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F 000	INITIAL COMMENTS This was a complaint and partial extended survey conducted at SSM Health St. Mary's Care Center from 9/4/24 through 9/12/24. This survey identified substandard quality of care at F689. Federal citations issued: 2 The most serious citation is F689 cited at a severity/scope level of J (Immediate jeopardy/Isolated). Census: 110 Sample size: 6	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure each resident (R) received adequate supervision to prevent accidents for 1 of 3 residents (R2) reviewed for altered diets out of a total sample of 6. R2 has had two choking episodes within a month's time. On 7/27/24, R2 choked on a hot dog. The Heimlich maneuver was performed, and R2 was sent to the emergency room and admitted to the hospital for acute hypoxic	F 689		

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

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respiratory failure, aspiration event/choking on a hot dog, and aspiration pneumonitis.

On 8/13/24, R2 was to receive a Level 6: soft and bite sized (no hot dogs), thin liquids consistency diet. CNA G (Certified Nursing Assistant) provided R2 a bowl of chunked honeydew that was not part of a Level 6 soft and bite sized diet with his supper, resulting in an aspiration event and another hospitalization.

The facility's failure to supervise R2 and ensure R2 received food items consistent with R2's prescribed diet created a finding of Immediate Jeopardy (IJ) that began on 8/13/24. Surveyor notified NHA A (Nursing Home Administrator) and DON B (Director of Nursing) of the IJ on 9/5/24 at 12:10 PM. The IJ was removed on 9/6/24; however, the deficient practice continues at a scope/severity of a D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan.

This is evidenced by:
The International Dysphagia Diet Standardization Initiative (2019), or IDDSI, developed the IDDSI Framework which is intended to provide "a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties." The IDDSI framework has a range of 8 levels. Drinks are measured from levels 0 through 4, while foods are measured from levels 3 through 7. Level definitions are as follows ... (https://iddsi.org/Framework)

Level 5 - Minced and Moist. Can be eaten with a fork or spoon, should be soft and moist with no separate thin liquid. Particles should be easily

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separated when pressed with a fork. Small lumps - equal to or less than 4mm width (about the gap between the prongs of a standard dinner fork) and no longer than 15mm in length for adults - may be present but should be easy to squash with tongue.

Level 6 - Soft & Bite-Sized. Can be eaten with a fork, spoon, or chopsticks and can be mashed or broken down with these utensils. Food should be soft, tender, and moist throughout but with no separate thin liquid. Chewing is required before swallowing. Food piece sizes are designed to minimize choking risk ... should be equal to or less than 1.5cm pieces.

R2 was admitted to the facility 1/4/23 and has diagnoses that include Pneumonitis (a general term for lung tissue inflammation that's not caused by an infection) due to inhalation of food and vomit, dysphagia (difficulty swallowing), Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and dementia (a group of thinking and social symptoms that interferes with daily functioning).

R2's Quarterly Minimum Data Set (MDS), dated 6/11/24, shows that R2 has a Brief Interview of Mental Status (BIMS) score of 8 indicating R2 has moderate cognitive impairment. Section K indicates R2 does not have a swallowing disorder and is not on an altered mechanical diet. Section GG indicates R2 requires set up assistance with meals and is dependent on staff for transfers from chair/bed to chair.

R2's Care Plan, dated 2/28/23, states:

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F 689	Continued From page 3 "Focus: Nutrition/Hydration: At Risk for Complications with Nutrition/Hydration d/t (due to) aspiration and long-standing dysphagia; tendency to eat/drink too fast. Date Initiated: 2/28/23 Revision: 8/15/24... Interventions: Set up meal per resident direction and assist with eating as/if needed. Honor food requests as able. Encourage resident to slow down while eating. Date Initiated: 2/28/23 Revision on: 8/15/24. RESOLVED: Serve prescribed diet of regular, regular thin liquids. Date Initiated: 11/29/23. Revision on: 8/1/24. Resolved Date: 8/1/24. Adaptive Equipment: divided plate. Date Initiated: 1/13/24 Revision on: 9/4/24. General Diet, Level 5 texture: moist and minced with divided plate/thin liquids. Resident to eat in doorway of room. Staff cue to slow down ... Date Initiated: 8/14/24 Revision on: 9/4/24. Monitor for changes in texture tolerance. Date Initiated: 8/26/24 ... Interventions: Eating - supervision. Bring resident to room door threshold to monitor during meals. Date Initiated: 8/14/24. Revision on: 8/16/24..." R2's CNA Kardex dated 8/1/24 shows R2 is on a General Diet, Level 6 texture: soft and bite sized (no hot dogs), thin liquids. R2's CNA Kardex dated 8/16/24 shows R2 is on a General Diet, Level 5 texture: moist and minced (no hot dogs) thin liquids.	F 689		

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F 689	Continued From page 4 Focus: ADL (activities of daily living) At risk and/or Potential for Complications with Deficits with ADLs R/T (related to) current medical/physical status. Has meds/dx (medication/diagnoses) that can/may affect ADLs. Date Initiated: 2/28/23 Revision on: 4/4/23..." R2's diet initiated 11/29/23, regular thin liquids. R2's Discharge Summary from the hospital dated 7/30/24, states, in part: "Date of Admission: 7/27/24 Date of Discharge: 7/30/24 HPI (history of present illness): Patient with schizophrenia, seizures, and dysphagia with recurrent aspiration events who presented to the ED after choking on a hot dog that required the Heimlich maneuver and is admitted with hypoxia... Hospital Course: Acute hypoxic respiratory failure Aspiration event/choking on a hot dog on July 27 Aspiration pneumonitis Chronic dysphagia with the recurrent aspiration events... Patient presented to emergency room after choking on a hot dog which required Heimlich maneuver. He was mildly hypoxic in the emergency room 89% on room air and placed on a 2L of oxygen. Chest x-ray was negative in the ER, he continues to remain afebrile with normal WBC (white blood cell count). Diet was continued since he has a prior episode of aspiration, requested SLP (Speech Language Pathologist) evaluation. He will be at risk for aspiration	F 689		

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pneumonia, continue to monitor closely...

Your Discharge Diagnosis: Aspiration into airway..."

R2's signed Physician Telephone orders dated 8/7/24, states, in part:
"Diet Clarification: Level 6 (Soft and Bite Sized) with bread, no hot dogs."

R2's meal ticket dated 8/13/24 shows:
- R2's diet: Level 6 Soft Bite
- Meal: 8/13/24 Tuesday Supper
- Divided Plate
- Supper Specials: Fruit, canned (chopped), soup, cream cauliflower (chopped), peas. Sugar snap (chopped) and scalloped potatoes & ham (ground).

R2's Incident Report dated 8/13/24, at 5:39PM, states, in part:
"Incident Description: R2 finished eating dinner and started coughing while brushing his teeth. Resident started coughing, nurse went to check on resident. Resident was audible, but breathing was labored. Emergency code was activated, code team came with crash cart, suctioning started, 8L (Liter) O2 administered via face mask. BP (Blood Pressure) 212/99, O2- 85%, P (Pulse)-101, R (Respirations)-22, T (Temperature)- 97.8. Nurse called on call and got order to send out to hospital via ambulance. Nurse placed order in resident's chart and have copy to charge nurse. POA, PCP (Primary Care Physician), DON notified.

Immediate Action Taken: ...call 911 transferred to ER (emergency room). POA, PCP, DON notified...

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F 689	Continued From page 6 Mental Status: Baseline for Individual, Increased Monitoring/Observation..." R2's Progress Note dated 8/13/24, at 5:30 PM, states: "Resident finished eating dinner and started coughing while brushing his teeth. Resident started coughing, nurse went to check on resident. Resident was audible, but breathing was labored. Emergency code was activated, Code Team came with crash cart, suctioning started, 8L O2 administered via face mask. BP-212/99, O2- 85%, P-101, R-22, T- 97.8. Nurse called on call and got order to send out to hospital via ambulance. Nurse placed order in resident's chart and have copy to charge nurse. POA, PCP, DON notified." R2's Progress Note, dated 8/13/24 at 6:00 PM, states: "Call to ER RN (Registered Nurse) regarding choking episode, resident sent to ER by 911. Report given." R2's Discharge Summary from the hospital dated 8/14/24, states, in part: "Date of Admission: 8/13/24 Date of Discharge: 8/14/24 Final Diagnosis: Aspiration event, s/p (status/post) laryngoscopy (a procedure that uses a thin tube with a light, lens, and video to examine your larynx (hollow tube in the middle of your neck-voice box) with retrieved foreign body (potato)... Hospital Course: Patient was admitted into the hospital after an aspiration event. He aspirated a potato. Given ketamine in the ER and ENT (Ears, nose, and throat doctor) did laryngoscopy with removal of foreign body..."	F 689		

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R2's ENT Progress Note dated 8/14/24 at 8:35 AM, states, in part: ...
"...History of Parkinson's disease with dysphagia, currently admitted with aspiration pneumonia ...On 8/13/24, he was eating dinner and aspirated mashed potatoes. In ER unresponsive initially, then able to awaken and answer questions. He spoke with difficulty with altered phonation and gurgling, and sounded as though a foreign body were obstructing. Dr. saw patient and multiple attempts were made to dislodge the foreign body with heavier cough, positioning, and Heimlich maneuvers without success. The patient was sedated in the ED (Emergency Department) and a 1 miller blade was used to visualize the area. Initial attempts with the suction did not work. Then a McGill forceps was used to remove an approximately 4.5 by 4 cm (centimeter) potato in one piece. Following the procedure, there was some non-obstructive edema of the arytenoids but no other signs of trauma. Patient tolerated the procedure well and was given Decadron in the ED to reduce the risk of delayed laryngeal edema.

Of note, the hospital records state a 4.5 x 4 centimeter potato was retrieved. (It was actually a honeydew melon.) This type and size of food was not consistent with the resident's care pakn and his dietary restrictions.

RN D's (Registered Nurse) statement, dated 8/13/24, states: "R2 was eating in his room. He has a soft bite size diet which is soft foods that can be easily chewed. Raw fruit is not appropriate for this diet. Residents diet is determined by care plan and the dietary ticket that is generated. The server checks the ticket and serves up the

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appropriate meal. The CNA checks the ticket and meal for appropriateness and serves it to the residents. I did not notice any breathing issues before eating but after he was coughing..."

CK F's (Cook) statement undated, states: "Around 5:30 PM, I was serving food to the resident (gave R2 food that was on the ticket). Staff took the honeydew melon and gave it to R2 with his food..."

Of note, honeydew melon is not on R2's diet. It was, however, part of the general menu served at supper on 8/13/24.

On 9/4/24 at 11:15 AM, Surveyor interviewed CNA I (Certified Nursing Assistant) who indicated CNAs and the dietary aide who dishes up the residents' meals are both responsible that the residents receive the correct diet. Surveyor asked CNA I how CNAs know what diet residents are to receive and CNA I indicated by the meal ticket on the trays. CNA I showed Surveyor the CNA Kardex that lists the resident's diet in R2's bathroom.

On 9/4/24 at 11:25 AM, Surveyor interviewed RN D. RN D stated he came into R2's room with Surveyor and CNA I and indicated after R2's incident on 8/13/24, R2's diet changed to Level 5 texture: moist and minced and R2 eats meals in his doorway. RN D could not recall R2's diet at time of incident. Surveyor asked RN D to tell her about the incident. RN D indicated he was one of the nurses to respond to R2 the evening of the incident on 8/13/24. RN D indicated R2 was in his room coughing and he entered R2's room to check on him. RN D indicated R2 was coughing and getting air. R2 was breathing, Emergency

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Code was called, and more nurses came to R2's room with the crash cart. RN D indicated it happened after supper. The staff did a mouth sweep and attempted suctioning oral cavity with a Yankauer and only had phlegm return with no food. RN D indicated vital signs were stable at first but as they were waiting for the ambulance to arrive vital signs became unstable. Surveyor asked RN D what led to the incident, and RN D indicated R2 choked on food and aspirated but could not recall what R2 choked on. Surveyor asked RN D who is responsible to check the residents' meal tickets for correct diet to prevent choking or hazards; RN D indicated CNAs and the dietary staff.

On 9/4/24 at 12:23 PM, Surveyor interviewed ST C (Speech Therapist) who indicated R2 has a history of dysphagia and a tendency to eat quickly. R2 does not take time to chew. Surveyor asked ST C if she was aware of the incident with R2 on 8/13/24. ST C indicated R2 was to be a Level 6: soft and bite sized at that time. Pieces were to be no bigger than 1.5cm (centimeters). On Level 6 diet, cantaloupe, pineapple, honeydew, melons are not allowed. R2 was given honeydew at supper and should not have had it. R2 ended up going to ER for choking on honeydew. ST C indicated the facility has a lot of agency staff that don't look at the meal tickets and just serve the trays. ST C indicated R2 is now on a Level 5 texture: moist and minced diet, this was a change after 8/13/24. ST C indicated on 9/5/24 the dietician and herself are conducting an in-service to CNAs and dietary staff regarding each level of diets in detail and meal tickets which will be videotaped. Surveyor asked ST C who is responsible for checking that residents are receiving correct diet and ST C indicated it is

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collaborative between CNAs and dietary aides. ST C indicated in the kitchen there is a binder that lists all the diets with as much detail as possible staff use this if there is a question on what is being served and how to serve it.

On 9/4/24 at 1:00 PM, Surveyor interviewed LPN E (Licensed Practical Nurse) who indicated she was another nurse that was there on 8/13/24 when R2's incident occurred. LPN E indicated she was doing her medication pass and RN D was at the nurse station, we both heard R2 trying to clear his throat. We both encouraged coughing and R2 was unable to clear. We called an Emergency Code where the charge nurse and two other nurses responded with the crash cart. His oral cavity was suctioned with only fluid return. There was nothing lodged in his mouth. 911 was called and while waiting for ambulance vital signs were declining. R2's oxygen level was in 80s - we applied oxygen at 6 or 8 L via face mask which brought R2 up into the 90s. R2's BP and P (blood pressure and pulse) were high. He was sent to the ER. Surveyor asked who is responsible for checking the meal tickets with what is served, LPN E indicated the CNAs serve the trays and the kitchen staff sets the tray up with meal ticket. The food is served according to the meal ticket.

On 9/4/24 at 3:25 PM, Surveyor interviewed CNA G and asked what he can recall with R2's incident on 8/13/24. CNA G indicated he served R2 his supper tray on 8/13/24. CNA G indicated R2 received the correct diet except for the bowl of honeydew. CNA G indicated he can't remember if the dietary aide handed him the bowl of honey dew or if someone had told CNA G to give a bowl of honeydew melon to R2. CNA G put the bowl of

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honeydew on R2's tray and served it. Surveyor asked CNA G who checks the meal tickets and CNA G indicated CNAs and dietary check the meal ticket with what is on the tray. Surveyor asked CNA G did R2 eat the honeydew and CNA G stated yes, he ate most of his meal. CNA G indicated R2 is now a pureed diet and eats out of doorway where staff can monitor him, and he is closer to the nurses' station.

On 9/4/24 at 3:55 PM, Surveyor interviewed CK F (Cook). Surveyor asked what the process is for obtaining resident meal tickets. CK F indicated the kitchen supervisor prints the meal tickets out. The meal tickets go to each neighborhood. CK F indicated he looks at the meal tickets and serves what is on the meal ticket onto the residents' trays. The CNAs then grab the desserts and put them on the trays before serving to the residents. R2 was supposed to get canned fruit but the CNA gave R2 a bowl of honeydew. CK F indicated R2 was not to have honeydew; R2 was to have canned fruit. CK F indicated R2 had a choking spell after supper and 911 was called. Surveyor asked CK F if he had received any training or education on diets or meal tickets and CK F indicated no, not at all.

Following this incident, R2's signed Physician Telephone orders dated 8/15/24, state, in part: "Diet Clarification: Level 5 minced and moist. Use divided plate. Have resident sit outside room with room tray. Provide Ensure shakes per request from POA (Power of Attorney). Staff cue to slow down."

On 9/5/24 at 9:35 AM, Surveyor interviewed DON B (Director of Nursing) and asked if she would expect residents to receive their ordered diet and

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DON B indicated yes. Surveyor asked what is the CNAs responsibility regarding serving meal trays and meal tickets? DON B indicated CNAs get the residents' order on the meal ticket from the residents. Dietary aides are responsible for serving all the food. The CNAs should verify the items on the tray are what is on the ticket. The CNAs are not responsible for checking the texture of the food. DON B indicated the facility is working on training with CNAs on diet textures and the meal slips. Surveyor asked DON B what interventions were put into place after the incident on 7/27/24. DON B indicated R2's diet changed on 8/1/24 to a general diet - soft and bite sized consistency and no hot dogs. Surveyor asked DON B what interventions were put into place from the incident on 8/13/24 and DON B indicated R2 is to eat meals in the threshold of his room doorway where staff are to supervise R2, and his diet changed to minced and moist. Surveyor then asked DON B if education was provided to staff on supervision and cueing during meals, and DON B indicated education was assigned to a nurse manager that no longer is employed at facility. DON B indicated she would look and see if it was done. Surveyor asked DON B if she would expect education to have been provided and DON B indicated yes. Surveyor asked DON B if any audits have been completed on meals being served and meal tickets. DON B indicated I don't believe so, but multiple observations were done. Surveyor asked if they had been documented and DON B indicated she would have to look into it. Surveyor asked if DON B would expect audits to be completed and documented and DON B indicated yes. Surveyor asked DON B if any competencies with the nursing staff on the Heimlich maneuver had been completed and DON B indicated no, but all

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F 689	Continued From page 13 nurses are CPR (cardiopulmonary resuscitation) certified. On 9/5/24 at 10:15 AM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked if it is the expectation that residents receive their ordered diets and NHA A indicated yes. Surveyor asked what the responsibilities of the CNAs and dietary aides regarding meal tickets are and serving the correct diets. NHA A indicated the CNAs get the information from the residents on what they would like to order then the meal ticket goes to the server. The dietary aide/server is to ensure it is the correct diet and plate the food on the trays. The CNA verifies the food to the meal ticket. Surveyor asked NHA A what education was provided to the CNAs and dietary staff. NHA A indicated the dietary staff received verbal education and an in-service by the dietician and speech therapist is scheduled for today. NHA A indicated for the CNAs the nurse manager was to write up a sheet and ensure they received it. That nurse manager is no longer employed by the facility. NHA A indicated she has no documentation to verify it was completed. Surveyor asked NHA A if any audits on serving meals and meal tickets had been completed and NHA A indicated the dietary manager does meal observations. NHA A indicated she asked the dietary manager for a log and no documentation was done. NHA A indicated she would expect audits to have been completed and documented. According to http://www.emedicinehealth.com/choking/article_em.htm, "Choking is a blockage of the upper airway by food or other objects, which prevents a person from breathing effectively. Choking can cause a simple coughing fit, but complete	F 689		

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blockage of the airway may lead to death. Choking is a true medical emergency that requires fast, appropriate action by anyone available. Emergency medical teams may not arrive in time to save a choking person's life. "...When someone is choking with a completely blocked airway, no oxygen can enter the lungs. The brain is extremely sensitive to this lack of oxygen and begins to die within four to six minutes. It is during this time that first aid must take place. Irreversible brain death occurs in as little as 10 minutes."

According to https://www.webmd.com>Lung Disease & Respiratory Health article, "Aspiration is when something you swallow "goes down the wrong way" and enters your airway (trachea or windpipe) or lungs. It can also happen when something goes back into your throat from your stomach. With aspiration, your airway isn't completely blocked, unlike with choking. People who have a hard time swallowing are more likely to aspirate. Up to 15 million Americans have trouble swallowing, called dysphagia. It can be temporary or part of a more serious condition .... Aspiration Symptoms ... Feel something stuck in your throat, cough while or after you eat or drink, have a gurgling or "wet sounding" voice..."

The facility's failure to supervise R2 and ensure r2 received a meal consistent with his care plan and dietary restrictions created a finding of immediate jeopardy. The facility removed the jeopardy on 9/6/24 when it had completed the following:

-The facility will complete mock drills and competency tests for all licensed nursing staff including how to support a resident with partial

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F 689	Continued From page 15 obstructed airway, choking, Heimlich etc. prior to their next working shift. -The facility will educate nursing, culinary and activities staff on altered diets/IDDSI. The training will include how to determine foods/fluids safe to consume on prescribed/altered diets. A competency will be completed following education. -The facility will provide instruction to culinary, activities and nursing staff on where to find a resident's diet prior to working next shift. -The facility has created a system where all meal tray cards for residents on an altered diet will be printed in a different orientation format, so it will be easily recognizable to staff to determine the appropriate diet and food/fluids safe to consume per the prescribed diet. -The facility will ensure that a licensed nurse is assigned to each dining room. -The facility will audit all resident diet orders, tray cards, care plan and Kardex to ensure correct orders and that orders match and include ST recommendations for residents who have been on ST caseload in the last 90 days. -The facility will complete meal audits to ensure receiving proper diet breakfast, lunch, and dinner in 2 dining rooms each meal. -The facility will audit all employee records for licensed nurses to ensure CPR certification. The facility will ensure a licensed nurse is assigned to each dining room during all meals.	F 689		

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F 947	Continued From page 16	F 947		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure 3 of 5 randomly sampled Certified Nursing Assistants (CNAs), who had been employed at the facility for over a year, had documented performance reviews (CNA J, CNA K, and CNA L). CNA J, CNA K, and CNA L's annual performance evaluations were not conducted yearly. This is evidenced by: The facility's policy titled "Competency Assessment and Validation", dated 6/12/2024,	F 947		

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states, in part: "SSM Health (SSM) will ensure all employees are competent to perform their assigned responsibilities and to establish a consistent and effective process to measure staff competence unique to job classifications, duties and responsibilities ...II. Competency Process ... B. Validation ... 2. Competency should be assessed annually."

On 9/12/24, Surveyor reviewed the list of CNAs that had worked for the facility longer than one year. The employment list documented:

CNA J was hired on 10/12/2015.
CNA K was hired on 6/29/2006.
CNA L was hired on 10/27/1999.

On 9/12/24, Surveyor reviewed the provided CNA yearly performance review documentation that was provided by the facility. This documentation showed:

CNA J's last performance review was conducted on 4/18/2022.
CNA K's last performance review was conducted on 4/24/2022.
CNA L's last performance review was conducted on 2/27/2022.

On 9/12/24 at 3:33 PM, Surveyor interviewed the facility's new NHA, NHA M (Nursing Home Administrator), CEO N (Chief Executive Officer), and RD O (Regional Director). NHA M and CEO N indicate that they have three CNA evaluations from 2022, but that the rest were not due yet. RD O indicates that according to facility policy, CNA evaluations only need to be conducted every three years they do not conduct annual performance evaluations. NHA M, CEO N, and

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F 947	Continued From page 18 RD O, indicate that they have provided the most recent CNA performance evaluations for the employees requested. No other documentation regarding performance evaluations could be provided.	F 947		