STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065189	A. BUILDING _____ B. WING _____	05/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAKS CARE CENTER THE	1440 COFFMAN ST LONGMONT, CO 80501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and record review the facility failed to ensure nine (#1, #2, #3, #4, #5, #6, #7, #8 and #9) of nine sampled residents received the care and services necessary to meet their nutrition and hydration needs and to maintain their highest level of physical well-being. -This failure created the likelihood of immediate and serious adverse outcome for Resident #2. -This failure compromised the nutritional status of Residents #1, #3, #4, #5, #6, #7, #8 and #9 who experienced weight loss, at a significant level. Specifically: ASPIRATION AND CHOKING RISK -Resident #2, severely cognitively impaired, had a long standing and significant history of dysphagia. In September 2019, speech therapy (ST) assessed the resident at severe risk of aspiration and choking, and recommended nectar thick liquids (NTL). Although the resident declined the recommendation, documented in a dietary waiver dated 9/10/19, the facility failed to take steps, beyond the waiver, to promote the resident's safe and adequate fluid intake. Specifically, ST recommendations (close supervision, upright at 90 degrees during and after meals, head of bed at 45 degrees at all times, alternating small bites/sips), were not incorporated into the resident's care plan and not implemented by staff. Further, when ST notes documented the resident's acceptance of NTL beginning the first week in April 2020, which lessened his risk of aspiration and choking, the facility failed to communicate this change by obtaining an order for [REDACTED].#2 experiencing aspiration, aspiration pneumonia and severe physical decline. -Resident #1 failed to receive supervision while eating after choosing to go against diet texture recommendations and eat regular texture food instead of the recommended puree texture based on [MEDICAL CONDITION] complications and a history of an emergent hospitalization related to eating regular texture food and food stuck in his esophagus. Lack of staff supervision created the potential for compromised nutritional status - aspiration, choking and physical decline. WEIGHT LOSS -Resident #2, who was severely cognitively impaired, required assistance with eating, and was at risk for aspiration and choking (see above), failed to receive adequate and timely interventions to promote his nutritional status (weight maintenance and/or weight gain). He experienced a severe weight loss in one month (23.2#/12.7%) -Resident #3, who was severely cognitively impaired and required extensive assistance with eating, failed to receive adequate and timely interventions to promote his nutritional status (weight maintenance and/or weight gain) after weight loss was identified and the resident began eating in his room, instead of the restorative dining room. He experienced a severe weight loss in one month (11.6#/ 7%). -Residents #4, #5, #6, #7, #8 and #9, identified with weight loss, failed to receive timely interventions to assist with weight maintenance and/or weight gain. All six residents experienced significant weight loss. Findings include: I. IMMEDIATE JEOPARDY A. Findings of immediate jeopardy Resident #2, severely cognitively impaired, had a long standing and significant history of dysphagia. In September 2019, speech therapy (ST) assessed the resident at severe risk of aspiration and choking, and recommended nectar thick liquids (NTL). Although the resident declined the recommendation, documented in a dietary waiver dated 9/10/19, the facility failed to take steps, beyond the waiver, to promote the resident's safe and adequate fluid intake. Specifically, ST recommendations (close supervision, upright at 90 degrees during and after meals, head of bed at 45 degrees at all times, and alternating small bites/sips), were not incorporated into the resident's care plan and not implemented by staff. Further, when ST notes documented the resident's acceptance of NTL beginning the first week in April 2020, which lessened his risk of aspiration and choking, the facility failed to communicate this change by obtaining an order for [REDACTED].#2 experiencing aspiration, aspiration pneumonia and severe physical decline. On 4/30/2020 7:06 p.m., the nursing home administrator (NHA), unit manager, and director of clinical operations (DCO) were notified of the immediate jeopardy situation created by the facility's failure to take steps, beyond the dietary waiver, to promote the Resident #2's safe and adequate nutritional intake. B. Facility plan to remove immediate jeopardy On 5/1/2020 at 1:04 p.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: Alleged Deficient Practice Staff did not monitor or provide cueing for the resident # 8219 (Resident #2) to eat and drink according to speech therapy directions for his dysphagia. Resident #8219 has order for Mechanical Soft texture and SLP has recommended nectar thick liquids. Power of Attorney is adamant of honoring resident's rights and has signed a waiver to allow thin liquids. Corrective Action On 4/30/2020 all staff providing care to resident #8219 were educated on the following: Food and liquids will not be left at bedside. The licensed nurse will offer food and liquids every two hours while awake. When resident is provided food or liquids the licensed nurse will assist and monitor. Resident will be encouraged to sit in an upright position when eating and drinking. Hydration and food log will be implemented to monitor intake. Certified nursing assistants will notify licensed nurse when resident is requesting food or liquids. Resident will continue to receive a mechanical soft diet and thin liquids per Power of Attorneys request and waiver in place. Identification of Others All residents at the facility have the potential of being affected by this alleged deficient practice. The Director of Nursing and Speech therapist will conduct an audit completed by 5/4/2020 on all residents that are currently receiving a modified diet to ensure those residents are receiving frequent monitoring and supervision when eating. The Speech Therapist will screen all residents receiving a(n) altered/modified diet. Systemic Changes Speech therapist provided dysphagia management education including; dysphagia definitions, Textures, adaptive equipment, strategies, feeding, oral care, waivers, and SLP role. This education was provided to clinical staff on 5/1/2020. Resident(s) that are receiving an altered/modified diet and are at risk of choking and/or aspirating requiring assistance with eating and drinking will receive the assistance needed. Monitoring The DON and/or designee will conduct an audit 5x/week for 90 days in order to ensure residents with altered/modified diets and are at risk for choking and/or aspirating are receiving monitoring and/or assistance during food and fluid intake. The DON/designee will report to QA Committee any identified issues. The DON/designee will be responsible for any follow up recommendations made by the QA Committee The above plan was accepted and the immediate jeopardy situation abated at 1:04 p.m. on 5/1/2020, based on interviews obtained with staff, indicating they had been informed of Resident #2's dietary restrictions. However, observations, record review and interviews revealed deficient practice remained at H level, a pattern of actual harm. II. RESIDENTS AT ASPIRATION AND CHOKING RISK A. Resident #2 Resident #2, [AGE] years old, admitted to the facility on [DATE]. According to the computerized physician orders [REDACTED]. The 4/6/2020 minimum data set (MDS) documented the resident was severely cognitively impaired and was unable to complete the brief interview for mental status. The assessment revealed he had short and long-term memory problems and decision-making was severely impaired. He required extensive assistance with all activities of daily living (ADL) and supervision with eating. The swallowing/nutritional status MDS dated [DATE], documented the resident would cough or choke during meals or when swallowing medication and required mechanically altered diet which required a change in texture of food or liquids. 1. Record review revealed the facility knew of the resident's need for supervision and assistance at meals to prevent aspiration and choking, well before the 4/6/2020 swallow/nutritional status MDS above. Although the most current dietary profile dated 12/16/19, after his readmission from the hospital for aspiration pneumonia, documented the resident was alert and did not have chewing or swallowing problems, a 9/10/19 speech evaluation and a subsequent evaluation 4/1/2020 indicated otherwise. a. The evaluation dated 9/10/19 documented the resident had long-standing dysphagia and swallowing had become worse. The

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

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

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F 0692 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) evaluation read: -Patient had modified [MEDICATION NAME] swallow studies in the hospital as recently 12/2018. At that time it was recommended the patient consume pureed food and nectar thick liquid. Patient refused recommendation and signed a waiver to continue regular textures and thin liquids. -PLOF (prior level of function): nectar thick liquids, and severe swallowing abilities. -Assessment summary: Patient as severe risk of aspiration and choking; ST eval(uation) only as patient wishes to remain on regular thin liquids. Patient may be offered nectar thick, waiver in place for regular thick liquids. POA (power of attorney) provided extensive education regarding risks and benefits of consuming regular diet vs benefits of following recommended diet. -Risk factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is a risk for aspiration, malnutrition, pneumonia, weight loss, dehydration and further decline function. -Recommendations: Solids=Puree Consistencies, Liquids=nectar thick liquids (NTL), close supervision, upright at 90 degrees, small bites/sips, alternate bites of solids with sips of liquieds. Upright for at least 30 minutes after meals, HOB (head of bed) at least 45 degrees at all times. Patient does not follow recommendations. b. A 4/1/2020 speech evaluation documented the resident had a recent change in medical condition and increased difficulty swallowing. The evaluation read: -Assessment summary: Patient with moderate to severe oropharyngeal dysphagia (difficulty initiating a swallow). Recommend pureed, nectar thick liquids. Decreased functional activity tolerance, requires frequent breaks due to medical condition. -Risk factors: Aspiration. -Recommendations: Solids=Puree consistencies, Liquids = nectar thick liquids, close supervision. Upright at 90 degrees, small bites/sips. Patient refuses recommendations of nectar and pureed. Agreeable to naturally soft. Diet order switched to mechanical soft, thin liquids. Subsequent ST encounter notes 4/1 and 4/2 read the resident continued to refuse NTL, despite risk of aspiration and cough with thin liquids by cup. 2. Resident #2 and facility response to speech evaluations and recommendations Resident #2, through his power of attorney (POA), declined the ST recommendations in a dietary waiver, dated the same day as the 9/10/19 speech evaluation. The waiver read a pureed meal with nectar thick liquids had been recommended because of the resident's frequent coughing, near choking at meals. It further read, I understand that eating foods of a texture that are not recommended by the doctor and speech-language pathologist could result in choking, aspiration pneumonia and/or death. Comments on the form read, may offer nectar thickened liquids, pureed. If (patient) declines, honor his wishes. 3. Although the resident declined the speech recommendation for NTL as set forth in the 9/10/19 dietary waiver, record review and interview revealed the facility failed to take steps, beyond the waiver, to promote the resident's safe and adequate fluid intake. a. Failure to provide Resident #2 close supervision at mealtime. Interview with the nursing home administrator (NHA) on 5/1/2020 at approximately 10:00 a.m., revealed that since the COVID-19 pandemic (in March when communal dining was restricted), Resident #2 has eaten his meals in his room. The NHA said before that, the resident ate in the restorative dining room; there a nurse supervised the resident. The 4/6/2020 MDS assessment read Resident #2 required supervision with eating (see above), and the 4/6/2020 MDS triggered care plan updates that referenced the resident's risk for fluid deficit related to thickened fluids and his risk for aspiration pneumonia and/or choking. However, neither care plan addressed the resident's need for close supervision at mealtime as recommended by the ST even though, currently, he was eating his meals in his room rather than under nursing supervision in the restorative dining room. Specifically: -The care plan revised 4/6/2020 that documented the resident was at risk for fluid deficit related to thickened fluids read, (R)esident adamantly declines thickened fluids, family aware and waiver has been signed. The goal was for the risk of fluid deficits to be minimized with interventions through review date. Interventions included document episodes of diarrhea and emesis, fluids at bedside if not contraindicated, offer fluids at meals and at medication pass, provide appropriate fluid consistenc(y) (undefined) and refer to speech therapist (ST) if indicated. -The care plan revised on 4/6/2020 that documented the resident was at risk for aspiration pneumonia and/or chocking due to making the choice of not following recommendations (in regards to diet texture/fluid consistency) by facility staff read, the goal was for the risk of aspiration/choking will be minimized with interventions. Interventions included to honor the residents choice, monitor lungs and vital signs as needed, provide resident and family education regarding risk factors, refer to ST as needed and review risk vs benefit statements quarterly and as needed. Record review and interviews confirmed both Resident #2's need for, yet staff's failure to provide, close supervision during meals for the resident's safety and to ensure adequate intake. -A 4/13/2020 physician note read the physician saw the resident on 4/13/2020 for [MEDICAL CONDITION], dehydration and a (recent) emergency room (ER) visit. The note read, The patient does have what appears to be fairly significant dysphagia. He is on a modified diet with pureed texture and nectar thick liquids. Continue to monitor closely for aspiration. He appears to be an ongoing aspiration risk given his history of [MEDICAL CONDITION](stroke). It further read under hospital course: Episodes where he has difficulty with swallowing and there is concern that he will have an aspiration event. He has had pneumonia in the past, presumably related to this. The director of rehabilitation (DOR), interviewed by phone on 4/30/2020 at 4:29 p.m., said her team had recently gotten involved with Resident #2 because he had increased difficulty with swallowing and the resident was experiencing weight loss. She said he should have close supervision while eating because he does have difficulty, coughs a lot and staff can encourage him to eat. She said Resident #2 was definitely at risk of aspiration pneumonia and death if he continues to eat what he wants. She said he is at more risk because of his prior [MEDICAL CONDITION]. Certified nurse aide (CNA) #5, interviewed on 4/30/2020 at 2:45 p.m. said Resident #2 required minimal assistance with meals. She said staff would cut up his food and cue him when they walked by his room, but said no one stays in there (his room) when he eats. The ST, interviewed on 5/1/2020 at approximately 3:00 p.m., said she met with Resident #2 and completed a speech evaluation. She said the resident should receive encouragement at mealtime and he required frequent checks; she said one to one supervision would be the best. She further stated his actual intake of food and drink should be observed and any signs and symptoms of difficulty (coughing, gurgling noise and spitting out food) should be reported. b. Failure to provide cueing to alternate small bites/sips, upright positioning at and during meals, head of bed at 45 degrees at all times as recommended by the ST. See care plan revisions above; none of the ST recommendations were addressed on Resident #2's care plan. While the CNA kardex read to monitor for and report any difficulty chewing/swallowing, or signs and symptoms of aspiration, and to report ST services as needed, the kardex did not address the resident's specific need for monitoring at mealtime. CNA documentation for April 2020 read staff did not provide the resident oversight during meals 35 times during the month out of 90 opportunities. Resident #2 was observed on 4/30/2020 at approximately 7:45 p.m. He was lying flat in bed, not at the recommended 45 degrees, and his overbed table was approximately 6 inches from the side of the bed. c. Failure to ensure the resident received NTL once he started accepting NTL in April 2020 to reduce his risk of aspiration. ST encounter notes after 4/2/2020 indicated Resident #2 had become less resistant to NTL. -A note 4/7/2020 read, Patient consumed sips of NTL, improved responsibility to cues for single sips, no overt s/sx (signs/symptoms) dysphagia. Therapist thinned out NTL to slightly thick pt (patient) with delayed min-mod cough 2/2 and trials discontinued. -A note 4/15/2020 read, Patient drinks 8 oz (ounces) of NTL with no coughing. -All notes from 4/3/2020 through 4/29/2020, except the notes from 4/13/2020 and 4/19/2020, documented oral intake for current liquids were NTL. In an interview on 4/30/2020 at 4:29 p.m. the DOR said Resident #2 was currently on NTL and mechanical soft foods because he will do better with this texture; it was the safest texture. In an interview on 5/1/2020 at 3:00 p.m., the ST said she had the resident trial the NTL and the resident tolerated it well. She said when she trialed thin liquids, thin was not okay, (the resident had) immediate and delayed coughing. Yet, there was a lack of communication, order, or evidence staff consistently provided and/or promoted the resident's intake of NTL. Specifically: -CNA #5, in her interview on 4/30/2020 at 2:45 p.m. (see above) said Resident #2 received regular textured food and regular liquids, nothing thickened -Record review revealed, and interview with licensed practical nurse (LPN) #1 on 4/30/2020 at 5:37 p.m. confirmed, Resident #2 did not have an order to receive NTL. -Review of Resident #2's waiver revealed it read that staff may offer NTL, and if the resident declined, to honor his wishes; however, there was no directive on Resident #2's care plan or CNA kardex for staff to start with an offer of NTL, as means to promote NTL and safe fluid intake. -Finally, observations of Resident #2's room on 4/30/2020 at 7:45 p.m. revealed the following liquids on his overbed table: a water pitcher, red punch, and a cup of coffee covered with foil. None of the drinks were NTL. 4. Staff interviews confirmed the facility failed to take steps, beyond the waiver, to promote the resident's safe and adequate nutritional fluid intake. The DOR, in her interview on 4/30/2020 at 4:29 p.m. stated at the NHA's request, she had conducted education with hospitality aides and nursing staff recently; she thought within the last ten days. However, she said nothing was written down, and she had not taken steps to ensure the education was understood and implemented. CNA #2, interviewed on 5/1/2020 at 9:20 a.m. (after immediate jeopardy had been called), said she had heard this morning that the resident needed puree foods and that she was not to feed him, rather the nurse would assist him. The ST, in her interview on 5/1/2020 at 9:05 a.m. (after immediate jeopardy had been called), said the DOR had asked her to go to the facility to educate staff about Resident #2. The director of clinical operations (DCO), NHA

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F 0692 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) and the ST were interviewed together on 5/1/2020 at 10:29 a.m. The DCO said, if the resident had a [DIAGNOSES REDACTED].? (However, the ST in an interview later the same day at 3:00 p.m. said not all aspiration is silent and described the seven levels of aspiration. She said there were only two levels that were considered silent; all the other levels involved coughing.) The DCO also questioned, whether with all of the changes related to COVID-19 and residents eating in their rooms, staff walking down the hall was not supervision enough. The DCO and the ST agreed, however, the resident required supervision, but stated the level of supervision was not defined. 5. Steps taken after abatement of the immediate jeopardy On 5/6/2020 at 12:17 p.m., the Director of Nursing (DON) provided a copy of the education she had completed on 5/5/2020 (five days after the immediate jeopardy was called) which documented Please be aware that the 2 residents (#1 and #2) who have waivers in place must be monitored at every meal. And documented on. There is an order in place that needs to be documented on every meal without fail. They need to be monitored by a LN (licensed nurse) and not a CNA for each meal. The DON agreed the education did not specify which nurses should conduct the monitoring or identify who the two residents were. The in-service training report dated 5/4/2020 at 8:15 a.m. completed by the ST documented for Resident #2, recommendation/approaches included: mechanical soft/thin per waiver and family request; recommend soft moist foods, add moisture to dryer foods and cut food bite size. Check patient frequently during meals and encourage him to eat/drink. Report/document and signs of difficulty swallowing and make sure patient is sitting upright for all PO (by mouth) intake. The goal was for the resident to increase safety and independence with least restrictive diet; decrease risk of malnutrition/dehydration. Signatures completed included an LPN, two CNAs and one hospitality aide. B. Resident #1 Resident #1, age 63, admitted the facility on 7/31/19. According to the CPO, [DIAGNOSES REDACTED]. The 4/21/2020 MDS documented Resident #1 had severe cognitive impairment with a BIMS score of six out of 15. He required supervision with most ADLs including eating, and extensive assistance with toileting and personal hygiene. The swallowing/nutritional status MDS documented the resident had no difficulty when swallowing and did not have a mechanically altered diet. 1. Record review revealed the facility knew of Resident #1's need for supervision and assistance at meals to prevent aspiration and choking, based his edentulous status (without teeth) and his history of choosing to go against diet texture recommendations and triggering emergent hospitalization . A 12/17/19 SLP (speech language pathology) evaluation and plan of treatment documented the resident's medical factors included [MEDICAL CONDITION] dysphagia, aspiration and choking. The oral peripheral exam read the resident was edentulous. The bedside swallowing assessment revealed in pertinent part: -Solids-Regular - Moderate: Clinical s/s (signs/symptoms) dysphagia: patient can masticate (chew) some regular solids; dysphagia appears to be more [MEDICAL CONDITION], as patient was very recently sent out to hospital with impacted solids in his esophagus. -Solids-Mech(anical) Soft - Mild:: Clinical s/s dysphagia; patient has easier time masticating mechanical soft solids, however, recommendation is still for puree due to poor [MEDICAL CONDITION] motility (contracting of esophagus). -[MEDICAL CONDITION] Phase - [MEDICAL CONDITION]: Patient/medial record indicates: Resident recent sent out to hospital to remove impacted solids from esophagus; per nursing, this is the 2nd time in it year he was sent out to hospital for this in the past year. Recommend GI follow up. -Recommendations - Solids = Puree Consistencies, Supervision for oral intake= Close supervision, upright at 90 degrees, small bites. Alternate bites of foods with sips of liquids. Slow rate. Recommend follow up with GI due to [MEDICAL CONDITION] dismotility. 2. Resident #1 and facility response to SLP recommendations Resident #1 declined the SLP recommendations, signing a dietary waiver the same day as the 12/17/19 SLP evaluation. The waiver read the interdisciplinary team had recommended the resident to be on a pureed diet because of narrow esophagus, risk of choking. The resident signed he understood the risk but prefer to make my own food choices and wish to decline the diet consistency that was prescribed. The DOR also signed the document. Comments on the form read, patient continues to decline trials of pureed (even mechanical soft) wants to continue regular (texture). 3. Repeat episodes of [MEDICAL CONDITION] obstruction following execution of waiver and facility's failure to take sufficient steps, beyond the waiver, to promote the resident's safe and adequate nutritional intake. a. Documentation of [MEDICAL CONDITION] obstruction Progress notes on 1/8/2020 at 3:16 p.m. and 10:55 p.m. revealed the resident was unable to swallow, the MD (physician) was in facility and assessed resident, sending to emergency department (ED) for evaluation and treatment. He returned at 10:55 p.m. from the ED after having procedure to push food through esophagus. It was reported to this nurse from ED that res(ident) should be on clear liquid diet if not wearing dentures while eating. Review of the hospital reports dated 1/8/2020 revealed Resident #1 was seen because of inability to swallow his secretions since having lunch today. It further read the resident has a history of recurrent [MEDICAL CONDITION] food impactions related to the fact that he refuses to wear his dentures and yet continues to eat solid food. His last foreign body extraction was less than a month ago. Food was found in the middle third and lower third of the esophagus. The resident was advised the only safe alternative in the future, if he continues to refuse to wear his dentures, would be to stay on a liquid diet. Physician notes 4/16 and 4/22/2020 documented the resident's multiple episodes of [MEDICAL CONDITION] obstruction. The 4/22/2020 note read, On a pureed diet or to eat with his dentures. Notably, he did not have his dentures in place today. b. Facility failure The care plan revised 2/4/2020 documented the resident was edentulous (without teeth) and currently did not have dentures. Resident received his new dentures but doesn't like them. Resident states that he's been without teeth for so long it just feels more natural to him. The goal was for the resident to be able to chew food sufficiently to swallow through review date. Interventions included refer to dentist as needed. The care plan revised 2/4/2020 documented the resident was at nutritional risk related to reported history of weight loss and food insecurity and was on a regular diet with thin liquids. The goal was to minimize risk of significant weight changes with appropriate interventions through next review. Interventions included monitor for and report any difficulty chewing/swallowing or signs and symptoms of aspiration and report to speech therapy as needed. Neither care plan referenced the resident's episodes of [MEDICAL CONDITION] obstruction in order to alert staff of this risk for serious harm. Neither of the care plans addressed or defined the resident's need for close supervision, or addressed other SLP recommendations to remain upright at 90 degrees, and to take small bites, alternating food with sips of liquids. Moreover, although the resident might and had the right to reject it, per the SLP, hospital notes as well as his physician, he was to receive a puree diet for safety when he was not wearing dentures. This, too, was not noted on the care plans; rather, the care plan (see above) documented the resident was on a regular diet. Finally, the care plans failed to include strategies staff had found effective in getting the resident to comply with SLP recommendations and to wear his dentures, or addressed the resident's history of hoarding, his panic behavior toward food (see interviews below) and interventions to lessen these behaviors which could contribute to unsafe food intake. The lack of the above information on the resident's care plans created the potential that staff would not consistently implement effective measures to promote the resident's safe nutritional intake. 3. Resident observation and interview Resident #1, interviewed on 5/1/2020 at approximately 4:20 p.m., said he went to the hospital a few months ago because food was stuck in his throat but he learned a valuable lesson. The resident was in bed and his overbed table was positioned next to him. He said he was told him he needed to wear his dentures if he was going to eat regular food but said he did not like to wear his dentures and knew that he needed to be more careful in the future. 4. Staff interviews a. LPN #1, interviewed on 5/1/2020 at approximately 4:00 p.m., said Resident #1 eats fast and in last few months, he ate so fast he had a bolus (mass of substance) of food and was sent to the hospital so they could push it down. She said sometimes when he eats he will make himself throw up so food will dislodge. She said he required constant education and said she has seen the resident almost panic when he doesn't have food. She said when she works with him, she will encourage fluid and tell him to tuck in his chin. She said she was told, after the IJ had been called that she needed to watch him through the night because he could choke at any time. She said he does not receive constant supervision during meals. b. LPN #2, interviewed on 5/6/2020 at 11:31 a.m., Resident #1 would choose regular textured food and not puree food; although she said she was always aware that the resident required puree texture. She said she knew the resident would cough, had an inability to swallow or clear his throat and would sometimes vomit the food. She said she and the resident had many conversations and she thought he understood the risk of choosing regular texture food. LPN #2 said a ST evaluation recommended the resident receive frequent checks, and the ST said the resident would not be at risk for aspiration as long as he was monitored. She said that she provides frequent monitoring by placing her cart outside of his door and keeping an eye on him every five minutes. She agreed he could choke instantly and in less time than in five minutes. LPN #2 said on 5/5/2020 (after the facility was notified of the immediate jeopardy situation), she talked with the DON about putting an order in the Medication Administration Record [REDACTED]. She said she had been told there should be a progress note entered to document whether the resident was tolerating meals, if there were any issues while eating, and that education was provided to ensure the resident was eating and chewing slowly. LPN #2 said Resident #1 had a history of [REDACTED]. She said he had a history of [REDACTED]. She said that the CNAs knew when they went in his room to provide cares throughout the day they would notify

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