Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: March 29, 2022

Dear Administrator:

On April 19, 2022, we notified you a remedy was imposed. On May 10, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 2, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective effective May 5, 2022, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 19, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 5, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered

May 11, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

Re: Reinspection Results
Event ID: J3DQ12

Dear Administrator:

On May 10, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted
April 19, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

RE: CCN: 245290
Cycle Start Date: March 29, 2022

Dear Administrator:

On March 29, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 29, 2022, the situation of immediate jeopardy to potential health and safety cited at F808 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 5, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 5, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 5, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Olivia Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 5, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 29, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services,

Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

<u>Tamika.Brown@cms.hhs.gov</u>

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services

Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 19, 2022

Administrator
Olivia Restorative Care Center
1003 West Maple
Olivia, MN 56277

Re: State Nursing Home Licensing Orders
Event ID: J3DQ11

Dear Administrator:

The above facility was surveyed on March 28, 2022 through March 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 34083 On 3/28/20 through 3/29/20, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5290042C (MN81625) with a deficiency cited at F808. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F808 began on 3/7/22, when the facility failed to provide a physician ordered mechanically ground diet of meat (pork roast) to 1 of 1 resident (R1). R1 subsequently began choking. Staff also failed to immediately perform the Heimlich maneuver, delaying potentially lifesaving treatment. The facility's administrator (A) and director of nursing (DON) were notified of the IJ on 3/29/22 at 2:00 p.m. The immediacy was removed on 3/29/22 at p.m. The above findings did not constitute Substandard Quality of Care; therefore NO extended survey was conducted. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 808 SS=J	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on interview and document review the facility failed to provide a physician ordered mechanically ground diet of meat (pork roast) to 1 of 1 resident (R1). R1 subsequently began choking. Staff also failed to immediately perform the Heimlich maneuver, delaying potentially lifesaving treatment. This resulted in actual harm as R1 required a higher level of care after developing aspiration pneumonia (when food, saliva, or liquids are breathed into the lungs or airway instead of swallowed into the stomach) requiring medical intervention at the regional hospital. The survey resulted in an immediate jeopardy (IJ) that began on 3/7/22 at 12:25 p.m., at J-ISOLATED, when the facility failed to provide the appropriate physician ordered altered texture	F 808	R1 diet order was reviewed. Staff were educated and a tray card was immediately implemented for R1 to ensure going forward the appropriate diet will be given to R1. Staff were also educated that if the inappropriate diet was given to immediately remove the food in question and do not leave it with the resident. To prevent further residents being affected by the deficient practice the tray identification policy was reviewed and reeducated to staff. Further all residents diet orders were reviewed for accuracy and if needed the appropriate diet implemented. A root cause analysis was completed as to the cause of the choking incident, and it was determined the cause to be lack of	5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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F 808	Continued From page 2 diet (mechanical ground), served R1 whole chunks of meat. Staff identified the meat was the incorrect consistency, however, they had left it within reach of R1, resulting in R1 eating the meat and choking. Staff saw R1 choking, but failed to immediately intervene and perform the Heimlich maneuver as staff waited for the director of nursing (DON) to arrive. R1 was later sent to the regional emergency department (ED) and was later admitted to the ICU for aspiration pneumonia. The administrator and DON were notified of the IJ on 3/29/22 at 2:00 p.m. The IJ was removed on 3/29/22 at 6:45 p.m., when it could be verified by interview and document review, the facility took steps to remove the immediacy by revising policies and procedures, educating nursing and dietary staff on ensuring diets were provided per physician order, and educated on how and when to provide the Heimlich maneuver. Non-compliance remained at the lower scope and severity level of D-isolated, potential for harm that is not immediate jeopardy. Findings include: R1's current, undated diagnoses list identified she experienced a stroke on 12/3/20, which resulted in dysphasia (difficulty swallowing), hemiplegia (paralysis of one side), aphasia (a language disorder that affects a person's ability to communicate), and anxiety disorder. R1's 2/7/22 Significant Change, Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and required supervision with eating. R1's current physician orders identified her diet was to be mechanical ground with nectar	F 808	following our tray identification policy. The tray identification policy was immediately reimplemented on 3/7/2022. Staff involved with tray identification and the use of tray cards were reeducated on 3/7/2022. Further, staff were reeducated on the importance of serving the appropriate meal, timely response, and the importance of not leaving the inappropriate meal in front of residents on the same date. Staff were educated on 3/29/22, or before their next shift for PRN staff, on the Heimlich Maneuver. The Dietary manager or designee will complete random audits on the use of meal cards and the appropriate diet being prepared and served in accordance with the residents diet. Audits will be performed weekly times 4 weeks, biweekly time 1-month, monthly times one month then randomly as needed. Any immediate action will be identified and corrected. Results will be brought to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING ______ B. WING ______	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVIA RESTORATIVE CARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	Continued From page 3 thickened liquids. Review of the 3/7/22 at 2:55 p.m., report to the State Agency (SA), identified R1 was reported to have choked on meat. Nursing assistants (NA)'s saw R1 choking and called the DON who was in her office across the hall from the dining room. R1 was noted to be cyanotic (blue in color from lack of oxygen) and stopped breathing for approximately 30 seconds. The DON performed the Heimlich Maneuver multiple times with good results. R1 "pinked up" and was responding as per her normal. R1 had some upper airway congestion. EMS was called and transported R1 to the local emergency department (ED) for evaluation. Review of the facility investigation documentation revealed on 3/7/22 at the noon meal, nurse aide (NA)-A retrieved R1's tray from the cart, and placed it in front of R1. When she removed the cover, she noted the meat and broccoli were not provided in the physician ordered mechanical ground texture. NA-A picked up the plate, scooped the meat into the cover, and set the cover in front of the food tray. NA-A instructed R1 (who was cognitively impaired) not to eat the meat, and left R1 unsupervised to obtain the correct textured meal. NA-A then spoke with the dietary manager (DM) who was in the hall, and explained R1 had received the incorrect textured meal. The DM went to obtain the correct meal, and NA-A returned to the dining room. NA-A observed R1 was actively coughing and choking. The director nursing (DON) was summoned and administered the Heimlich Maneuver multiple times to R1 before she was able to expel large chunks of unground meat. R1 became cyanotic and experienced a short period of apnea	F 808		

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	245290	A. BUILDING ______ B. WING ______	C 03/29/2022

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F 808	Continued From page 4 (absence of breathing), before the meat was able to be removed. R1 continued to cough and choke and the Heimlich Maneuver was repeated with more chunks of meat expelled. R1 was then transported to the local (ED) for evaluation at 12:20 p.m., and returned at 1:30 p.m. R1 was placed into bed with the head of her bed elevated and continued to experience increasing secretions and upper airway congestion in addition to cyanosis when coughing. MD-B was updated and provided orders to send to a regional hospital for evaluation and possible bronchoscope if the problems continued or it was felt she was declining. At 6:51 p.m., R1 was noted to have increased secretions and was unable to clear on her own. At times she did cough up thick phlegm but was not able to cough on command. R1 received oral suctioning multiple times with little relief. She was positioned on her side to allow the phlegm to drain from mouth, the ambulance was contacted and R1 was transferred to a regional hospital for further evaluation. On 3/7/22 at 7:22 p.m., the facility received a phone update that R1 had been admitted (ICU) on oxygen with a diagnosis of aspiration pneumonia. Observation and interview on 3/28/22 at 3:30 p.m., with Cook-B in the kitchen identified prior to the incident on 3/7/22 the facility had not utilized diet tray cards. Resident trays were dished up and placed onto the numbered shelves of the cart. There was a list of residents with the corresponding room number and diet posted on the inside of the cart door, but no identification on the tray which identified the specific resident the tray was for. Cook-B reported if staff had a question on a diet or food that was on a tray, the only way they had to verify the contents was to	F 808		

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F 808	Continued From page 5	F 808		

ask the cook or a nurse. Directly across from the steam table in the kitchen, notes were taped to the wall listing special diet types, resident allergies, and other "reminders" the cook would be able to reference if needed. R1's diet was not included in the notes. Cook-B reported R1 had been at the facility "a long time" and "everyone knows" her diet needs. Cook-B identified at the time new residents were admitted or there were changes in diet orders, they were posted by the entrance to the kitchen where staff were to review upon reporting for their shift. The notices remained on the board for a week or two and were then taken down and filed in a book that was on a shelf by the door. Following the incident on 3/7/22, the DM had implemented diet tray cards that were printed for each meal and contained the resident's name, room number, diet and choices in addition to any special orders, such as any altered texture, or thickened liquids. The cards were now used by the cook when plating food and immediately placed on the tray containing individual resident food items. It was the responsibility of the dietary aide (DA) to ensure all trays had a card before the cart was taken from the kitchen.

Interview on 3/28/22 at 3:14 p.m., with the medical director (MD)-A identified he was in agreement if R1 had been served the appropriate mechanical therapeutic diet verses a regular diet, she would likely not have choked or aspirated. MD-A was unaware the facility did not have a system in place as a safeguard against this type of incident prior to the occurrence. He agreed the facility should have had measures in place, such as utilization of diet cards to ensure residents received their medically ordered diets to prevent choking.

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F 808	Continued From page 6 Interview on 3/28/22 at 4:00 p.m., with the DON identified she was in her office on 3/7/22 at 12:25 p.m. when NA-H knocked on the door and stated she was needed in the dining room right away. The DON reported she had immediately gone to the dining room and observed R1 seated at a table across the room. R1 was "trying to cough" and was choking. She rushed to R1 who appeared cyanotic. R1 had a pulse, and then stopped breathing for approximately 30 seconds. The DON told staff to call 911, and performed the Heimlich maneuver several times when a chunk of "stringy-textured meat" came out of R1's mouth. She began gasping and attempting to speak. R1 was wheeled from the dining room to the hall where she continued to cough, gag and choke. The DON performed the Heimlich several more times with more pieces of meat removed each time. R1 was breathing and able to talk, but sounded congested. Her color became "pinker", but she remained cyanotic around her mouth. EMS arrived and R1 was transported to the local hospital for further evaluation. R1 returned about 1.5 to 2 hours later, but her O2 sats remained in the upper 70's to low 80's. She required staff to suction her mouth frequently due to excessive phlegm that she was not able to cough out. The DON reported she was not comfortable with R1 remaining in the facility with her oxygen levels low, so she contacted R1's primary medical provider. The DON reported she had immediately telephoned MD-B and updated him on R1's condition. MD-B gave orders that R1 should be transferred to a larger regional hospital for further evaluation that was not available locally. The DON contacted the regional hospital and contacted EMS. Later that evening, she was updated R1 had received x-rays and had been	F 808		

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F 808	Continued From page 7	F 808		

admitted to ICU with aspiration pneumonia. The DON identified the cause of the incident as dietary staff served R1 the incorrect consistency meat. The error was not discovered until NA-A delivered and uncovered the meal tray. NA-A removed the meat from R1's plate, and put it in the plate cover which she set on the table in front of R1's meal tray. NA-A instructed R1 not to eat the meat and she "would be right back". The DON agreed NA-A left R1 unsupervised with the plate cover containing the chunks of meat within reach, while she went to get the correct consistency meat. While NA-A was gone, R1 attempted to eat the meal and choked. The DON identified R1's cognition was coded as severe due to her inability to communicate. The DON identified her expectation would be for dietary to have plated the correct diet.and NA staff were not to leave incorrect consistency food on the table where a resident could attempt to eat it. The DON agreed there was a potential for harm and or death as a result of being served incorrect diets such as choking and airway obstruction. NA-A received verbal counseling following the incident, but no documentation of counseling and/or coaching was provided. Cook-A was suspended pending the investigation and was allowed to return following re-education on diets and the new system that was put into place. The DON made no mention the facility identified staff delay in administering the Heimlich maneuver to any resident could result in harm or death.

R1's current, undated care plan identified R1 had a nutritional problem due to dysphasia. Staff were to ensure she had use of a lip plate, encourage R1 to feed herself as able, and provide assistance as needed. Per speech therapy, staff were to have R1 turn her head to the right with

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F 808	Continued From page 8 swallowing and instruct her to swallow twice with each bite. It was noted R1 may take up to 10 seconds for second swallowing effort. Staff were to sit with R1 for the first 5-10 minutes of each meal and provide reminders for swallowing, and continue to monitor and encourage R1 throughout the remainder of the meal. Review of the 3/7/22 at 12:16 p.m., local hospital ED report identified R1 was seen due to choking on a piece of meat that was removed after application of the Heimlich Maneuver. R1 was able to breathe but did have increased upper airway secretions. R1 had a weak cough and x-ray identified her lungs appeared clear with no acute infiltrates identified. Discharge instructions included to elevate the head of her bed at least 30 degrees, provide frequent suction to assist with secretions, and follow up with primary provider (MD)-B. If hypoxia (low oxygen saturation level(O2 sat)) less than 90%, the ED recommended the facility consult with R1's physician and possibly return to ED for further evaluation. Review of the 3/7/22 at 7:55 p.m., regional hospital ED report identified R1 was able to respond to questions with occasional "yes/no", responses but was not able to provide information on her condition. R1 had been transferred to the regional ED due to excessive respiratory tract secretions following a choking episode earlier that day. R1's oxygen level (SpO2) was reported as 82% (normal 92 - 100%) on room air at the time of arrival. Earlier that day, R1 had received a regular texture meal, choked, and required the Heimlich in an attempt to remove the obstruction. R1 was diagnosed with acute hypoxic (lack of oxygen) respiratory failure from the aspiration	F 808		

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F 808	Continued From page 9	F 808		

episode and aspiration pneumonia. The 3/9/22, hospital discharge summary identified R1 had a history of Barrette's esophagus (damage to the lower portion of the esophagus), stroke with aphasia, and right sided weakness. R1 had received Speech Therapy since 2020 and was on a mechanical ground diet with thickened liquids. On 3/7/22, R1 had received the wrong meal and had choked with some aspiration. R1 was treated with antibiotics and high flow oxygen therapy and weaned back to room air at the time of discharge. The hospital speech therapy evaluated R1 prior to discharge and recommended a pureed texture diet with nectar thickened liquids.

R1's progress notes identified on 3/7/22 at:
1) 12:00 p.m., R1 was in the dining room eating lunch and choked on meat. An unidentified NA ran to get the DON from her office and informed her that R1 was choking. R1 was cyanotic and did stop breathing for approximately 30 seconds. DON administered Heimlich maneuver multiple times with success. R1 continued to have upper airway congestion and coughing and required additional Heimlich attempts.
2) 12:20 p.m., R1 was transported to local ED via ambulance.
3) 1:45 p.m., R1 returned from the ED, a chest x-ray appeared to be clear, but her airway was likely inflamed. R1 was noted to be expected to have increased secretions and require suctioning as needed with the head of her bed elevated to 30 degrees.
4) 5:10 p.m. R1 was noted to be having increased secretions and upper airway congestion. R1 had couple episodes of "turning blue". R1's physician (MD)-B was updated and directed staff if R1 continued to have problems, or worsened, she was to be sent to the regional

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F 808	Continued From page 10 hospital. 5) 6:51 p.m., R1 continued to have increased secretions. She was not able to clear her airway without assistance, and continued to have thick phlegm. She was unable to cough on command. R1 did become cyanotic at times with coughing and was suctioned multiple times with little relief. 6) 5:40 p.m., R1 was transferred to the regional hospital via ambulance. 7) 7:22 p.m., R1 was being admitted with a diagnosis of aspiration pneumonia. Interview on 3/29/22 at 8:30 a.m., with cook-A identified when a resident was admitted to the facility, the kitchen was notified via a paper form of the dietary order and/or any special type or consistency. The form was posted on the bulletin board for a 1-2 week period to allow all dietary staff to review the order. That form was then filed in a binder kept in the kitchen. Diet tray cards were now to be used by the cook as she plated food for the meal service. Cook-A served the noon meal on 3/7/22, and was aware R1's diet was supposed to be mechanical ground with thickened liquids. She stated she did not know what happened or how she had made the error, but she was not aware of the incident until she was telephoned prior to her return for the 3/7/22, evening shift. Following the incident, she had been suspended during an investigation from 3/7/22 until 3/12/22 when she returned to work. She had received education on the implementation of new diet tray cards and education on dietary requirements and acceptable foods allowed for altered diets. Interview on 3/29/22 at 8:40 a.m., with MD-B identified R1 should not have been served the improper diet, NA-A should not have left he plate	F 808		

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F 808	Continued From page 11 near her, and immediate intervention should have occurred. The incident had the potential for harm and/or death. R1 had severely decreased cognition and in his opinion likely was not able to understand simple commands. Interview on 3/29/22 at 9:46 a.m., with NA-A identified she was working on 3/7/22. She retrieved R1's tray and placed it in front of R1 and removed the cover. NA-A recognized the diet was not correct, as the meat was cut into pieces and was not mechanically ground. NA-A stated she transferred the meat from R1's plate into the cover, which she placed on the table in front of R1's tray. She instructed R1 to not eat the meat and advised her she would be right back. NA-A left the dining room, and met the DM in the hall. She explained she needed a different meat for R1 that was ground and returned to the dining room where she discovered R1 choking. When she reached R1 she observed R1 had taken the pieces of meat from the cover and was choking. NA-A directed NA-H to get the DON and remained with R1 who she encouraged her to cough up the food. NA-A stated she did not know why she had not removed the meat from the table, but felt R1 would begin eating her other food items until she got back with the ground meat. NA-A realized she should have taken the meat with her and not risked R1, who could and did try to eat it. After the incident, diet tray cards had been implemented and included the resident name, diet, dislikes, and allergies. The card was placed on the tray at the time it was plated. The card remained on the tray with the resident's plate at the table. NA-A stated she had received training on identifying a resident choking and how to respond with the Heimlich maneuver on 3/29/22. NA-A reported Speech Therapy had	F 808		

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F 808	Continued From page 12 also provided staff instruction on how to asssit R1 when she was eating following her readmission on 3/10/22. NA-A identified Nursing staff are in the hall passing medications during meals and were to be able to be reached by use of a walkie talkie if they are needed in the dining room for a concern. Interview on 3/29/22 at 11:43 a.m., with the dietary manager (DM) confirmed prior to the incident, orders were posted on the bulletin board for staff review upon entering the kitchen and remained posted for 2 weeks. After that, they were placed into a binder kept in the kitchen. When questioned about diet orders and how staff knew what a resident's diet was, she replied, staff "knew the residents and their diets since they served them repeatedly" in a small facility. New diet trays were implemented after the incident. The DM agreed there was no method in place at the time of the incident to prevent dietary from accidentally plating the incorrect meal. Review of the International Dysphasia Diet Standardization Initiative (IDDSI) Level 5 Minced and Moist diet identified ground mechanically altered meat to be served finely minced or chopped to 4 millimeter lump size served in a thick, smooth, non-pouring sauce or gravy. The size of the lump of meat was defined as the gap between the prongs of a standard fork. Review of the April 2007, Tray Identification policy identified the Food Services Department was to use appropriate identification to identify diets. The DM or supervisor was to have checked trays for correct diets before they are taken from the kitchen. Nursing staff were to check that each tray contained the correct diet before serving it to	F 808		

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F 808	Continued From page 13 a resident. The dietary department was to be notified immediately if there was an error and dietary staff were to immediately provide the correct diet. The immediate jeopardy that began on 3/7/22 at 12:00 p.m. was removed on 3/29/22 at 6:45 p.m., when it was verified by interview and document review the facility reviewed and provided competency on dietary policies and procedures. Both nursing and dietary staff had received education on identifying resident diet cards for trays and ensure the appropriate diet was being provided. All staff also were educated to identify and respond to choking situations and how and when to perform the Heimlich maneuver if necessary.	F 808		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: Surveyor: 34083 On 3/28/29 through 3/29/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic	2 000		

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2 000	Continued From page 1 plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5290042C (MN81625) with a licensing order issued at 0945. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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OLIVIA RESTORATIVE CARE CENTER	**1003 WEST MAPLE OLIVIA, MN 56277**

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on interview and document review the facility failed to provide a physician ordered mechanically ground diet of meat (pork roast) to 1	2 945	Corrected.	5/2/22

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2 945	Continued From page 3 of 1 resident (R1). R1 subsequently began choking. Staff also failed to immediately perform the Heimlich maneuver, delaying potentially lifesaving treatment. This resulted in actual harm as R1 required a higher level of care after developing aspiration pneumonia (when food, saliva, or liquids are breathed into the lungs or airway instead of swallowed into the stomach) requiring medical intervention at the regional hospital. Findings include: R1's current, undated diagnoses list identified she experienced a stroke on 12/3/20, which resulted in dysphasia (difficulty swallowing), hemiplegia (paralysis of one side), aphasia (a language disorder that affects a person's ability to communicate), and anxiety disorder. R1's 2/7/22 Significant Change, Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and required supervision with eating. R1's current physician orders identified her diet was to be mechanical ground with nectar thickened liquids. Review of the 3/7/22 at 2:55 p.m., report to the State Agency (SA), identified R1 was reported to have choked on meat. Nursing assistants (NA)'s saw R1 choking and called the DON who was in her office across the hall from the dining room. R1 was noted to be cyanotic (blue in color from lack of oxygen) and stopped breathing for approximately 30 seconds. The DON performed the Heimlich Maneuver multiple times with good results. R1 "pinked up" and was responding as per her normal. R1 had some upper airway	2 945		

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2 945	Continued From page 4 congestion. EMS was called and transported R1 to the local emergency department (ED) for evaluation. Review of the facility investigation documentation revealed on 3/7/22 at the noon meal, nurse aide (NA)-A retrieved R1's tray from the cart, and placed it in front of R1. When she removed the cover, she noted the meat and broccoli were not provided in the physician ordered mechanical ground texture. NA-A picked up the plate, scooped the meat into the cover, and set the cover in front of the food tray. NA-A instructed R1 (who was cognitively impaired) not to eat the meat, and left R1 unsupervised to obtain the correct textured meal. NA-A then spoke with the dietary manager (DM) who was in the hall, and explained R1 had received the incorrect textured meal. The DM went to obtain the correct meal, and NA-A returned to the dining room. NA-A observed R1 was actively coughing and choking. The director nursing (DON) was summoned and administered the Heimlich Maneuver multiple times to R1 before she was able to expel large chunks of unground meat. R1 became cyanotic and experienced a short period of apnea (absence of breathing), before the meat was able to be removed. R1 continued to cough and choke and the Heimlich Maneuver was repeated with more chunks of meat expelled. R1 was then transported to the local (ED) for evaluation at 12:20 p.m., and returned at 1:30 p.m. R1 was placed into bed with the head of her bed elevated and continued to experience increasing secretions and upper airway congestion in addition to cyanosis when coughing. MD-B was updated and provided orders to send to a regional hospital for evaluation and possible bronchoscope if the problems continued or it was felt she was declining. At 6:51 p.m., R1 was	2 945		

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2 945	Continued From page 5 noted to have increased secretions and was unable to clear on her own. At times she did cough up thick phlegm but was not able to cough on command. R1 received oral suctioning multiple times with little relief. She was positioned on her side to allow the phlegm to drain from mouth, the ambulance was contacted and R1 was transferred to a regional hospital for further evaluation. On 3/7/22 at 7:22 p.m., the facility received a phone update that R1 had been admitted (ICU) on oxygen with a diagnosis of aspiration pneumonia. Observation and interview on 3/28/22 at 3:30 p.m., with Cook-B in the kitchen identified prior to the incident on 3/7/22 the facility had not utilized diet tray cards. Resident trays were dished up and placed onto the numbered shelves of the cart. There was a list of residents with the corresponding room number and diet posted on the inside of the cart door, but no identification on the tray which identified the specific resident the tray was for. Cook-B reported if staff had a question on a diet or food that was on a tray, the only way they had to verify the contents was to ask the cook or a nurse. Directly across from the steam table in the kitchen, notes were taped to the wall listing special diet types, resident allergies, and other "reminders" the cook would be able to reference if needed. R1's diet was not included in the notes. Cook-B reported R1 had been at the facility "a long time" and "everyone knows" her diet needs. Cook-B identified at the time new residents were admitted or there were changes in diet orders, they were posted by the entrance to the kitchen where staff were to review upon reporting for their shift. The notices remained on the board for a week or two and were then taken down and filed in a book that was on a shelf by the door. Following the incident	2 945		

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2 945	Continued From page 6	2 945		

on 3/7/22, the DM had implemented diet tray cards that were printed for each meal and contained the resident's name, room number, diet and choices in addition to any special orders, such as any altered texture, or thickened liquids. The cards were now used by the cook when plating food and immediately placed on the tray containing individual resident food items. It was the responsibility of the dietary aide (DA) to ensure all trays had a card before the cart was taken from the kitchen.

Interview on 3/28/22 at 3:14 p.m., with the medical director (MD)-A identified he was in agreement if R1 had been served the appropriate mechanical therapeutic diet verses a regular diet, she would likely not have choked or aspirated. MD-A was unaware the facility did not have a system in place as a safeguard against this type of incident prior to the occurrence. He agreed the facility should have had measures in place, such as utilization of diet cards to ensure residents received their medically ordered diets to prevent choking.

Interview on 3/28/22 at 4:00 p.m., with the DON identified she was in her office on 3/7/22 at 12:25 p.m. when NA-H knocked on the door and stated she was needed in the dining room right away. The DON reported she had immediately gone to the dining room and observed R1 seated at a table across the room. R1 was "trying to cough" and was choking. She rushed to R1 who appeared cyanotic. R1 had a pulse, and then stopped breathing for approximately 30 seconds. The DON told staff to call 911, and performed the Heimlich maneuver several times when a chunk of "stringy-textured meat" came out of R1's mouth. She began gasping and attempting to speak. R1 was wheeled from the dining room to

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2 945	Continued From page 7	2 945		
	the hall where she continued to cough, gag and choke. The DON performed the Heimlich several more times with more pieces of meat removed each time. R1 was breathing and able to talk, but sounded congested. Her color became "pinker", but she remained cyanotic around her mouth. EMS arrived and R1 was transported to the local hospital for further evaluation. R1 returned about 1.5 to 2 hours later, but her O2 sats remained in the upper 70's to low 80's. She required staff to suction her mouth frequently due to excessive phlegm that she was not able to cough out. The DON reported she was not comfortable with R1 remaining in the facility with her oxygen levels low, so she contacted R1's primary medical provider. The DON reported she had immediately telephoned MD-B and updated him on R1's condition. MD-B gave orders that R1 should be transferred to a larger regional hospital for further evaluation that was not available locally. The DON contacted the regional hospital and contacted EMS. Later that evening, she was updated R1 had received x-rays and had been admitted to ICU with aspiration pneumonia. The DON identified the cause of the incident as dietary staff served R1 the incorrect consistency meat. The error was not discovered until NA-A delivered and uncovered the meal tray. NA-A removed the meat from R1's plate, and put it in the plate cover which she set on the table in front of R1's meal tray. NA-A instructed R1 not to eat the meat and she "would be right back". The DON agreed NA-A left R1 unsupervised with the plate cover containing the chunks of meat within reach, while she went to get the correct consistency meat. While NA-A was gone, R1 attempted to eat the meal and choked. The DON identified R1's cognition was coded as severe due to her inability to communicate. The DON identified her expectation would be for dietary to			

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2 945	Continued From page 8	2 945		

have plated the correct diet.and NA staff were not to leave incorrect consistency food on the table where a resident could attempt to eat it. The DON agreed there was a potential for harm and or death as a result of being served incorrect diets such as choking and airway obstruction. NA-A received verbal counseling following the incident, but no documentation of counseling and/or coaching was provided. Cook-A was suspended pending the investigation and was allowed to return following re-education on diets and the new system that was put into place. The DON made no mention the facility identified staff delay in administering the Heimlich maneuver to any resident could result in harm or death.

R1's current, undated care plan identified R1 had a nutritional problem due to dysphasia. Staff were to ensure she had use of a lip plate, encourage R1 to feed herself as able, and provide assistance as needed. Per speech therapy, staff were to have R1 turn her head to the right with swallowing and instruct her to swallow twice with each bite. It was noted R1 may take up to 10 seconds for second swallowing effort. Staff were to sit with R1 for the first 5-10 minutes of each meal and provide reminders for swallowing, and continue to monitor and encourage R1 throughout the remainder of the meal.

Review of the 3/7/22 at 12:16 p.m., local hospital ED report identified R1 was seen due to choking on a piece of meat that was removed after application of the Heimlich Maneuver. R1 was able to breathe but did have increased upper airway secretions. R1 had a weak cough and x-ray identified her lungs appeared clear with no acute infiltrates identified. Discharge instructions included to elevate the head of her bed at least 30 degrees, provide frequent suction to assist

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2 945	Continued From page 9	2 945		

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with secretions, and follow up with primary provider (MD)-B. If hypoxia (low oxygen saturation level(O2 sat)) less than 90%, the ED recommended the facility consult with R1's physician and possibly return to ED for further evaluation.

Review of the 3/7/22 at 7:55 p.m., regional hospital ED report identified R1 was able to respond to questions with occasional "yes/no", responses but was not able to provide information on her condition. R1 had been transferred to the regional ED due to excessive respiratory tract secretions following a choking episode earlier that day. R1's oxygen level (SpO2) was reported as 82% (normal 92 - 100%) on room air at the time of arrival. Earlier that day, R1 had received a regular texture meal, choked, and required the Heimlich in an attempt to remove the obstruction. R1 was diagnosed with acute hypoxic (lack of oxygen) respiratory failure from the aspiration episode and aspiration pneumonia. The 3/9/22, hospital discharge summary identified R1 had a history of Barrette's esophagus (damage to the lower portion of the esophagus), stroke with aphasia, and right sided weakness. R1 had received Speech Therapy since 2020 and was on a mechanical ground diet with thickened liquids. On 3/7/22, R1 had received the wrong meal and had choked with some aspiration. R1 was treated with antibiotics and high flow oxygen therapy and weaned back to room air at the time of discharge. The hospital speech therapy evaluated R1 prior to discharge and recommended a pureed texture diet with nectar thickened liquids.

R1's progress notes identified on 3/7/22 at:
1) 12:00 p.m., R1 was in the dining room eating lunch and choked on meat. An unidentified NA ran to get the DON from her office and informed

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2 945	Continued From page 10 her that R1 was choking. R1 was cyanotic and did stop breathing for approximately 30 seconds. DON administered Heimlich maneuver multiple times with success. R1 continued to have upper airway congestion and coughing and required additional Heimlich attempts. 2) 12:20 p.m., R1 was transported to local ED via ambulance. 3) 1:45 p.m., R1 returned from the ED, a chest x-ray appeared to be clear, but her airway was likely inflamed. R1 was noted to be expected to have increased secretions and require suctioning as needed with the head of her bed elevated to 30 degrees. 4) 5:10 p.m. R1 was noted to be having increased secretions and upper airway congestion. R1 had couple episodes of "turning blue". R1's physician (MD)-B was updated and directed staff if R1 continued to have problems, or worsened, she was to be sent to the regional hospital. 5) 6:51 p.m., R1 continued to have increased secretions. She was not able to clear her airway without assistance, and continued to have thick phlegm. She was unable to cough on command. R1 did become cyanotic at times with coughing and was suctioned multiple times with little relief. 6) 5:40 p.m., R1 was transferred to the regional hospital via ambulance. 7) 7:22 p.m., R1 was being admitted with a diagnosis of aspiration pneumonia. Interview on 3/29/22 at 8:30 a.m., with cook-A identified when a resident was admitted to the facility, the kitchen was notified via a paper form of the dietary order and/or any special type or consistency. The form was posted on the bulletin board for a 1-2 week period to allow all dietary staff to review the order. That form was then filed in a binder kept in the kitchen. Diet tray cards	2 945		

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were now to be used by the cook as she plated food for the meal service.
Cook-A served the noon meal on 3/7/22, and was aware R1's diet was supposed to be mechanical ground with thickened liquids. She stated she did not know what happened or how she had made the error, but she was not aware of the incident until she was telephoned prior to her return for the 3/7/22, evening shift. Following the incident, she had been suspended during an investigation from 3/7/22 until 3/12/22 when she returned to work. She had received education on the implementation of new diet tray cards and education on dietary requirements and acceptable foods allowed for altered diets.

Interview on 3/29/22 at 8:40 a.m., with MD-B identified R1 should not have been served the improper diet, NA-A should not have left he plate near her, and immediate intervention should have occurred. The incident had the potential for harm and/or death. R1 had severely decreased cognition and in his opinion likely was not able to understand simple commands.

Interview on 3/29/22 at 9:46 a.m., with NA-A identified she was working on 3/7/22. She retrieved R1's tray and placed it in front of R1 and removed the cover. NA-A recognized the diet was not correct, as the meat was cut into pieces and was not mechanically ground. NA-A stated she transferred the meat from R1's plate into the cover, which she placed on the table in front of R1's tray. She instructed R1 to not eat the meat and advised her she would be right back. NA-A left the dining room, and met the DM in the hall. She explained she needed a different meat for R1 that was ground and returned to the dining room where she discovered R1 choking. When she reached R1 she observed R1 had taken the

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pieces of meat from the cover and was choking. NA-A directed NA-H to get the DON and remained with R1 who she encouraged her to cough up the food. NA-A stated she did not know why she had not removed the meat from the table, but felt R1 would begin eating her other food items until she got back with the ground meat. NA-A realized she should have taken the meat with her and not risked R1, who could and did try to eat it. After the incident, diet tray cards had been implemented and included the resident name, diet, dislikes, and allergies. The card was placed on the tray at the time it was plated. The card remained on the tray with the resident's plate at the table. NA-A stated she had received training on identifying a resident choking and how to respond with the Heimlich maneuver on 3/29/22. NA-A reported Speech Therapy had also provided staff instruction on how to asssit R1 when she was eating following her readmission on 3/10/22. NA-A identified Nursing staff are in the hall passing medications during meals and were to be able to be reached by use of a walkie talkie if they are needed in the dining room for a concern.

Interview on 3/29/22 at 11:43 a.m., with the dietary manager (DM) confirmed prior to the incident, orders were posted on the bulletin board for staff review upon entering the kitchen and remained posted for 2 weeks. After that, they were placed into a binder kept in the kitchen. When questioned about diet orders and how staff knew what a resident's diet was, she replied, staff "knew the residents and their diets since they served them repeatedly" in a small facility. New diet trays were implemented after the incident. The DM agreed there was no method in place at the time of the incident to prevent dietary from accidentally plating the incorrect meal.

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Review of the International Dysphasia Diet Standardization Initiative (IDDSI) Level 5 Minced and Moist diet identified ground mechanically altered meat to be served finely minced or chopped to 4 millimeter lump size served in a thick, smooth, non-pouring sauce or gravy. The size of the lump of meat was defined as the gap between the prongs of a standard fork.

Review of the April 2007, Tray Identification policy identified the Food Services Department was to use appropriate identification to identify diets. The DM or supervisor was to have checked trays for correct diets before they are taken from the kitchen. Nursing staff were to check that each tray contained the correct diet before serving it to a resident. The dietary department was to be notified immediately if there was an error and dietary staff were to immediately provide the correct diet.

The immediate jeopardy that began on 3/7/22 at 12:00 p.m. was removed on 3/29/22 at 6:45 p.m., when it was verified by interview and document review the facility reviewed and provided competency on dietary policies and procedures. Both nursing and dietary staff had received education on identifying resident diet cards for trays and ensure the appropriate diet was being provided. All staff also were educated to identify and respond to choking situations and how and when to perform the Heimlich maneuver if necessary.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures to ensure the correct diet order was served and any potentially lifesaving measures such as Heimlich

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2 945	Continued From page 14 maneuver are provided. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents are provided food according to the correct diet type and consistency, and that all staff are educated and deemed competent in performing life-saving maneuvers to prevent delay. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 945		