STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. BUILDING _____ B. WING _____	12/29/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIRMONT LONGVIEW	3201 N FOURTH ST LONGVIEW, TX 75605

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Protect each resident from all abuse, physical punishment, and being separated from others.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 8 residents reviewed for neglect (Resident #1) was free from neglect. The facility did not ensure Resident #1 received the physician ordered diet. Resident #1 had orders for a pureed diet, and ate a peanut butter sandwich. Resident #1 choked on the sandwich which likely contributed to his death. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place 38 residents receiving mechanically altered diets, including pureed diets, at risk for harm or death. Findings included: Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE], and transferred to a local hospital on [DATE]. His [DIAGNOSES REDACTED]. His physician orders [REDACTED]. An incomplete Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was sometimes understood and was severely impaired cognitively. The MDS indicated Resident #1 was easily agitated, continually slapped himself in his face, and was at significant risk for physical injury. This MDS did not contain information regarding Resident #1's dietary restrictions for dysphagia. An undated care plan indicated Resident #1 was at nutritional risk related to dysphagia. Interventions included providing a pureed diet as ordered and evaluating for proper consistency of diet. The care plan indicated Resident #1 exhibited behaviors of hitting himself. The care plan did not address Resident #1's behaviors of grabbing other resident's food or personal items. The Admission (MDS) data set [DATE] indicated Resident #1 had severely impaired cognition, sometimes understood, and was restless. The Admission Data Set indicated Resident #1 had swallowing problems and a history of dysphagia. A psychological assessment dated [DATE] indicated Resident #1 was essentially non-verbal, but agitated and attempted to leave the facility. Resident #1 responded to being offered preferred items to eat or drink. It was recommended that Resident #1 be monitored at all times. A Nutritional assessment dated [DATE] indicated Resident #1 required a dysphagia puree diet. A physician progress notes [REDACTED].#1 had dysphagia and required aspiration precautions. During an interview on [DATE] at 3:31 p.m., CNA C said on [DATE] she was working on the secure unit. She said between 8:45 p.m. and 8:55 p.m., she saw Resident #1 sitting in a chair with a bed side table in front of him, by the nursing station of Hall 100. She said they spoke to each other and then she went into the secure unit. She said approximately ,[DATE] minutes later, she came out of the secure unit and Resident #1 was lying across the bedside table, his eyes and mouth were open, and his lips were blue. She said she began screaming at the 2 nurses sitting behind the nursing station that Resident #1 was blue. She said she pulled Resident #1 from the chair and began performing the [MEDICATION NAME] maneuver. She said a piece of bread that smelled like peanut butter came out of his mouth. She said the nurses began CPR and EMS arrived. She said the nurses were seated behind the nursing station and they could not have seen Resident #1 where he was seated. She said the snack tray that included peanut butter sandwiches were delivered to the nursing station around 7:30 p.m. to 8:00 p.m. on [DATE]. During an interview on [DATE] at 12:16 p.m., CNA D, said he saw Resident #1 sitting near the nursing station on Hall 100 between 8:35 p.m. to 8:50 p.m. He said he and CNA E went into another resident's room to perform care. He said about 5 minutes later, he heard commotion at the nursing station. He said he and CNA E went to the nursing station and saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1. He said he saw a peanut butter sandwich in his mouth. He said CPR was started on Resident #1 and EMS arrived. He said after the incident, RN A told him that she gave Resident #1 a sandwich and asked CNA D not to tell anybody. He said he did not tell administration about what RN A told him until [DATE]. He said the snack tray was on the nursing station around 8:00 p.m. on [DATE], and peanut butter sandwiches were on the tray. During an interview on [DATE] at 12:22 p.m., CNA E said she saw Resident #1 sitting by the Hall 100 nursing station with a bedside table in front of him on [DATE] at approximately 8:45 p.m. She said CNA D and she were making rounds and ,[DATE] minutes later she heard hollering at the nursing station. She said she saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1, and saw part of a peanut butter sandwich come out of Resident #1's mouth. She said Resident #1's lips were blue. She said peanut butter sandwiches were on the snack tray at the nursing station. She said after the incident, RN A told her that she gave Resident #1 a sandwich and asked her not to tell anybody. She said she did not report the information to administration until [DATE]. During an interview on [DATE] at 1:14 p.m., RN A said on [DATE] at approximately 8:45 p.m., she sat Resident #1 down in his chair by the nursing station and put the bedside table in front of him. She said she went behind the nursing station with LVN B and they both began charting. She said maybe 2 minutes later, CNA C came out of the secure unit and began yelling that Resident #1 was lying on the bedside table and was blue. She said Resident #1 was blue and CNA C began the [MEDICATION NAME] maneuver. She said LVN B went to get the crash cart and she called 911. She said she did not give him a sandwich, but she believed he ate a sandwich. She said the snack tray had peanut butter sandwiches on it and Resident #1 had a history of [REDACTED]. She said earlier in the shift, Resident #1 was drinking from the water pitcher on the medication cart. She said Resident #1 was admitted to this facility from a group home because the staff there was unable to provide the one to one supervision that he needed. During an interview on [DATE] at 9:39 a.m., LVN B said Resident #1 was sitting by the nursing station while she and RN A were behind the nursing station charting. She said CNA C came out the secure unit and began yelling that Resident #1 was blue. She said she went to get the crash cart and when she came back, Resident #1 had food in his mouth. She said the snack tray was sitting on the nursing station and there were peanut butter sandwiches on the tray. She said she caught Resident #1 going into the kitchen trying to get something to eat the night before. She said Resident #1 was impulsive and tried to grab whatever he could. She said he did not like the pureed diet and wanted what other residents were eating. During an interview on [DATE] at 2:22 p.m., Resident #2 said he saw Resident #1 sitting near the nursing station on Hall 100 on the evening of [DATE]. He said Resident #1 was eating a sandwich. An EMS report dated [DATE] indicated Resident #1 was choking and had [MEDICAL CONDITION]. The report indicated Resident #1's [MEDICAL CONDITION] was due to respiratory/asphyxia. Resident #1 was transferred to a local ER.

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 0223 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) Hospital records dated [DATE] indicated Resident #1 was choking on food preceding his [MEDICAL CONDITION]. EMS reported suctioning ,[DATE] mL of gastric content from Resident #1. Resident #1 was intubated and he did not have eye response, verbal response, or motor response. The hospital records indicated his [DIAGNOSES REDACTED]. Resident #1 was admitted to the ICU with concern for organ failure and [MEDICAL CONDITIONS]. During an interview on [DATE] at 2:28 p.m., Resident #2 said Resident #1's family came to the facility to pick up Resident #1's belongings. Resident #2 said Resident #1's family said Resident #1 died in the hospital on [DATE]. During an interview on [DATE] at 2:36 p.m., LVN F said Resident #1 had impulsive behaviors and would grab anything he could in his reach. During an interview on [DATE] at 4:16 p.m., the DON said the snack tray included peanut butter sandwiches and were delivered the nursing stations around 7:30 p.m. to 8:00 p.m. She said snacks were not locked up. She said Resident #1 was ambulatory and would grab anything he could reach. During an interview on [DATE] at 3:28 p.m., the administrator said Resident #1 was not on one to one supervision. The facility's Abuse/Neglect Policy dated [DATE] defined neglect as, .the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness . The administrator was notified on [DATE] at 12:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on [DATE] at 3:41 p.m. and included: Corrective Action and Identification: o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding CPR/[MEDICATION NAME] maneuver to include signs/symptoms of choking. Staff will be re-educated prior to starting their next shift. o On [DATE] the Director of Nursing or designee will review all resident diet orders and will update all Kardex and care plans accordingly to ensure all residents will receive correct diet. o On [DATE], residents' care plans were updated by the Director of Nursing and designees in the medical record. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding use of the Kardex to communicate a Resident's specific diet. Staff will be re-educated prior to starting their next shift. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding snack pass procedure to include delivery to nursing who will store in med room until passed to residents or discarded. Staff will be re-educated prior to starting their next shift. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding how to deal with residents with behaviors and cognitive deficits. Staff will be re-educated prior to starting their next shift. o On [DATE], an Interdisciplinary Team meeting (IDT) was held. Residents with non-compliance behaviors were reviewed for changes needed to care plan. The IDT's recommendations were discussed with the Medical Director and attending physicians. o On [DATE], the responsible parties of the residents who had recommendations from the IDT meeting were contacted by the Social Worker or designee. (sic) On [DATE] the surveyors confirmed the POR had been implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 4 LVNs, 1 MAs, 4 CNAs, 1 dietary worker, 1 dietitian, and 1 staffing coordinator were interviewed and said they were in-serviced about abuse/neglect, that snack trays were to be kept locked in the medication room until passed out, and how to locate residents' ordered diets. On [DATE] at 3:18 p.m., the administrator and DON were informed the Immediate Jeopardy was removed; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The CMS 672 dated [DATE] indicated 38 residents had mechanically altered diets.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement written policies and procedures to prohibit neglect for 1 of 8 residents reviewed for neglect. (Resident #1) The facility did not ensure Resident #1 received the physician ordered diet. Resident #1 had orders for a pureed diet, and ate a peanut butter sandwich. Resident #1 choked on the sandwich which likely contributed to his death. An Immediate Jeopardy situation was identified on [DATE]. The Immediate Jeopardy was removed on [DATE]; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place 38 residents receiving mechanically altered diets, including pureed diets, at risk for harm or death. Findings included: The facility's Abuse/Neglect Policy dated [DATE] defined neglect as .the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness . Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE], and transferred to a local hospital on [DATE]. His [DIAGNOSES REDACTED]. His physician orders [REDACTED]. An incomplete Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was sometimes understood and was severely impaired cognitively. The MDS indicated Resident #1 was easily agitated, continually slapped himself in his face, and was at significant risk for physical injury. This MDS did not contain information regarding Resident #1's dietary restrictions for dysphagia. An undated care plan indicated Resident #1 was at nutritional risk related to dysphagia. Interventions included providing a pureed diet as ordered and evaluating for proper consistency of diet. The care plan indicated Resident #1 exhibited behaviors of hitting himself. The care plan did not address Resident #1's behaviors of grabbing other resident's food or personal items. The Admission (MDS) data set [DATE] indicated Resident #1 had severely impaired cognition, sometimes understood, and was restless. The Admission Data Set indicated Resident #1 had swallowing problems and a history of dysphagia. A psychological assessment dated [DATE] indicated Resident #1 was essentially non-verbal, but agitated and attempted to leave the facility. Resident #1 responded to being offered preferred items to eat or drink. It was recommended that Resident #1 be monitored at all times. A Nutritional assessment dated [DATE] indicated Resident #1 required a dysphagia puree diet. A physician progress notes [REDACTED].#1 had dysphagia and required aspiration precautions. During an interview on [DATE] at 3:31 p.m., CNA C said on [DATE] she was working on the secure unit. She said between 8:45 p.m. and 8:55 p.m., she saw Resident #1 sitting in a chair with a bed side table in front of him, by the nursing station of Hall 100. She said they spoke to each other and then she went into the secure unit. She said approximately ,[DATE] minutes later, she came out of the secure unit and Resident #1 was lying across the bedside table, his eyes and mouth were open, and his lips were blue. She said she began screaming at the 2 nurses sitting behind the nursing station that Resident #1 was blue. She said she pulled Resident #1 from the chair and began performing the [MEDICATION NAME] maneuver. She said a piece of bread that smelled like peanut butter came out of his mouth. She said the nurses began CPR and EMS arrived. She said the nurses were seated behind the nursing station and they could not have seen Resident #1 where he was seated. She said the snack tray that included peanut butter sandwiches were delivered to the nursing station around 7:30 p.m. to 8:00 p.m. on [DATE]. During an interview on [DATE] at 12:16 p.m., CNA D, said he saw Resident #1 sitting near the nursing station on Hall 100 between 8:35 p.m. to 8:50 p.m. He said he and CNA E went into another resident's room to perform care. He said about 5 minutes later, he heard commotion at the nursing station. He said he and CNA E went to the nursing station and saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1. He said he saw a peanut butter sandwich in his mouth. He said CPR was started on Resident #1 and EMS arrived. He said after the incident, RN A told him that she gave Resident #1 a sandwich

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) and asked CNA D not to tell anybody. He said he did not tell administration about what RN A told him until [DATE]. He said the snack tray was on the nursing station around 8:00 p.m. on [DATE], and peanut butter sandwiches were on the tray. During an interview on [DATE] at 12:22 p.m., CNA E said she saw Resident #1 sitting by the Hall 100 nursing station with a bedside table in front of him on [DATE] at approximately 8:45 p.m. She said CNA D and she were making rounds and ,[DATE] minutes later she heard hollering at the nursing station. She said she saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1, and saw part of a peanut butter sandwich come out of Resident #1's mouth. She said Resident #1's lips were blue. She said peanut butter sandwiches were on the snack tray at the nursing station. She said after the incident, RN A told her that she gave Resident #1 a sandwich and asked her not to tell anybody. She said she did not report the information to administration until [DATE]. During an interview on [DATE] at 1:14 p.m., RN A said on [DATE] at approximately 8:45 p.m., she sat Resident #1 down in his chair by the nursing station and put the bedside table in front of him. She said she went behind the nursing station with LVN B and they both began charting. She said maybe 2 minutes later, CNA C came out of the secure unit and began yelling that Resident #1 was lying on the bedside table and was blue. She said Resident #1 was blue and CNA C began the [MEDICATION NAME] maneuver. She said LVN B went to get the crash cart and she called 911. She said she did not give him a sandwich, but she believed he ate a sandwich. She said the snack tray had peanut butter sandwiches on it and Resident #1 had a history of [REDACTED]. She said earlier in the shift, Resident #1 was drinking from the water pitcher on the medication cart. She said Resident #1 was admitted to this facility from a group home because the staff there was unable to provide the one to one supervision that he needed. During an interview on [DATE] at 9:39 a.m., LVN B said Resident #1 was sitting by the nursing station while she and RN A were behind the nursing station charting. She said CNA C came out the secure unit and began yelling that Resident #1 was blue. She said she went to get the crash cart and when she came back, Resident #1 had food in his mouth. She said the snack tray was sitting on the nursing station and there were peanut butter sandwiches on the tray. She said she caught Resident #1 going into the kitchen trying to get something to eat the night before. She said Resident #1 was impulsive and tried to grab whatever he could. She said he did not like the pureed diet and wanted what other residents were eating. During an interview on [DATE] at 2:22 p.m., Resident #2 said he saw Resident #1 sitting near the nursing station on Hall 100 on the evening of [DATE]. He said Resident #1 was eating a sandwich. An EMS report dated [DATE] indicated Resident #1 was choking and had [MEDICAL CONDITION]. The report indicated Resident #1's [MEDICAL CONDITION] was due to respiratory/asphyxia. Resident #1 was transferred to a local ER. Hospital records dated [DATE] indicated Resident #1 was choking on food preceding his [MEDICAL CONDITION]. EMS reported suctioning ,[DATE] mL of gastric content from Resident #1. Resident #1 was intubated and he did not have eye response, verbal response, or motor response. The hospital records indicated his [DIAGNOSES REDACTED]. Resident #1 was admitted to the ICU with concern for organ failure and [MEDICAL CONDITIONS]. During an interview on [DATE] at 2:28 p.m., Resident #2 said Resident #1's family came to the facility to pick up Resident #1's belongings. Resident #2 said Resident #1's family said Resident #1 died in the hospital on [DATE]. During an interview on [DATE] at 2:36 p.m., LVN F said Resident #1 had impulsive behaviors and would grab anything he could in his reach. During an interview on [DATE] at 4:16 p.m., the DON said the snack tray included peanut butter sandwiches and were delivered the nursing stations around 7:30 p.m. to 8:00 p.m. She said snacks were not locked up. She said Resident #1 was ambulatory and would grab anything he could reach. During an interview on [DATE] at 3:28 p.m., the administrator said Resident #1 was not on one to one supervision. The administrator was notified on [DATE] at 12:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on [DATE] at 3:41 p.m. and included: Corrective Action and Identification: o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding CPR/[MEDICATION NAME] maneuver to include signs/symptoms of choking. Staff will be re-educated prior to starting their next shift. o On [DATE] the Director of Nursing or designee will review all resident diet orders and will update all Kardex and care plans accordingly to ensure all residents will receive correct diet. o On [DATE], residents' care plans were updated by the Director of Nursing and designees in the medical record. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding use of the Kardex to communicate a Resident's specific diet. Staff will be re-educated prior to starting their next shift. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding snack pass procedure to include delivery to nursing who will store in med room until passed to residents or discarded. Staff will be re-educated prior to starting their next shift. o On [DATE], the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding how to deal with residents with behaviors and cognitive deficits. Staff will be re-educated prior to starting their next shift. o On [DATE], an Interdisciplinary Team meeting (IDT) was held. Residents with non-compliance behaviors were reviewed for changes needed to care plan. The IDT's recommendations were discussed with the Medical Director and attending physicians. o On [DATE], the responsible parties of the residents who had recommendations from the IDT meeting were contacted by the Social Worker or designee. (sic) On [DATE] the surveyors confirmed the POR had been implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 4 LVNs, 1 MAs, 4 CNAs, 1 dietary worker, 1 dietitian, and 1 staffing coordinator were interviewed and said they were in-serviced about abuse/neglect, that snack trays were to be kept locked in the medication room until passed out, and how to locate residents' ordered diets. On [DATE] at 3:18 p.m., the administrator and DON were informed the Immediate Jeopardy was removed; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. The CMS 672 dated [DATE] indicated 38 residents had mechanically altered diets.
F 0365 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide food in a way that meets a resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received food prepared in a form designed to meet individual needs for 1 of 8 residents reviewed for dietary intake. (Resident #1) The facility did not ensure Resident #1 received the physician ordered diet. Resident #1 had orders for a pureed diet, and ate a peanut butter sandwich. Resident #1 choked on the sandwich which likely contributed to his death. An Immediate Jeopardy situation was identified on 12/28/16. The Immediate Jeopardy was removed on 12/29/16; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place 38 residents receiving mechanically altered diets, including pureed diets, at risk for harm or death. Findings included: The facility's Abuse/Neglect Policy dated 11/28/16 defined neglect as .the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness . Physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE], and transferred to a local hospital on [DATE]. His [DIAGNOSES REDACTED]. His physician orders [REDACTED]. An incomplete Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was sometimes understood and was severely impaired cognitively. The MDS indicated Resident #1 was easily agitated, continually slapped himself in his face, and was at significant risk for physical injury. This MDS did not contain information regarding Resident #1's dietary restrictions for dysphagia. An undated care plan indicated Resident #1 was at nutritional risk related to dysphagia. Interventions included providing a pureed diet as ordered and evaluating for proper consistency of diet. The care plan indicated Resident #1 exhibited behaviors of hitting himself. The care plan did not address Resident #1's behaviors of grabbing other resident's food or

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F 0365 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) personal items. The Admission (MDS) data set [DATE] indicated Resident #1 had severely impaired cognition, sometimes understood, and was restless. The Admission Data Set indicated Resident #1 had swallowing problems and a history of dysphagia. A psychological assessment dated [DATE] indicated Resident #1 was essentially non-verbal, but agitated and attempted to leave the facility. Resident #1 responded to being offered preferred items to eat or drink. It was recommended that Resident #1 be monitored at all times. A Nutritional assessment dated [DATE] indicated Resident #1 required a dysphagia puree diet. A physician progress notes [REDACTED].#1 had dysphagia and required aspiration precautions. During an interview on 12/27/16 at 3:31 p.m., CNA C said on 12/24/16 she was working on the secure unit. She said between 8:45 p.m. and 8:55 p.m., she saw Resident #1 sitting in a chair with a bed side table in front of him, by the nursing station of Hall 100. She said they spoke to each other and then she went into the secure unit. She said approximately 5-10 minutes later, she came out of the secure unit and Resident #1 was lying across the bedside table, his eyes and mouth were open, and his lips were blue. She said she began screaming at the 2 nurses sitting behind the nursing station that Resident #1 was blue. She said she pulled Resident #1 from the chair and began performing the [MEDICATION NAME] maneuver. She said a piece of bread that smelled like peanut butter came out of his mouth. She said the nurses began CPR and EMS arrived. She said the nurses were seated behind the nursing station and they could not have seen Resident #1 where he was seated. She said the snack tray that included peanut butter sandwiches were delivered to the nursing station around 7:30 p.m. to 8:00 p.m. on 12/24/16. During an interview on 12/28/16 at 12:16 p.m., CNA D, said he saw Resident #1 sitting near the nursing station on Hall 100 between 8:35 p.m. to 8:50 p.m. He said he and CNA E went into another resident's room to perform care. He said about 5 minutes later, he heard commotion at the nursing station. He said he and CNA E went to the nursing station and saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1. He said he saw a peanut butter sandwich in his mouth. He said CPR was started on Resident #1 and EMS arrived. He said after the incident, RN A told him that she gave Resident #1 a sandwich and asked CNA D not to tell anybody. He said he did not tell administration about what RN A told him until 12/27/16. He said the snack tray was on the nursing station around 8:00 p.m. on 12/24/16, and peanut butter sandwiches were on the tray. During an interview on 12/28/16 at 12:22 p.m., CNA E said she saw Resident #1 sitting by the Hall 100 nursing station with a bedside table in front of him on 12/24/16 at approximately 8:45 p.m. She said CNA D and she were making rounds and 5-10 minutes later she heard hollering at the nursing station. She said she saw CNA C performing the [MEDICATION NAME] maneuver on Resident #1, and saw part of a peanut butter sandwich come out of Resident #1's mouth. She said Resident #1's lips were blue. She said peanut butter sandwiches were on the snack tray at the nursing station. She said after the incident, RN A told her that she gave Resident #1 a sandwich and asked her not to tell anybody. She said she did not report the information to administration until 12/27/16. During an interview on 12/28/16 at 1:14 p.m., RN A said on 12/24/16 at approximately 8:45 p.m., she sat Resident #1 down in his chair by the nursing station and put the bedside table in front of him. She said she went behind the nursing station with LVN B and they both began charting. She said maybe 2 minutes later, CNA C came out of the secure unit and began yelling that Resident #1 was lying on the bedside table and was blue. She said Resident #1 was blue and CNA C began the [MEDICATION NAME] maneuver. She said LVN B went to get the crash cart and she called 911. She said she did not give him a sandwich, but she believed he ate a sandwich. She said the snack tray had peanut butter sandwiches on it and Resident #1 had a history of [REDACTED]. She said earlier in the shift, Resident #1 was drinking from the water pitcher on the medication cart. She said Resident #1 was admitted to this facility from a group home because the staff there was unable to provide the one to one supervision that he needed. During an interview on 12/28/16 at 9:39 a.m., LVN B said Resident #1 was sitting by the nursing station while she and RN A were behind the nursing station charting. She said CNA C came out the secure unit and began yelling that Resident #1 was blue. She said she went to get the crash cart and when she came back, Resident #1 had food in his mouth. She said the snack tray was sitting on the nursing station and there were peanut butter sandwiches on the tray. She said she caught Resident #1 going into the kitchen trying to get something to eat the night before. She said Resident #1 was impulsive and tried to grab whatever he could. She said he did not like the pureed diet and wanted what other residents were eating. During an interview on 12/28/16 at 2:22 p.m., Resident #2 said he saw Resident #1 sitting near the nursing station on Hall 100 on the evening of 12/24/16. He said Resident #1 was eating a sandwich. An EMS report dated 12/24/16 indicated Resident #1 was choking and had [MEDICAL CONDITION]. The report indicated Resident #1's [MEDICAL CONDITION] was due to respiratory/asphyxia. Resident #1 was transferred to a local ER. Hospital records dated 12/24/16 indicated Resident #1 was choking on food preceding his [MEDICAL CONDITION]. EMS reported suctioning 50-100 mL of gastric content from Resident #1. Resident #1 was intubated and he did not have eye response, verbal response, or motor response. The hospital records indicated his [DIAGNOSES REDACTED]. Resident #1 was admitted to the ICU with concern for organ failure and [MEDICAL CONDITIONS]. During an interview on 12/29/16 at 2:28 p.m., Resident #2 said Resident #1's family came to the facility to pick up Resident #1's belongings. Resident #2 said Resident #1's family said Resident #1 died in the hospital on [DATE]. During an interview on 12/27/16 at 2:36 p.m., LVN F said Resident #1 had impulsive behaviors and would grab anything he could in his reach. During an interview on 12/28/16 at 4:16 p.m., the DON said the snack tray included peanut butter sandwiches and were delivered the nursing stations around 7:30 p.m. to 8:00 p.m. She said snacks were not locked up. She said Resident #1 was ambulatory and would grab anything he could reach. During an interview on 12/28/16 at 3:28 p.m., the administrator said Resident #1 was not on one to one supervision. The administrator was notified on 12/28/16 at 12:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The facility's revised Plan of Removal was accepted on 12/28/16 at 3:41 p.m. and included: Corrective Action and Identification: o On December 28, 2016, the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding CPR/[MEDICATION NAME] maneuver to include signs/symptoms of choking. Staff will be re-educated prior to starting their next shift. o On December 28, 2016 the Director of Nursing or designee will review all resident diet orders and will update all Kardex and care plans accordingly to ensure all residents will receive correct diet. o On December 28, 2016, residents' care plans were updated by the Director of Nursing and designees in the medical record. o On December 28, 2016, the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding use of the Kardex to communicate a Resident's specific diet. Staff will be re-educated prior to starting their next shift. o On December 28, 2016, the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding snack pass procedure to include delivery to nursing who will store in med room until passed to residents or discarded. Staff will be re-educated prior to starting their next shift. o On December 28, 2016, the Nurse Practice Educator or designee began conducting an in-service with direct care staff regarding how to deal with residents with behaviors and cognitive deficits. Staff will be re-educated prior to starting their next shift. o On December 28, 2016, an Interdisciplinary Team meeting (IDT) was held. Residents with non-compliance behaviors were reviewed for changes needed to care plan. The IDT's recommendations were discussed with the Medical Director and attending physicians. o On December 28, 2016, the responsible parties of the residents who had recommendations from the IDT meeting were contacted by the Social Worker or designee. (sic) On 12/29/16 the surveyors confirmed the POR had been implemented sufficiently to remove the Immediate Jeopardy by: Two RNs, 4 LVNs, 1 MAs, 4 CNAs, 1 dietary worker, 1 dietitian, and 1 staffing coordinator were interviewed and said they were in-serviced about abuse/neglect, that snack trays were to be kept locked in the medication room until passed out, and how to locate residents' ordered diets. On 12/29/16 at 3:18 p.m., the administrator and DON were informed the Immediate Jeopardy was removed; however, the facility remained out of compliance at isolated actual harm due to the facility's need to complete in-service training and evaluate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. BUILDING _____ B. WING _____	**12/29/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLAIRMONT LONGVIEW	**3201 N FOURTH ST LONGVIEW, TX 75605**

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 0365 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) the effectiveness of the corrective systems. The CMS 672 dated 12/27/16 indicated 38 residents had mechanically altered diets.