observe for acute changes with difficulty swallowing; provide tray set up and supervise as needed; nosey cup (cups with a cut out on the non-drinking side so they may be tilted without interference by the nose) as ordered; report signs and symptoms of Pneumonia/Aspiration; observe for any acute signs and symptoms or difficulty swallowing and report promptly if noted; and provide diet, and snacks as ordered. The care plan was reviewed on [DATE]. Review of the Speech Therapist Progress and Discharge Summary, dated [DATE], revealed Resident #1's diet recommendations were for Puree Texture and Honey thick Liquids. Further review revealed the resident was to be out of bed positioned at ninety (90) degrees for all meals and to remain upright for at least ninety (90) minutes to decrease risk of aspiration, and should remain under standard aspiration precautions. Review of Resident #1's physician's orders [REDACTED]. Review of the Departmental Note, dated [DATE], at 1:27 PM, signed by LPN #1, revealed Resident #1 was found unresponsive in his/her chair with head down at approximately 11:45 AM, and staff alerted nurses and other staff members of the resident's condition. Further review of the same Note revealed prior to being found in this condition, staff stated that the resident was sitting in his/her chair watching television. The Note revealed there was ice cream that was opened on his/her table that appeared to have some missing. Per the Note, the nurses and Registered Nurse (RN) from the other hall performed the [MEDICATION NAME] Maneuver in case of possible choking, and the the resident was still seated in his/her wheelchair at the time with no success for several thrusts. Continued review of the Note, revealed the RN instructed staff to transfer the resident to bed, and once in the bed a mouth sweep done by RN with no results. Per the Note, Resident #1 expired on [DATE] at 11:57 AM. Interview on [DATE] at 3:32 PM, with Certified Medication Technician (CMT) /Certified Nursing Aide (CNA) #6, revealed on [DATE] the Administrator called her name and stated help me, help me, which was about 11:55 AM. CMT/CNA #6 revealed when she looked at Resident #1 he/she was already blue (cyanotic-the appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation). CMT/CNA #6 revealed the Administrator told her, it was all my fault, I did it. CMT/CNA #6 further revealed she asked the Administrator what she did, and the Administrator pointed to the table. Continued interview with CMT/CNA #6, revealed she saw a one half (,[DATE]) of a McDonald's fish sandwich in a box, which was described in regular food form, not pureed, which was pointed out by the Administrator. Interview on [DATE] at 3:32 PM, with CNA #7, revealed she witnessed the Administrator come in the facility with a McDonalds's bag in her hand. CNA #7, further revealed when they transferred Resident #1 from the wheelchair to the bed, she noticed the wheelchair was full of fish crumbs. Per interview, she heard the Administrator say, do something, do something, it's all my fault. Interview on [DATE] at 2:23 PM, with LPN #1, revealed the Administrator was very upset and kept repeating, it's my fault I gave him/her a fish sandwich. Further interview on [DATE] at 4:19 PM with LPN #1, revealed Resident #1's care plan was not followed on [DATE] because Resident #1 received food that was not prescribed. Interview on [DATE] at 3:22 PM, with CNA #4, revealed on [DATE] she entered Resident #1's room as RN #1 and CNA #7 were transferring the resident to bed. CNA #4 revealed, there was fish still on his/her wheelchair. appropriate for individuals on a pureed diet Frozen Dessert Frozen DessertInterview on [DATE] at 2:51 PM, with CNA #3, revealed on [DATE]. she did not see the Administrator bring in the fish sandwich; however, she observed fish crumbs in Resident #1's wheel chair and the resident was already gone (deceased) by the time she got to the room. Interview on [DATE] at 11:40 AM, with RN #1, revealed when she entered the resident's room she did not see any remains of a fish sandwich when she entered the room on [DATE]. Interview on [DATE] at 3:04 PM, with the Speech Therapist (ST), revealed Resident #1 was on a pureed diet and honey thick fluids. Per interview, mashing up fish and putting honey thick liquids on the fish was definitely not pureed food and pre-made thickened water should never be mixed with any type of food. She further stated under no circumstances would cutting up the food and adding honey thick liquids be the same as pureed food. Per interview, pureed food was a blended diet very smooth, like pudding and apple sauce, and Resident #1 should not have received any type of food unless it came from dietary. The ST stated, aspiration was always a concern when there was variance in the mechanically altered diet. Interview on [DATE] at 4:21 PM, with the Dietary Manager (DM), revealed the dietary department did not serve fish on [DATE]. The DM revealed Resident #1's food had to be blended to a creamy like texture as per the prescribed Pureed diet. Continued interview, revealed Resident #1 should not have received food outside the kitchen, and mixing honey thickened water to fish was not the same as pureed food. Per the DM, the fish would still have lumpy like constancy and that was not pureed consistency. The DM revealed the physician's orders [REDACTED]. Interview on [DATE] at 3:06 PM, with the Consultant Registered Dietitian (RD), revealed Resident #1's diet recommendations came from the ST and she followed the ST's recommendations. Per the RD, when a resident was on a pureed diet it was a blended textured food and needed to be prepared only in the kitchen. She further stated fish mashed up with honey thickened liquids added was not the same consistency as pureed food and should not be given to a resident on a pureed diet. The RD stated, doing this would possibly cause choking or aspiration. The RD revealed the DM was responsible for updating the care plan and there was not an intervention on the care plan related to receiving food outside of the dietary department. Additional interview revealed if Resident #1 received food that was not pureed the care plan was not followed. Interview on [DATE] at 1:26 PM with the MDS Coordinator, revealed the Care Plan was a guide for the staff to follow in caring for the residents and the Administrator did not follow the care plan or the physician's orders [REDACTED].#1 food which was not prescribed. Interview on [DATE] at 12:50 PM with the DON, revealed the Administrator gave the resident the fish out of the goodness of her heart, it was an error in judgment, and Resident #1 was placed at risk by the facility not following his/her prescribed diet. Additional interview on [DATE] at 4:52 PM, with the DON, revealed she expected everyone to follow the physician's orders [REDACTED].

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) Interview on [DATE] at 12:45 PM, with the Administrator, revealed , she was the Manager on Duty for [DATE], and on [DATE] at 11:15 AM, she left the facility to get the fish sandwich, and gave Resident #1 the fish at 11:30 AM. She stated she was aware of Resident's #1's orders for a pureed diet, and took the bread off the fish and mashed the fish to what she thought was oatmeal consistency, thinking Resident #1 would be able to consume the fish. She revealed Resident #1 was in his/her room when she left the resident unsupervised with the fish. Per interview with the Administrator, when she came back to Resident #1's room to check on him/her at 11:45 AM, she found him/her slumped over in his/her wheelchair. Additional interview on [DATE] at 5:02 PM with the Administrator, revealed she did not follow the care plan as she did not provide the resident the diet prescribed when she gave the resident the fish, and it was important to review the care plans before providing care for a resident. The facility provided an acceptable credible allegation of compliance (AOC) on [DATE] that alleged removal of Immediate Jeopardy (IJ) effective [DATE]. Review of the AOC revealed the facility implemented the following: 1. Resident #1 expired on [DATE]. 2. On [DATE], the RVP notified the ADON of the sister facility to initiate an action plan to identify all residents on a modified texture diet ensuring the physician's orders [REDACTED]. This was completed by the ADON of the sister facility using the Diet Audit Tool. 3. On [DATE] the SDCO/APRN implemented an immediate education tool , the Nicholasville Quality Focused Team Member in-service, for the Administrator and the DON regarding modified textures diets. 4. On [DATE] all departments in the facility received in-services on modified textured diets, thickened liquids and care plan compliance by the DON and Speech Therapist. 5. On [DATE], the Educational Tool Nicholasville Quality Focused Team Member in-service was added to the new hire orientation packet. 6. On [DATE], the facility continued Quality Assurance (QA) audits to ensure system compliance initiated on [DATE] and continued through [DATE], by the management team of the facility. 7. The Quality Assurance Performance Improvement (QAPI) committee met on [DATE] with the attendance of the Administrator, Director of Nursing (DON), Dietary Manager (DM) and Medical Director (MD) via phone. 8. On [DATE], random team members across all departments were questioned about their knowledge of provision of correct consistency of food and liquids using the QAPI questionnaire document. 9. Questionnaires have been and will continue to be completed by members of the QAPI team which includes the Administrator, DON, Assistant Director of Nursing (ADON), regional support team members and the DM. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Resident #1 received food that was not of part of the pureed diet in which the resident was prescribed, on [DATE] at 11:30 AM, and was found unresponsive at 11:55 AM, with time of death called at 11:57 AM. 2. Review of the Physician order [REDACTED]. Review of the Diet Audit, validated the Care Plan, SRNA Care Guide, and Meal Tray Ticket were accurate compared to the physician's orders [REDACTED]. 3. Review of the re-education tool, Nicholasville Quality Forced Team Member in-service attendance record sheet, dated [DATE] validated signatures of the SDCO/APRN, DON and the Administrator. Review of the Nicholasville Quality Focused Team Member in-service, revealed the in-service titled modified textured diets, contained information defining each modified diet. The two (2) modified diets listed were Mechanical soft and Pureed Diet. The in-serviced also included education on thicken liquids; Honey, Nectar, and Pudding. Continued review of the in-service revealed all modified textured diets were prepared in the kitchen as they had the equipment necessary to grind, blend and mash foods to the recommendation textures. Additional review of the in-service revealed there were three (3) types of thickened liquids served in the facility, Nectar-like thicken, Honey-like and Pudding-thick liquid. Interview on [DATE] at 12:30, with the Administrator and [DATE] at 12:50 PM, with the DON, confirmed they received the in-services presented by the SDCO/ARNP and were able to voice the two (2) types of mechanical altered diets as well as the three (3) types of thickened liquids. 4. Review of the in-service Attendance Record dated [DATE], validated each department's signatures for the in-service given by the DON and the Speech Therapist on Modified texture diets, Thickened liquids, and Care Plan compliance. Further review revealed the departments listed on the in-service sign in list included: Therapy department, Activity department, Housekeeping department, Dietary department, and Nursing department. Interview on [DATE] at 2:30 PM with CNA #1, [DATE] at 2:40 PM with CNA #2, [DATE] at 2:51 PM with CNA #3, [DATE] at 3:22 PM with CNA #4, [DATE] at 3:32 PM with CNA #5, [DATE] at 3:43 PM with CNA #6, [DATE] at 2:58 PM with CNA #7, [DATE] at 2:23 PM with LPN #1, [DATE] at 12:30 PM LPN #2, [DATE] at 12:58 PM with CNA #9, [DATE] at 2:52 PM with the Activity Supervisor, [DATE] at 3:58 PM with Housekeeping #1, [DATE] at 4:02 PM with Housekeeping #2, [DATE] at 4:07 PM with Dietary Aide #1, [DATE] at 4:11 PM with Dietary aide #2, [DATE] at 4:14 PM with the Physical Therapist (PT), and [DATE] at 4:28 PM with Occupational Therapist (OT), revealed they had received an in-service on mechanical soft and pureed diet textures and different types of thickened liquids; and they were able to explain the difference between the two (2) textured foods and name the thickened liquids. 5. Review of the New Hire Orientation Packet, validated the addition of the Nicholasville Quality Focused Team Member in-service. Interview on [DATE] at 12:13 PM with the SDCO/APRN, revealed the teaching tool was added; however, at the time the four (4) point plan was developed, no new employees had started at the facility. 6. Review of the diet and meal delivery audits tool first initiated by the ADON on [DATE], validated the audits continued to include date of audit, meal served, name of auditor, area monitored, if all meals were served accurately based on Physician orders, and if orders were followed for thickened liquids. Review of each area was documented by the auditors and if there was recorded variances, it was documented what the variances were. Observation of the lunch meal service on [DATE] at 11:20 AM, of Resident #3 revealed he/she was on a mechanical soft diet and his/her meal card matched the Physician orders [REDACTED]. Continued observation of the lunch meal service, revealed Resident #4's meal card revealed he/she was on a regular texture diet and was validated as correct on the Physician orders [REDACTED]. 7. Review the QAPI Improvement Meeting sign-in sheet dated [DATE], validated the signature of the Administrator, the DON, the DM and Medical Director (MD) via phone. A review of the meeting agenda validated the subject covered was Modified Textured diets. 8. Review of the QAPI calendar titled, Ten Team Member Questionnaires per Week, validated two (2) questionnaires were completed on [DATE], nine (9) questionnaires were completed [DATE], fourteen (14) questionnaires were completed [DATE], seventeen (17) questionnaires were completed on [DATE]. one (1) questionnaire was completed on [DATE], ten (10) questionnaires were completed on [DATE] and two (2) questionnaires were completed on [DATE]. Additional review revealed the questionnaires completed correlated with the QAPI calendar number of employees that received the QAPI questionnaires quiz with answers attached. Interview on [DATE] at 2:52 with the Activity Supervisor, [DATE] at 3:03 with CNA #5, [DATE] at 3:09 with CNA #2, [DATE] at 3:10 with CNA #1, [DATE] at 3:27 PM with RN #2, [DATE] at 3:37 with CNA #4, [DATE] at 3:58 PM with Housekeeping #1, [DATE] at 4:02 PM with Housekeeping #2, [DATE] at 4:07 PM with Dietary Aide #1, [DATE] at 4:11 PM with Dietary Aide #2, [DATE] at 4:14 PM with the Physical Therapist (PT), [DATE] at 4:19 PM with LPN #1, and [DATE] at 4:28 PM with the Occupational Therapist (OT), revealed they received the QAPI questionnaire and were able to identify their names for the surveyor on the sign in sheet and on their test. 9. Interview on [DATE] with the DON, revealed the Administrator, the DM, the ADON from the sister facility, the regional support team, and herself, would continue to present the staff with the QAPI questionnaires. Further interview revealed the facility posted signs at each nurse's station and the front entrance alerting staff that no was to bring food into the facility, and if a family member brought in food, it was to be reported immediately. Observation [DATE] at 1:15 PM of the A and B wing nurses station, and the font door entrance validated the signs were posted. Interview on [DATE] at 5:02 PM, with the Administrator verified she planned to ensure the audits continued well

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) after the Plan of Correction (POC) was completed and accepted. Further interview revealed she would ensure everyone including herself would follow the four point plan and comply with the resident's ordered diets. Additional interview with the Administrator, revealed, the agenda for the next meeting had not been completed; however, the audits would be at the top of the list.
F 0367 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that special or therapeutic diets are ordered by the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Department of Health and Human Services National Institute on [DIAGNOSES REDACTED] and other Communication Disorders- Dysphasia, revised 03/09/16, review of the Dysphasia Resources for Professionals and Patients- Aspiration Precautions Policy undated, review of the facility's Therapeutic Diet Policy, effective 08/01/12, and review of the facility's investigation, it was determined the facility failed to provide a therapeutic diet in proper form as assessed by the Speech Therapist and prescribed by the Physician for one (1) of four (4) sampled residents (Resident #1). On 05/07/16, at approximately 11:30 AM, the Administrator brought a fish sandwich to Resident #1, removed the bread, mashed up half of the fish, and added thickened water. The fish was not prepared in the Dietary department and was not properly pureed (cooked food that has been blended to the consistency of a soft creamy paste or thick liquid), and the resident was not supervised to ensure he/she did not aspirate or choke. At approximately 11:45 to 11:55 AM, the resident was found to be unresponsive and cyanotic (the appearance of a blue or purple coloration of the skin or mucous membranes due to the tissues near the skin surface having low oxygen saturation), and the [MEDICATION NAME] Maneuver was attempted without success. Resident #1 expired in the facility at 11:57 AM. The facility's failure to provide a therapeutic diet in proper form as assessed by the Speech Therapist and prescribed by the Physician has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 05/27/16, and determined to exist on 05/07/16. The facility was notified of the Immediate Jeopardy on 05/27/16. The facility provided an acceptable credible Allegation of Compliance (AOC) on 05/31/16, with the facility alleging removal of the Immediate Jeopardy on 05/20/16. Based on the validation of the AOC, on 05/31/16, the State Agency verified the deficient practice was corrected on 05/20/16, prior to the initiation of the investigation on 05/26/16; therefore, it was determined to be Past Immediate Jeopardy. The findings include: Review of the Department of Health and Human Services National Institutes of Health-National Institute on [DIAGNOSES REDACTED] and other Communication Disorders- Dysphasia, revised 03/09/16, revealed Dysphasia occurred when there was a problem with the neural control or the structures involved in any part of the swallowing process. Weak tongue or cheek muscles may make it hard to move food around in the mouth for chewing. Food pieces that are too large for swallowing may enter the throat and block the passage of air. In addition, when foods, air, and liquids entered the airway of someone who had dysphasia, coughing or throat clearing sometimes could not remove it. Swallowing disorders may also include the development of a pocket outside the esophagus caused by weakness in the [MEDICAL CONDITION] wall. Further review, revealed the esophagus may also be too narrow, causing food to stick. Review of the Dysphasia Resources for Professional and Patients- Aspiration Precautions Policy, undated, revealed all licensed and unlicensed personnel caring for inpatients must be informed of a patient at risk for aspiration and its complications. Personnel will be instructed in, and take appropriate precautions. Further review, revealed aspiration was a misdirection of foreign materials (oropharyngeal bacteria, food, liquids or regurgitated gastric contents) into the larynx and lower respiration tract. Review of the facility policy titled Therapeutic Diets dated 08/01/12, revealed, it was the policy of the facility to provide therapeutic diets when prescribed by the attending physician and to serve diets as ordered. Review of Resident #1's medical record, revealed the facility admitted the resident on 12/23/14 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15), indicating the resident was severely cognitive impaired. Continued review of the MDS, revealed the facility assessed Resident #1 as requiring supervision with meals (oversight, encouragement, or cueing) with the support of one (1) person physical assist, and as receiving a mechanically altered diet. Review of the Comprehensive Care Plan, dated 12/23/14, revealed Resident #1 was at risk for altered nutritional status related to receiving a mechanically altered diet-pureed for a [DIAGNOSES REDACTED]. The Care Plan goal revealed the resident's weight would remain stable with no signs and symptoms of dehydration. There were several Care Plan approaches including: observe for acute changes with difficulty swallowing; provide tray set up and supervise as needed; nosey cup (cups with a cut out on the non-drinking side so they may be tilted without interference by the nose) as ordered; report signs and symptoms of Pneumonia/Aspiration; observe for any acute signs and symptoms or difficulty swallowing and report promptly if noted; and, provide diet and snacks as ordered. The care plan was reviewed on a quarterly review dated 06/25/15. Review of the Hospital Report of Consultation, dated 10/26/15 revealed the patient presented with moderate Oropharyngeal Dysphasia. Further review, revealed the recommendations included: 1) Puree diet with nectar liquids 2) medication crushed in puree, and 3) ninety (90) degrees for all PO (by mouth) foods. Review of the Speech Therapist Progress and Discharge Summary, dated 01/06/16, revealed the resident was discharged back to the skilled nursing facility (SNF) with recommendations to continue current dietary orders and recommendations for Puree Texture and Honey thick Liquids. Further review revealed the resident was to be out of bed positioned at ninety (90) degrees for all meals and to remain upright for at least ninety (90) minutes to decrease risk of aspiration, and the resident should remain under standard aspiration precautions. Review of the Physician's orders dated May 2016, revealed orders for a pureed diet, honey thickened liquids, no straws, nosey cup for all meals, and to keep upright in the chair at least ninety (90) minutes following all meals. Review of the facility's Quality Assurance Document-Investigation Template dated 05/17/16, revealed under Description of the Allegation: a paragraph from a Topix Posting (forum website) by Concerned. Review of the Topix Posting, revealed the Administrator of the facility gave a resident a fish sandwich who was supposed to be on a pureed diet, and apparently the patient choked to death. Continued review revealed it was heard the Director of Nursing (DON) and nurses tried to cover it up by documenting the resident choked on ice cream, and something needed to be done. Further review of the facility's Quality Assurance Document-Investigation Template revealed under the heading titled Investigation Summary, revealed upon resident request, the Administrator brought a fish sandwich to the resident, on 05/07/16 at 11:30 AM. The Administrator removed the bread and mashed up half of the fish, also adding thickened (honey) water to the fish patty making it the consistency of oatmeal. The resident had a food tray from lunch still in the room at this time, and the resident always fed self. After consuming the fish the resident was noted to be sitting up in his/her chair in his/her room watching Television (TV) and his/her lunch tray was picked up, and no one at this time noted the resident to be in distress. Further review of the Investigation Summary, revealed at 11:55 AM the Administrator went back down the hallway and looked in the room and saw the resident slumped over and noticed all food items were removed from the resident's room. The Administrator called for assistance and the CMA came and was unable to assist so she sent the CNA (Certified Nursing Assistant) to get the Licensed Practical Nurse (LPN) who was assisting with lunch. During this time the CMA and CNA assisted the Administrator with performing the [MEDICATION NAME] maneuver (abdominal thrusts used to treat upper airway obstruction or choking by a foreign object), while the LPN went to get the Registered Nurse (RN). Further review revealed the Administrator was Cardiopulmonary Resuscitation (CPR) certified, and the [MEDICATION NAME] Maneuver produced no food or other object of obstruction. Continued review of the Investigation Summary, revealed when the RN entered the room, she requested the resident to be placed on the bed for a better exam. A finger sweep (technique of clearing a mechanical obstruction from the upper airway of an unconscious patient) was performed by the RN with no discovery of food, food particles, only clear saliva. The RN requested the LPN to go verify CODE status. Once the resident was in the bed, the RN noted three (3) agonal breaths (sporadic gasping breaths) and then complete respiration and cardiac cessation which was noted to occur at 11:57 AM. Further review, revealed code status was confirmed by the LPN as a Do Not Resuscitate (DNR), and the RN pronounced the

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F 0367 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) resident deceased at 11:57 AM. Review of the Departmental Note, dated 05/07/16, at 1:27 PM, signed by LPN #1, revealed Resident #1 was found unresponsive in his/her chair with head down at approximately 11:45 AM. Staff alerted nurses and other staff members of the resident's condition. Further review of the same Note revealed prior to being found in this condition staff stated that he/she was sitting in his/her chair watching television. The Note further revealed there was ice cream that was opened on his/her table that appeared to have some missing. Continued review revealed the nurses and a RN from the other hall performed the [MEDICATION NAME] maneuver in case of possible choking. Per the Note, the resident was still seated in his/her wheelchair at the time with no success for several thrusts. Continued review of the Note, revealed the RN instructed staff to transfer the resident to the bed, and once the resident was on the bed a mouth sweep done by RN with no results. Continued review of the Note, revealed the resident took approximately three (3) agonal respirations once he/she was transferred to the bed, and the resident's pulse check was performed by the RN with no pulse felt. Per the Note, the resident had a Do Not Resuscitate (DNR) Advanced Directive, so Cardiopulmonary Resuscitation (CPR) was not initiated. Continued review, revealed the Nurses then immediately auscultated heart rate (HR) and respirations for approximately two (2) minutes with no heart beat or respirations heard, and the RN called time of death (TOD) at 11:57 AM. Telephone Interview on 05/26/16 at 12:14 PM with Resident #1's Former Case Manager (FCM), revealed he was Resident #1's case Manager through Pre-admission Screening and Resident Review (PASRR); however, in 2012 he changed companies and was no longer over his/her case. The FCM revealed Resident#1 had been in the hospital for problems with swallowing and dysphasia, and that was the main reason for the referral to the nursing home in 2014. Continued interview with the FCM revealed he continued to be very active in Resident #1's care and attended his/her care plan meetings, even though he was no longer the resident's FCM. The FCM revealed he was informed of Resident #1's death and was shocked to hear how he/she expired. Further interview with the FCM, revealed he was informed by a staff member that was not present on 05/07/16, that the Administrator gave the resident a fish sandwich and the staff member was afraid to state his/her name for fear of retaliation from the facility. Interview on 05/26/16 at 3:32 PM, with Certified Medication Technician (CMT) /Certified Nursing Aide (CNA) #6, revealed she was working on 05/07/16 and went to the kitchen to ask the cook for Ice cream for Resident #1. She stated the cook informed her Resident #1 was on thickened liquids and could not have ice cream, but could have a Magic Cup (Frozen Desert appropriate for individuals on a Pureed diet). She stated she placed the Magic Cup on the resident's table, opened it for the resident, and left the room, leaving the unit to get food for herself. Further interview, revealed upon her return she heard the Administrator call her name and state help me, help me, which was about 11:55 AM. CMT/CNA #6 revealed when she looked at Resident #1 he/she was already blue (cyanotic). Continued interview with CMT/CNA #6 revealed the Administrator told her, it was all my fault, I did it. CMT/CNA #6 revealed she asked the Administrator what she did, and the Administrator pointed to the table. Further interview with CMT/CNA #6, revealed she saw a one half (1/2) of a McDonald's fish sandwich in a box, which was described in regular food form, not pureed, and she would not have noticed except it was pointed out by the Administrator. She stated she told LPN #1 and CNA #7 and they went to the room, and LPN #1 attempted to do the [MEDICATION NAME] Maneuver with the resident being lifted by two (2) staff. Additional interview with CMT/CNA#6, revealed she went for help when RN #1 came and called the time of death. Further interview with CMT/CNA #6 revealed when she stepped back into the room the half (½) fish sandwich was gone. CMT/CNA #6 revealed I can't tell you what actually caused his/her death; however, I know it was not ice cream, and I saw the half fish sandwich on the table. Interview on 05/26/16 at 3:32 PM, with CNA #7, revealed she was working on 05/07/16 and was the CNA assigned to Resident #1. CNA #7 revealed before her break, she witnessed the Administrator come in the facility with a McDonalds's bag in her hand and when she returned from her break, CNA #8 called to her, and told her to check on Resident #1. Continued interview with CNA #7, revealed when she entered Resident #1's room, the resident was slumped over in the wheelchair and was blue (cyanotic). She stated RN #1 instructed her to get on the other side of Resident #1 and hold him/her with LPN #1, while RN #1 performed the abdominal thrust. CNA#7 revealed they had a problem holding the resident up in performing the [MEDICATION NAME] Maneuver and they moved Resident #1 from the wheelchair to the bed. Additional interview with CNA #7, revealed when they moved Resident #1 from the wheelchair to the bed, she noticed the wheelchair was full of fish crumbs. Per interview, due to being upset about the resident, she didn't know if staff performed further finger sweeps or thrusts after the resident was in bed. She stated I never heard any sounds coming from Resident #1. Further interview with CNA #7, revealed she heard the Administrator say, do something, do something, it's all my fault. Interview on 05/27/16 at 2:23 PM, with LPN #1, revealed she was in the dining room with other residents when she was informed that something was happening on her floor. She revealed when she entered Resident #1's room, the Administrator, CMT/CNA #6, and CNA #7 were attempting the [MEDICATION NAME] Maneuver. LPN #1 stated RN #1 entered the room right behind her, and she and RN #1 attempted an abdominal thrust and could not get anything out. She stated the resident's lips were blue and he/she was not breathing. Continued interview with LPN #1, revealed Resident #1 was placed on his/her bed, and she was sent by RN #1 to get the Pulse Oximeter (a device that measures the oxygen saturation of arterial blood by utilizing a sensor attached typically to a finger). LPN #1 revealed when she returned, RN #1 stated she did a sweep of Resident #1's mouth; however, she did not witness the sweep nor did she witness breath sounds. Additional interview with LPN #1, revealed the Administrator was very upset and kept repeating, it's my fault I gave him/her a fish sandwich. Interview on 05/26/16 at 3:22 PM, with CNA #4, revealed she was present when Resident #1 died , but she was not assigned to the resident on that date. CNA #4 revealed she entered Resident #1's room as RN #1 and CNA #7 was assisting the resident to bed. She revealed RN #1 did a sweep of Resident #1's mouth; however, she did not witness an abdominal thrust being done. She stated after the finger sweep of the mouth, the RN pronounced the resident dead around 11:57 AM. Additional interview with CNA #4 revealed, there was fish still on his/her wheelchair; however, she did not see any ice cream. appropriate for individuals on a pureed diet Frozen Dessert Frozen DessertInterview on 05/26/16 at 2:51 PM, with CNA #3, revealed she was not assigned to Resident #1; however, did work on 05/07/16. She revealed she was told to get an oxygen (02) tank for the resident by RN #1. CNA #3 stated by the time she retrieved the tank and entered Resident #1's room, RN #1 was calling the time of death at 11:57 PM. Additional interview with CNA #3, revealed she did not see the Administrator bring in the fish sandwich; however, she observed fish crumbs in Resident #1's wheel chair and the resident was already gone (deceased) by the time she got to the room. Additional Phone interview with CNA #5, on 05/30/16 at 1:24 PM, revealed on 05/30/16 at approximately 1:15 PM, she was informed by RN #1 to say she did hear breaths coming from Resident #1 and to say she had witnessed the time of death. However, she stated she did not witness any breath sounds and she did not know who pronounced the resident's death or did not know the time of death, because Resident #1 was already deceased when she came into the room. Interview on 05/28/16 at 11:40 AM, with RN #1, revealed she was the charge nurse the weekend of 05/07/16, and was on the B wing when she received a call over the walkie-talkie related to Resident #1 being found unresponsive. She stated she grabbed her stethoscope and ran to the A Hall. RN #1 revealed when she entered Resident #1's room, LPN #1 and CMT/CNA #6 were holding the resident up out of the wheelchair while attempting the abdominal thrust without success, and she then attempted the abdominal thrust while the other staff held the resident up, without success. RN #1 revealed she then instructed staff to transfer Resident #1 to the bed and at that time she heard three (3) agonal breaths from the resident and she did a finger sweep with no foreign objects noted in the resident's throat. Further interview with RN #1, revealed CNA #5 was beside her, heard the breaths and was present when she called the time of death at 11:57 AM. Interview on 05/26/16 at 3:04 PM, with the Speech Therapist (ST), revealed Resident #1 was referred to her and the start of care date was 12/08/15 and end of care date was 01/06/16. She revealed the discharge instructions were made available for staff in her Progress and Discharge Summary. The ST stated her recommendations were to keep Resident #1 on a pureed diet and honey thick fluids as per her Discharge Summary. Further interview with the ST, revealed mashing up fish and putting honey thick liquids on the fish was definitely not pureed food and pre-made thickened water should never be mixed with any type of food. She stated pureed food must be completed in dietary with a special limit process, and under no circumstances would cutting up the food and adding honey thick liquids be the same as pureed food. Further interview revealed Pureed food was a blended diet very smooth, like pudding and apple sauce,

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F 0367 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) and Resident #1 should not have received any type of food unless it came from dietary. She stated aspiration was always a concern when there was variance in the mechanically altered diet. Post Survey interview with the ST on 06/07/16 at 10:48 AM, revealed standard precautions were used for every resident in the building which meant if a resident was seen having difficulty with coughing on liquids or foods, to alert the nurse and physician as needed. She stated Resident #1 was on standard precautions; however, was safe to be left alone to eat only with the diet and thickened liquids she had recommended for the resident, which was pureed diet and honey thickened liquids. Interview on 05/26/16 at 4:21 PM, with the Dietary Manager (DM), revealed Resident #1's food had to be blended to a creamy like texture as per the prescribed Pureed diet. Continued interview with the DM, revealed Resident #1 should not have received food outside the kitchen, and mixing honey thickened water to fish was not the same as pureed food. She revealed the fish would still have lumpy like constancy and that was not pureed consistency. Additional interview with the DM, revealed the recommendation of ST and Physician's orders should be followed for all special diets to ensure the correct consistency to prevent choking or any other concerns. Interview on 05/27/16 at 3:06 PM, with the Consultant Registered Dietitian (RD), revealed Resident #1's diet recommendations came from the ST and she followed the ST's recommendations. The RD revealed when a resident was on a pureed diet it was a blended textured food and needed to be prepared only in the kitchen. She stated fish mashed up with honey thickened liquids added was not the same consistency as pureed food and should not be given to a resident on a pureed diet. The RD revealed doing this would possibly cause choking or aspiration. Interview on 05/27/16 at 12:50 PM with the DON, revealed she was not in the building when Resident #1 expired; however, when the resident was found, the Resident's code status was checked and it was noted the resident was a Do not Resuscitate (DNR) code status. The DON revealed the facility did not report the death because they did not feel it was a reportable incident. However, after receiving training from the Service Director of Clinical Operations (SDCO)/Advance Practice Register Nurse (APRN) along with the Administrator, she realized Resident #1 should not have received the fish. Further interview, revealed although the Administrator gave the resident the fish out of the goodness of her heart, it was an error in judgment. The DON revealed Resident #1 was placed at risk by the facility not following his/her prescribed diet. Interview on 05/26/16 at 12:45 PM, with the Administrator revealed on 05/06/16 she had asked Resident #1 if he/she wanted a fish sandwich, and the resident said yes. She further stated she was the Manager on Duty for 5/07/16, and on 05/07/16 at 11:15 AM she left the facility to get the fish sandwich, and gave the resident the fish at 11:30 AM. The Administrator revealed she did not check with dietary or nursing; however, was aware of Resident's #1's orders for a pureed diet. Continued interview with the Administrator revealed she took the bread off the fish and mashed the fish to what she thought was oatmeal consistency and felt Resident #1 would be able to consume the fish. She revealed Resident #1 was in his/her room when she left the resident alone with the fish. Further interview with the Administrator, revealed she came back to Resident #1's room to check on him/her at 11:45 AM, and found him/her slumped over in his/her wheelchair. She revealed she called for help and CMT/CNA #6 and LPN #1 lifted the resident up from the wheelchair and she did the [MEDICATION NAME] Maneuver without any results. Further interview with the Administrator revealed she could not recall telling staff anything regarding it being her fault, and she spoke with RN #1 and was informed she was not at fault because when RN #1 performed a sweep of Resident #1's mouth, nothing was there. Continued interview with the Administrator, revealed the Topix Posting was found on 05/16/16, and she called her Regional Vice President (RVP) to inform her of the posting. Continued interview with the Administrator revealed she did not report to the RVP she gave Resident #1 the fish because she thought it was a sudden death as the RN had indicated. The Administrator revealed it was not until the Assistant Director of Nursing (ADON) from a sister facility was sent by the RVP to enquire about the posting, did corporate realize she gave the resident the fish. She stated on 05/17/16 the SDCO/APRN entered the building once the RVP realized the fish was not mechanically altered in the dietary department. Further interview with the Administrator revealed Resident #1 did not get the right type of food for his/her diet, and received food that was not mechanical altered in the kitchen. Interview on 05/26/16 at 5:08 PM, with the ADON from a sister facility, revealed the Administrator discovered the Topix Posting and she arrived at the facility 05/17/16 per request of the RVP. The ADON revealed she interviewed the staff regarding the Topix Posting and her role was to assist the DON with in-services. Interview on 05/29/16 at 12:13 PM with the RVP, revealed she was notified on 05/16/16 by the Administrator in regards to the Topic Posting and was not aware prior to that call of the incident. The RVP revealed she did not find out until 05/17/16 the food which was given to Resident #1 was not mechanically altered in the dietary department. She stated, We sent one of our nurses from another facility to come down and to see what physically was going on in the facility. Continued interview with the RVP revealed the Administrator gave the resident the fish out of the goodness of her heart, and immediately received re-education from the SDCO/APRN. The RVP revealed the incident was not reported because she did not fill it met any reportable requirements. She stated, they did not see any evidence of signs of her choking when they looked in his/her mouth, they did not see any food . Interview on 05/27/16 at 12:13 PM, SDCO/APRN, revealed she entered the building on 05/16/16 at 5:18 PM when the RVP notified her the fish Resident #1 consumed was not mechanically altered in the kitchen. Per the SDCO/APRN, the facility did not follow the resident's prescribed diet and did not contact the regional office of the incident until the Topix Posting. Additional interview with the SDCO/APRN revealed her main focus was to re-educate the Administrator and ensure she understood she placed the resident at risk by not following his/her ordered diet and plan of care. Interview on 05/29/16 at 8:10 PM, with Resident #1's Guardian, revealed she requested a test to see if Resident #1 could have other foods, and was informed by the Medical Director his/her diet needed to continue as a pureed diet and it was not in the resident's best interest to give him/her food alternate to the diet. The Guardian revealed she left the decision up to the Medical Director. Interview on 06/02/16 at 3:30 PM, with the Medical Director (MD), of the facility revealed he did not find out about the true nature of the concern until 05/19/16 by the DON, after they heard about the Topix Posting. He stated, prior to that I assumed his/her death was other medical issues, he/she was a DNR, so I didn't expect a report other than he/she expired in the facility. Continued interview revealed he was not immediately informed of the Administrator providing fish, and he would not have approved of Resident #1 receiving food alternate to his/her approved diet. Additional interview with the MD revealed there was a medical reason for Resident #1 to be on a pureed diet and the diet should have been followed related to physician's orders and ST recommendations. He stated, the Administrator should not have given him/her the fish; she was not the Power of Attorney (POA) or the dietary department. The MD revealed the facility did not follow proper protocol regarding this resident and they went against his orders. The facility provided an acceptable credible allegation of compliance (AOC) on 06/20/16 that alleged removal of Immediate Jeopardy (IJ) effective 05/31/16. Review of the AOC revealed the facility implemented the following: 1. Resident #1 expired on 05/07/16. 2. On 05/18/16, the RVP notified the ADON of the sister facility to initiate an action plan to identify all residents on a modified texture diet ensuring the Physician's orders, care plan and meal card correlated. This was completed by the ADON of the sister facility using the Diet Audit Tool. 3. On 05/18/6 the SDCO/APRN implemented an immediate education tool , the Nicholasville Quality Focused Team Member in-service, for the Administrator and the DON regarding modified textures diets. 4. On 05/19/16 all departments in the facility received in-services on modified textured diets, thickened liquids and care plan compliance by the DON and Speech Therapist. 5. On 05/19/16, the Educational Tool Nicholasville Quality Focused Team Member in-service was added to the new hire orientation packet. 6. On 05/19/16, the facility continued Quality Assurance (QA) audits to ensure system compliance initiated on 05/17/16 and continued through 05/31/16, by the management team of the facility. 7. The Quality Assurance Performance Improvement (QAPI) committee met on 05/09/16 with the attendance of the Administrator, Director of Nursing (DON), Dietary Manager (DM) and Medical Director (MD) via phone. 8. On 05/19/16, random team members across all departments were questioned about their knowledge of provision of correct consistency of food and liquids using the QAPI questionnaire document. 9. Questionnaires have been and will continue to be completed by members of the QAPI team which includes the Administrator,

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F 0367 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) DON, Assistant Director of Nursing (ADON), regional support team members and the DM. The State Survey Agency validated the implementation of the facility's AOC as follows: 1. Resident #1 received food that was not of part of the pureed diet in which the resident was prescribed, on 05/07/16 at 11:30 AM, and was found unresponsive at 11:55 AM, with time of death called at 11:57 AM. 2. Review of the Physician order List, revealed fifty eight (58) residents were identified on 05/18/16 by the ADON of the sister facility, as having a modified textured diet and five (5) residents were identified as having thickened liquids. Review of the Diet Audit, validated the Care Plan, SRNA Care Guide, and Meal Tray Ticket were accurate compared to the Physician's order list. 3. Review of the re-education tool, Nicholasville Quality Forced Team Member in-service attendance record sheet, dated 05/18/16 validated signatures of the SDCO/APRN, DON and the Administrator. Review of the Nicholasville Quality Focused Team Member in-service, revealed the in-service titled modified textured diets, contained information defining each modified diet. The two (2) modified diets listed were Mechanical soft and Pureed Diet. The in-serviced also included education on thicken liquids; Honey, Nectar, and Pudding. Continued review of the in-service revealed all modified textured diets were prepared in the kitchen as they had the equipment necessary to grind, blend and mash foods to the recommendation textures. Additional review of the in-service revealed there were three (3) types of thickened liquids served in the facility, Nectar-like thicken, Honey-like and Pudding-thick liquid. Interview on 05/27/16 at 12:30, with the Administrator and 05/27/16 at 12:50 PM, with the DON, confirmed they received the in-services presented by the SDCO/ARNP and were able to voice the two (2) types of mechanical altered diets as well as the three (3) types of thickened liquids. 4. Review of the in-service Attendance Record dated 05/19/19, validated each department's signatures for the in-service given by the DON and the Speech Therapist on Modified texture diets, Thickened liquids, and Care Plan compliance. Further review revealed the departments listed on the in-service sign in list included: Therapy department, Activity department, Housekeeping department, Dietary department, and Nursing department. Inte