STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105506	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENCORE AT BOCA RATON REHABILITATION AND NURSING CE	**7300 DEL PRADO CIRCLE SOUTH BOCA RATON, FL 33433**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff and family interview, clinical record review and facility policy review on 02/26/20, it was determined facility staff neglected to ensure Resident #1 was provided adequate supervision with eating. Resident #1 with a [DIAGNOSES REDACTED].#1 choking on a whole Brussel sprout requiring immediate intervention by the facility and subsequent emergent transfer to the hospital for treatment. A return to the facility for additional information was conducted on 03/06/20. On 03/06/20 it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on 03/06/20 at 2:30 PM. The Immediate Jeopardy was identified on 03/06/20, as beginning on 02/08/20 and removed on 03/06/20. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The scope and severity were lowered as a result of the facility's corrective actions implemented as of 02/10/20 and verified by interview, observation and record review on 03/06/20. Although the facility implemented multiple corrective actions to remove the immediacy of the deficient practice, the potential for harm remains without the implementation of a plan of correction and the monitoring of the corrective actions. Cross Reference - F689 The findings included: Review of the facility Abuse, Neglect and Exploitation of Residents Policy stated, 'Neglect is the failure to provide goods or services which are necessary to maintain physical or mental health, and necessary to avoid physical harm, mental anguish or mental illness. Neglect may be a repeated course of conduct or a single incident. Neglect is also the repeated failure to follow the plan of care, and a failure to follow the plan of care that results in injury of the resident.' Review of the clinical record for Resident #1 revealed he was admitted to the facility on [DATE] for long term care residency. Resident #1 is dependent on facility staff for all ADLs (activities of daily living) and required assistance and supervision with meals. Resident #1 resided in a semiprivate room and on 02/08/20 his roommate was Resident #4. Review of a Dietary Note dated 06/19/19 at 9:13 AM documents 'Nursing reported Resident #1 was having difficulties with mechanical soft consistency diet. He was unable to complete his dinner meal on 06/18 due to problems chewing/swallowing. Diet consistency was downgraded to puree. ST (Speech Therapist) to screen and follow up.' Review of a ST Progress Note dated 06/19/19 at 1:54 PM documents 'Resident #1 observed to have extreme difficulty managing mechanical soft diet texture at breakfast on report. Observed by ST to not manage mechanical soft texture at lunch, resulting in coughing and sudden expectoration of the bolus. Swallow evaluation completed at lunch today. Tolerated puree texture. Diet recommendations are for pureed texture; all liquids to be thickened to nectar consistency.' Resident #1's nutritional [DIAGNOSES REDACTED]. Review of a Dietary Quarterly assessment dated [DATE] documents 'Resident on no added salt puree with nectar thick liquids. Requires assistance with meals. On mechanical altered therapeutic diet; nectar thick liquids is appropriate to promote safe swallowing.' Review of Resident #1's quarterly MDS (Minimum Data Set) comprehensive resident assessment dated [DATE], under Section C - Cognitive Patterns documents Resident #1 has a BIMS (Brief Interview for Mental Status) of 5 out of a score of 15, indicating the resident has severe cognitive impairment. Review of documentation under Section K - Swallowing/Nutritional Status documents 'Coughing or choking during meals or when swallowing medications - YES. Remains on a mechanically altered therapeutic diet.' Review of a quarterly Social Services assessment dated [DATE] at 4:24 PM documents 'Speech pattern - Unclear speech; Ability to express ideas and wants - Sometimes understood; Understanding verbal content - Sometimes understands; BIMS - 5.0 Severe Impairment.' Review of a Social Services Progress Note dated 02/05/20 at 2:58 PM documents in part, 'Team discussed resident's diet; resident receives assistance with feeding. Resident continues to self-propel in wheelchair down hallways to attend open gym daily.' Review of Resident #1's Care Plans documents 'Resident has impaired cognitive function and impaired thought processes. Has impaired decision making - will benefit from cues and supervision and or assistance in decision making. Intervention to include - The resident needs supervision and or assistance with all decision making.' Further review of the Care Plans documents 'Resident has an alteration in ability to communicate needs (unclear speech) related to impaired cognitive ability. Intervention to include: Limit sensory input when resident is agitated as needed.' Review of a dietary Care Plan documents 'The resident is at nutritional risk related to past medical history of [REDACTED]. Requires mechanical altered foods and nectar thick liquids due to history of dysphagia. Intervention to include - Provide dining assistance as per assessed needs as needed.' Review of a Nursing Progress Note dated 02/08/20 at 4:53 PM, completed by the resident's evening Licensed Practical Nurse (LPN) Staff 'L' states in part, 'Propelled resident in wheelchair back to his room. No distress voiced or noted. Left in room watching TV. Resident stated, I am ready to eat. Further review of the Nursing Progress Notes completed by Resident #1's evening LPN dated 0[DATE] at 7:02 PM documents, 'While on lunch writer informed that resident vital signs blood pressure 200/115, pulse 110, Oxygen saturation 68% and non-responsive. Non-rebreather applied saturation increased 76%. Floor nurse called 911. When writer arrived, paramedics were transporting resident to hospital for evaluation. MD notified, (family member) of resident notified.' On 02/25/20 at 10:40 AM, the Risk Manager (RM) provided the facility Adverse Incident Log which documented the Federal Immediate report was submitted on 02/10/20; the Federal 5- day report was submitted on 02/17/20; and the 15 day Adverse Incident report was submitted on 02/21/20 documenting after their investigation it was determined an allegation of neglect was Unsubstantiated. A request was made to the RM for their investigation notes. On 02/25/20 at 10:55 AM, the Administrator and RM provided the facility investigation notes for the incident with Resident #1 on 02/08/20. The RM stated after their investigation they determined it was not an adverse incident. The RM stated in a puzzled expression 'they found a Brussel sprout in the resident's throat.' Further the RM stated in their investigation, they did not consider leaving a resident requiring supervision with food, unsupervised, an act of neglect however could not speak to how they made that determination. An inquiry was made who was Resident #1's roommate at that time to which they identified and confirmed it was Resident #4. Review of the hospital record Emergency Department (ED) physician note dated 02/08/20 at 6:50 PM states in part, 'The patient apparently was eating food and possibly may have choked. EMS arrived the patient was in severe respiratory distress with agonal (abnormal breathing pattern) respirations. They started bagging (manual respirations provided by an oxygen apparatus) the patient and brought him here to the emergency department . The patient was noted to be tachypneic (increased respirations) in the 40's, oxygen saturation 89-90%, blood pressure was 172/116 and heart rate 112. Due to concern about his increased work of breathing patient was thus intubated (breathing tube inserted down the trachea) without difficulty. Subsequently while NG (nasogastric tube placed down the esophagus into the stomach) was being placed he was found to have full Brussel sprout in his throat which was removed No evidence for aspiration pneumonitis (inflammation of lung tissue) at this time based on chest x-ray but did have Brussel sprout in throat raising concern for aspiration.' Further review of the hospital records in brief summation revealed - Resident #1 was transported via 911 emergency to the ED in severe respiratory distress. He was intubated and mechanically ventilated. He had a NG tube inserted into his stomach and during

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) this procedure a whole Brussel sprout was discovered. He had a Foley urinary catheter inserted with subsequent urinalysis indicating he had a urinary tract infection. He required intravenous (IV) sedation while on the ventilator. Due to the IV sedation, his blood pressure was low and he required IV medication to maintain his blood pressure within normal parameters. Diagnostic tests included chest x-rays, a CT scan of his chest and an electroencephalogram (EKG). He was administered IV fluids and started on IV antibiotics. From the ED he was transferred to the Intensive Care Unit for continuous monitoring. On 02/25/20 at 2:55 PM an interview was conducted with the evening LPN Staff 'A', the nurse who responded to the emergency with Resident #1 on 02/08/20. The RM was also present. The events of the evening of 02/08/20 were reviewed with the explanation Resident #1 was brought back to his room after a visit with a family member and placed next to his bed, left to watch television. His roommate, Resident #4, who usually ate his meals in the dining room was in bed and did not want to go to the dining room for dinner that evening. The evening CNA Staff 'B' brought in Resident #4's dinner tray which she had to collect from the dining room and brought it to the resident in his room and placed it on Resident #4's bedside table. CNA Staff 'B' then left the room to get a clothing protector and on her way back to the room stopped and answered 2 call bells before going back to Resident #1 and Resident #4's room. CNA Staff 'B' left a second time to get a gown for Resident #4. LPN Staff 'A' stated Resident #1 was not on her assignment but she was at the nursing station when she heard CNA Staff 'B' coming down the hall screaming she needed a nurse and when LPN Staff 'A' entered the resident's room she observed Resident #1 in his wheelchair looking like he was choking and could not breathe so she did the [MEDICATION NAME] maneuver, tapped on his back and looked in his mouth but did not see anything. She stated the resident passed out for a few seconds and they got him into bed and elevated the head of the bed. LPN Staff 'A' stated they called a Rapid Response and started Resident #1 on oxygen and did vital signs and called 911 emergency. LPN Staff 'A' stated 911 arrived fast and they took over the resident's care and took him to the hospital. An inquiry was made regarding if Resident #1 always eats in his room and Resident #4 always eats in the dining room and LPN Staff 'A' confirmed that was the case except on this evening, Resident #4 wanted to eat in his bed. An inquiry was made about Resident #1's eating ability to which she stated he requires assistance with meals but does try to help out and is able to use his hands and propel himself in his wheelchair. The RM stated Resident #1's dinner tray had not even arrived yet when the incident occurred, and the aide had to go to the dining room to get Resident #4's tray as he eats in the dining room. An inquiry was made to LPN Staff 'A' regarding what was Resident #1's diet to which she stated he was on puree with nectar thick liquids. An inquiry was made regarding what was Resident #4's diet to which she stated he was on a regular diet. Review of the dinner meal ticket for Resident #4 from 02/08/20 documented 'Restorative -1 LCS/NAS (low concentrated sweets/no added salt) mechanical soft. Puree Meat. Mechanical soft roast turkey, gravy, cornbread dressing, Brussel sprouts, fruit crisp, minestrone soup, sugar free beverage; plate guard.' Review of the Individual Service Care Plan Report for Resident #1, which CNAs use as a reference to identify what diets their residents were on, revealed no section for Eating/Nutrition documented to indicate what the resident's eating and dietary restrictions/requirements were. On 02/26/20 at 3:40 PM, an interview was conducted with Resident #1's family member who was extremely distraught about what happened to Resident #1, stating 'they almost killed him. She stated how could they feed him something that he can't have. It was a Brussel sprout and he is on puree and cannot have Brussel sprouts.' On 02/26/20 at 4:00 PM, an interview was conducted with CNA Staff 'B' who had Resident #1 and Resident #4 on her assignment the evening of 02/08/20. The RM was also present during the interview. A request was made to explain the events that occurred on the evening of 02/08/20 with Resident #1. CNA Staff 'B' confirmed Resident #1 and Resident #4 shared a room. She stated Resident #4 was in bed, so she went to the dining room to get his dinner tray. She stated she placed the tray on the table between the 2 beds. She confirmed Resident #1 was watching television. She stated she left the room to get a clothing protector and stopped at 2 resident rooms to answer call lights, then went back to Resident #1 and Resident #4's room. She stated she set up the tray and started to feed Resident #4, then left again to get a gown. An inquiry was made regarding if she put the lid back on the dinner plate when she left to which she stated she did not remember. An inquiry was made regarding where was Resident #1 when she was in the room and when she left and came back, to which she stated she did not remember. An inquiry was made regarding what happened to Resident #1 to which she stated she was feeding Resident #4 and then heard Resident #1 not breathing right so she called the nurse right away and they got him into bed and the nurse took over. An inquiry was made reagdring if Resident #4 usually ate in the dining room to which she stated he usually eats in the dining room but on that evening when she started her shift he was in bed. An inquiry was made regarding if Resident #1 always eats his meals in his room to which she stated he always has his dinner in his room and he needs assistance with eating, however CNA Staff 'B' did not indicate Resident #1 should be supervised during meals at all times. An inquiry was made regarding if Resident #1 was able to self-propel his wheelchair around, was he able to assist with eating, to which CNA Staff 'B' stated Resident #1 gets around in his wheelchair and he can move his arms and hands and can hold onto things. She stated Resident #1 was on a puree diet and he was a 'Feeder', just like Resident #4, but Resident #1 could move his hands and would try to take some things from his tray. The RM added, they try to encourage residents to do as much as they can and Resident #1 could assist with meals. An inquiry was made to CNA Staff 'B' regarding where would she look to see what a resident's diet was to which she stated it is on the paper on the tray and there is a Book. An inquiry was made regarding where the Book was to which she stated she would have to find it, but she can look on the paper on the tray. On 02/26/20 at 5:00 PM, a conference was held with a facility panel including the Administrator, Risk Manager, Director of Social Services and the Regional Nurse. The incident with Resident #1 was recapped. There was a failure to provide adequate supervision of Resident #1 leading to a choking incident and subsequent emergent hospitalization . Additionally, Resident #1 was able to self-propel in his wheelchair and had mobility of his upper extremities to be able to grasp objects. The resident was left unattended with a dinner tray left in plain view which was not intended for him. Review of nursing notes documented when the resident was brought back to his room after visiting with family the resident commented 'I am ready to eat.' His roommate, Resident #4, who usually eats his meals in the dining room was in bed at the time of dinner, so the aide went to the dining room to retrieve his dinner tray. After she brought it to the room, she left on 2 occasions leaving Resident #1 alone with a tray he may have thought was his as he always ate in his room. The facility Adverse Incident investigation documented Resident #1 had never attempted to take food off other resident's trays. Resident #1 would not have had the opportunity to take food off of other resident's trays if he always ate in his room with assistance and supervision of an aide, and Resident #4 always ate in the dining room. Resident #1's dinner tray had not yet arrived and CNA Staff 'B' began feeding Resident #4 because his dinner tray was retrieved from the dining room which was served before meal tray delivery to the rooms. Resident #1 was left unsupervised with a meal tray not intended for him which consisted of a diet that put the resident at risk for harm. Resident #1 was readmitted to the facility on [DATE], 19 days after the choking incident. Resident #1 was readmitted with a gastric feeding tube and no longer is able to eat or drink anything by mouth. The facility's Immediate Jeopardy removal plan dated 03/06/20 included the following: Identification of other residents to be affected by deficient practice - All residents with a [DIAGNOSES REDACTED]. Systemic Corrective Actions: On 02/10/20 the Federal Immediate Report was submitted. On 02/17/20 the Federal 5 Day report was submitted. On 02/21/20 the 15-day State Adverse Incident report was submitted. Diet order and level of assistance residents require with meal audits were initiated on 02/10/20 and completed on 02/10/20. Audit of all resident's diets were initiated on 02/10/20 and completed on 02/10/20. Resident diet care plan audits were initiated on 02/10/20 and completed on 02/10/20. Audit of resident diets on the electronic charting system and Plan of Care banner were initiated on 02/10/20 and completed on 02/10/20. Staff were educated re resident care plans reflecting resident's current diet and level of assistance residents required with meals are not to be left unattended during meal time was initiated on 02/10/20 and remains ongoing. In-service how to perform the [MEDICATION NAME] maneuver and signs and symptoms of choking was conducted on 02/10/20 for the day and evening shift licensed nurses and CNAs. On 02/10/20 in-services were conducted for the day, evening and night shift staff on abuse and neglect. Random audits on tray accuracy and diet orders was initiated on 02/11/20 and is ongoing. Random audits on assistance provided to residents that require assistance with meals was initiated on 02/11/20 and is ongoing. Random audits on knowledge of different diet consistencies and CNA knowledge of resident's diets was initiated on 02/11/20 and is ongoing. Random audits on CNA knowledge of resident's diet on the plan of care was initiated on 02/28/20 and is ongoing. Random audits on supervision provided with resident meals was initiated on 02/28/20 and is ongoing. A Performance Improvement Plan was developed and implemented on 02/10/20 and revisions implemented on 02/26/20 related to CNAs were not able to verbalize accurately where to locate a resident's diet with further education required in addition to providing assistance and supervision during meals. A Quality Assurance Performance Improvement meeting was held on 02/28/20 reviewing the Performance Improvement Plan. On 03/06/20 the information in the facility's removal plan was verified. Six day shift CNAs and nine evening shift CNAs were interviewed

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) and all were able to demonstrate on the electronic documentation kiosk where to locate resident diets. Additionally, they all stated they have received education on not leaving residents unsupervised during meal times or if they are around food. Review of the facility employee roster verification sheet revealed 41 of 66 CNAs, to include CNA Staff 'B' had received in-service training on residents that require assistance with meals are not to be left unattended at meal times and ensuring resident's care plans accurately reflect the resident's current diet. Additionally, 20 of 38 licensed nurses; 3 of 4 activities staff; 20 of 20 dietary staff; 3 of 3 MDS staff; 12 of 14 rehabilitation staff and 3 of 3 social services staff have been verified as receiving this in-service training. Interviews conducted on 03/06/20 with the Director of Nursing, Dietary Director, Assistant Food Service Manager, Registered Dietician, Speech Therapist, MDS Director, Risk Manager and Regional Nurse confirmed staff training and audits have been and will continue to be conducted related to supervision to be provided during resident meals; CNA knowledge of resident's diets; CNA knowledge of resident diet consistencies; ensuring accurate diet orders and meal tray accuracy. Resident #1 was observed on 03/06/20 to be residing in a semiprivate room with a resident who is alert and oriented and able to stop Resident #1 from access to his meal trays. The facility's Immediate Jeopardy was removed on 03/06/20 at 8:15 PM.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility staff interview, clinical record review and facility policy review it was determined on 02/26/20 the facility failed to ensure adequate supervision was provided on 02/08/20 for 1 of 1 sampled residents with a [DIAGNOSES REDACTED].#1. Resident #1 was left unsupervised in close proximity to a dinner meal not intended for him. Resident #1 choked on his roommate's food requiring immediate intervention by facility staff and and subsequent emergent transfer to the hospital for medical treatment. A return to the facility for additional information was conducted on 03/06/20. On 03/06/20 it was determined the findings of the survey posed Immediate Jeopardy to the health and safety of the residents in the facility. The Administrator was informed of the Immediate Jeopardy on 03/06/20 at 2:30 PM. The Immediate Jeopardy was identified on 03/06/20, as beginning on 02/08/20 and removed on 03/06/20. The scope and severity was decreased to a D, no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy. The scope and severity were lowered as a result of the facility's corrective actions implemented as of 02/10/20 and verified by interview, observation and record review on 03/06/20. Although the facility implemented multiple corrective actions to remove the immediacy of the deficient practice, the potential for harm remains without the implementation of a plan of correction and the monitoring of the corrective actions. Cross Reference - F600 The findings included: Review of the facility policy for Safety and Supervision of Residents states in part, 'Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. System Approach to Safety: Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.' Review of the clinical record for Resident #1 revealed he was admitted to the facility on [DATE] for long term care residency. Resident #1 is dependent on facility staff for all ADLs (activities of daily living) and requires assistance and supervision with meals. Resident #1 resided in a semiprivate room and on 02/08/20 his roommate was Resident #4. Review of a Dietary Note dated 06/19/19 at 9:13 AM documents 'Nursing reported Resident #1 was having difficulties with mechanical soft consistency diet. He was unable to complete his dinner meal on 06/18 due to problems chewing/swallowing. Diet consistency was downgraded to puree. ST (Speech Therapist) to screen and follow up.' Review of a ST Progress Note dated 06/19/19 at 1:54 PM documents 'Resident #1 observed to have extreme difficulty managing mechanical soft diet texture at breakfast on report. Observed by ST to not manage mechanical soft texture at lunch, resulting in coughing and sudden expectoration of the bolus. Swallow evaluation completed at lunch today. Tolerated puree texture. Diet recommendations are for pureed texture; all liquids to be thickened to nectar consistency.' Resident #1's nutritional [DIAGNOSES REDACTED]. Review of a Dietary Quarterly assessment dated [DATE] documents 'Resident on no added salt puree with nectar thick liquids. Requires assistance with meals. On mechanical altered therapeutic diet; nectar thick liquids is appropriate to promote safe swallowing.' Review of Resident #1's quarterly MDS (Minimum Data Set) comprehensive resident assessment dated [DATE], under Section C - Cognitive Patterns documented Resident #1 had a BIMS (Brief Interview for Mental Status) of 5 out of a score of 15, indicating the resident has severe cognitive impairment. Review of documentation under Section K - Swallowing/Nutritional Status documents 'Coughing or choking during meals or when swallowing medications - YES. Remains on a mechanically altered therapeutic diet.' Review of a quarterly Social Services assessment dated [DATE] at 4:24 PM documents 'Speech pattern - Unclear speech; Ability to express ideas and wants - Sometimes understood; Understanding verbal content - Sometimes understands; BIMS - 5.0 Severe Impairment.' 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Requires mechanical altered foods and nectar thick liquids due to history of dysphagia (difficulty swallowing). Intervention to include - Provide dining assistance as per assessed needs as needed.' Review of a Nursing Progress Note dated 02/08/20 at 4:53 PM, completed by the resident's evening Licensed Practical Nurse (LPN) Staff 'L' stated in part, 'Propelled resident in wheelchair back to his room. No distress voiced or noted. Left in room watching TV. Resident stated, I am ready to eat. Further review of the Nursing Progress Notes completed by Resident #1's evening LPN dated 0[DATE] at 7:02 PM documents, 'While on lunch writer informed that resident vital signs blood pressure 200/115, pulse 110, Oxygen saturation 68% and non-responsive. Non-rebreather applied saturation increased 76%. Floor nurse called 911. When writer arrived, paramedics were transporting resident to hospital for evaluation. MD notified, (family member) of resident notified.' 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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) Diagnostic tests included chest x-rays, a CT scan of his chest and an electroencephalogram (EKG). He was administered IV fluids and started on IV antibiotics. From the ED he was transferred to the Intensive Care Unit for continuous monitoring. On 02/25/20 at 2:55 PM an interview was conducted with the evening LPN Staff 'A', the nurse who responded to the emergency situation with Resident #1 on 02/08/20. The RM was also present. The events of the evening of 02/08/20 were reviewed with the explanation Resident #1 was brought back to his room after a visit with a family member and placed next to his bed, left to watch television. His roommate, Resident #4, who usually ate his meals in the dining room was in bed and did not want to go to the dining room for dinner that evening. The evening CNA Staff 'B' brought in Resident #4's dinner tray which she had to collect from the dining room and brought it to the resident in his room and placed it on Resident #4's bedside table. CNA Staff 'B' then left the room to get a clothing protector and on her way back to the room stopped and answered 2 call bells before going back to Resident #1 and Resident #4's room. CNA Staff 'B' left a second time to get a gown for Resident #4. LPN Staff 'A' stated Resident #1 was not on her assignment but she was at the nursing station when she heard CNA Staff 'B' coming down the hall screaming she needed a nurse and when LPN Staff 'A' entered the resident's room she observed Resident #1 in his wheelchair looking like he was choking and could not breathe so she did the [MEDICATION NAME] maneuver, tapped on his back and looked in his mouth but did not see anything. She stated the resident passed out for a few seconds and they got him into bed and elevated the head of the bed. LPN Staff 'A' stated they called a Rapid Response and started Resident #1 on oxygen and did vital signs and called 911 emergency. LPN Staff 'A' stated 911 arrived fast and they took over the resident's care and took him to the hospital. An inquiry was made regarding if Resident #1 always eats in his room and Resident #4 always eats in the dining room and LPN Staff 'A' confirmed that was the case except on this evening, Resident #4 wanted to eat in his bed. An inquiry was made about Resident #1's eating ability to which she stated he requires assistance with meals but does try to help out and is able to use his hands and propel himself in his wheelchair. The RM stated Resident #1's dinner tray had not even arrived yet when the incident occurred and the aide had to go to the dining room to get Resident #4's tray as he eats in the dining room. An inquiry was made to LPN Staff 'A' what was Resident #1's diet to which she stated he was on puree with nectar thick liquids. An inquiry was made regarding what was Resident #4's diet to which she stated he was on a regular diet. Review of the dinner meal ticket for Resident #4 from 02/08/20 documented 'Restorative -1 LCS/NAS (low concentrated sweets/no added salt) mechanical soft. Puree Meat. Mechanical soft roast turkey, gravy, cornbread dressing, Brussel sprouts, fruit crisp, minestrone soup, sugar free beverage; plate guard.' On 02/26/20 at 3:40 PM, an interview was conducted with Resident #1's family member who was extremely distraught about what happened to Resident #1, stating 'they almost killed him. She stated how could they feed him something that he can't have. It was a Brussel sprout and he is on puree and cannot have Brussel sprouts.' On 02/26/20 at 4:00 PM, an interview was conducted with CNA Staff 'B' who had Resident #1 and Resident #4 on her assignment the evening of 02/08/20. The RM was also present during the interview. A request was made to explain the events that occurred on the evening of 02/08/20 with Resident #1. CNA Staff 'B' confirmed Resident #1 and Resident #4 shared a room. She stated Resident #4 was in bed so she went to the dining room to get his dinner tray. She stated she placed the tray on the table between the 2 beds. She confirmed Resident #1 was watching television. She stated she left the room to get a clothing protector and stopped at 2 resident rooms to answer call lights, then went back to Resident #1 and Resident #4's room. She stated she set up the tray and started to feed Resident #4, then left again to get a gown. An inquiry was made regarding if she put the lid back on the dinner plate when she left to which she stated she did not remember. An inquiry was made regarding where was Resident #1 when she was in the room and when she left and came back, to which she stated she did not remember. An inquiry was made regarding what happened to Resident #1 to which she stated she was feeding Resident #4 and then heard Resident #1 not breathing right so she called the nurse right away and they got him into bed and the nurse took over. An inquiry was made regarding if Resident #4 usually ate in the dining room to which she stated he usually eats in the dining room but on that evening when she started her shift he was in bed. An inquiry was made regarding if Resident #1 always eats his meals in his room to which she stated he always has his dinner in his room and he needs assistance with eating, however CNA Staff 'B' did not indicate Resident #1 should be supervised during meals at all times. An inquiry was made if Resident #1 was able to self propel his wheelchair around, was he able to assist with eating, to which CNA Staff 'B' stated Resident #1 gets around in his wheelchair and he can move his arms and hands and can hold onto things. She stated Resident #1 was on a puree diet and he was a 'Feeder', just like Resident #4, but Resident #1 could move his hands and would try to take some things from his tray. The RM added, they try to encourage residents to do as much as they can and Resident #1 could assist with meals. On 02/26/20 at 5:00 PM, a conference was held with a facility panel including the Administrator, Risk Manager, Director of Social Services and the Regional Nurse. The incident with Resident #1 was recapped. There was a failure to provide adequate supervision of Resident #1 leading to a choking incident and subsequent emergent hospitalization . Additionally, Resident #1 was able to self-propel in his wheelchair and had mobility of his upper extremities to be able to grasp objects. The resident was left unattended with a dinner tray left in plain view which was not intended for him. Review of nursing notes documented when the resident was brought back to his room after visiting with family the resident commented 'I am ready to eat.' His roommate, Resident #4, who usually eats his meals in the dining room was in bed at the time of dinner, so the aide went to the dining room to retrieve his dinner tray. After she brought it to the room, she left on 2 occasions leaving Resident #1 alone with a tray he may have thought was his as he always ate in his room. The facility Adverse Incident investigation documented Resident #1 had never attempted to take food off other resident's trays. Resident #1 would not have had the opportunity to take food off of other resident's trays if he always ate in his room with assistance and supervision of an aide, and Resident #4 always ate in the dining room. LPN Staff 'A' stated during the interview on 02/25/20 at 2:55 PM, Resident #1 passed out for a few seconds and they got him into his bed. Resident #1's dinner tray had not yet arrived and CNA Staff 'B' began feeding Resident #4 because his dinner tray was retrieved from the dining room which was served before meal tray delivery to the rooms. Review of Resident #1's Care Plans revealed he has a history of agitation. Resident #1 was left unsupervised with a meal tray not intended for him which consisted of a diet that put the resident at risk for harm. Resident #1 was readmitted to the facility on [DATE], 19 days after the choking incident. Resident #1 was readmitted with a gastric feeding tube and no longer is able to eat or drink anything by mouth. The facility's Immediate Jeopardy removal plan dated 03/06/20 included the following: Identification of other residents to be affected by deficient practice - All residents with a [DIAGNOSES REDACTED]. Systemic Corrective Actions: On 02/10/20 the Federal Immediate Report was submitted. On 02/17/20 the Federal 5 Day report was submitted. On 02/21/20 the 15 day State Adverse Incident report was submitted. Diet order and level of assistance residents require with meal audits were initiated on 02/10/20 and completed on 02/10/20. Audit of all resident's diets were initiated on 02/10/20 and completed on 02/10/20. Resident diet care plan audits were initiated on 02/10/20 and completed on 02/10/20. Audit of resident diets on the electronic charting system and Plan of Care banner were initiated on 02/10/20 and completed on 02/10/20. Staff were educated re resident care plans reflecting resident's current diet and level of assistance residents required with meals are not to be left unattended during meal time was initiated on 02/10/20 and remains ongoing. In-service how to perform the [MEDICATION NAME] maneuver and signs and symptoms of choking was conducted on 02/10/20 for the day and evening shift licensed nurses and CNAs. On 02/10/20 in-services were conducted for the day, evening and night shift staff on abuse and neglect. Random audits on tray accuracy and diet orders was initiated on 02/11/20 and is ongoing. Random audits on assistance provided to residents that require assistance with meals was initiated on 02/11/20 and is ongoing. Random audits on knowledge of different diet consistencies and CNA knowledge of resident's diets was initiated on 02/11/20 and is ongoing. Random audits on CNA knowledge of resident's diet on the plan of care was initiated on 02/28/20 and is ongoing. Random audits on supervision provided with resident meals was initiated on 02/28/20 and is ongoing. A Performance Improvement Plan was developed and implemented on 02/10/20 and revisions implemented on 02/26/20 related to CNAs were not able to verbalize accurately where to locate a resident's diet with further education required in addition to providing assistance and supervision during meals. A Quality Assurance Performance Improvement meeting was held on 02/28/20 reviewing the Performance Improvement Plan. On 03/06/20 the information in the facility's removal plan was verified. Six day shift CNAs and nine evening shift CNAs were interviewed and all were able to demonstrate on the electronic documentation kiosk where to locate resident diets in addition to stating they have received education regarding supervising residents during meal times. Review of the facility employee roster verification sheet revealed 41 of 66 CNAs, to include CNA Staff 'B'; 20 of 38 licensed nurses; 3 of 4 activities staff; 20 of 20 dietary staff; 3 of 3 MDS staff; 12 of 14 rehabilitation staff; and 3 of 3 social services staff have been verified as receiving in-service training on residents that require assistance with meals are not to be left unattended at meal times and ensuring resident's care plans accurately reflect the resident's current diet. Interviews conducted on

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	105506	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ENCORE AT BOCA RATON REHABILITATION AND NURSING CE	**7300 DEL PRADO CIRCLE SOUTH BOCA RATON, FL 33433**

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) 03/06/20 with the Director of Nursing, Dietary Director, Assistant Food Service Manager, Registered Dietician, Speech Therapist, MDS Director, Risk Manager and Regional Nurse confirmed staff training and audits have been and will continue to be conducted related to supervision to be provided during resident meals; CNA knowledge of resident's diets; CNA knowledge of resident diet consistencies; ensuring accurate diet orders and meal tray accuracy. Resident #1 was observed on 03/06/20 to be residing in a semiprivate room with a resident who is alert and oriented and able to stop Resident #1 from access to his meal trays. The facility's Immediate Jeopardy was removed on 03/06/20 at 8:15 PM.
F 0805 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility staff interview, clinical record review and facility policy review, the facility failed to ensure residents with chewing and swallowing difficulty (dysphagia) were provided with a diet in a form appropriate for their needs and to ensure safety with eating; and failed to ensure Certified Nursing Assistants (CNAs) had the knowledge of where to locate documentation of resident diets as evidenced by 10 of 11 CNA interviews conducted, staff failed to have knowledge of where to locate the prescribed diet information for residents to include CNAs Staff 'B', Staff 'D', Staff 'E', Staff 'F', Staff 'G', Staff 'I', Staff 'J', Staff 'K', Staff 'L' and Staff 'M'. The findings included: Review of the facility guideline for Mechanical Soft Diet states in part, 'The Mechanical Soft Diet provides mechanically altered (ground, chopped or blended) tasty foods with consistencies that are easier to chew and swallow. The diet is designed to provide a texture modification of the Soft Diet and is indicated for those individuals with chewing and swallowing problems due to irritation of the mouth, lack of teeth or dysphagia.' 1) Review of the clinical record for Resident #1 revealed he was admitted to the facility on [DATE] for long term care residency. Resident #1 is dependent on facility staff for all ADLs (activities of daily living) and requires assistance and supervision with meals. Resident #1 resided in a semiprivate room and on 02/08/20 his roommate was Resident #4. Review of a Dietary Quarterly assessment dated [DATE] documents 'Resident (#1) on no added salt puree with nectar thick liquids. Requires assistance with meals. On mechanical altered therapeutic diet; nectar thick liquids is appropriate to promote safe swallowing.' Review of Resident #1's quarterly MDS (Minimum Data Set) comprehensive resident assessment dated [DATE], under Section C - Cognitive Patterns documents Resident #1 has a BIMS (Brief Interview for Mental Status) of 5 out of a score of 15, indicating the resident has severe cognitive impairment. Review of documentation under Section K - Swallowing/Nutritional Status documents 'Coughing or choking during meals or when swallowing medications - YES. Remains on a mechanically altered therapeutic diet.' Review of a Nursing Progress Note dated 02/08/20 at 4:53 PM, completed by the resident's evening Licensed Practical Nurse (LPN) Staff 'L' states in part, 'Propelled resident in wheelchair back to his room. No distress voiced or noted. Left in room watching TV. Resident stated, I am ready to eat. Investigation revealed on 02/08/20, Resident #1 was left unsupervised in his room with access to his roommate, Resident #4's dinner meal, which consisted of whole Brussel sprouts. Resident #4's diet was documented as mechanical soft, puree meats. Resident #1 gained access to the whole Brussel sprouts and subsequently choked. Immediate facility response was required and he was subsequently transferred to the hospital for emergent treatment. On 02/26/20 at 4:00 PM, an interview was conducted with CNA Staff 'B' who had Resident #1 and Resident #4 on her assignment the evening of 02/08/20. An inquiry was made regarding where would she look to see what a resident's diet was to which she stated it is on the paper on the tray and there is a Book. An inquiry was made regardsing where the Book was to which she stated she would have to find it, but she can look on the paper on the tray. 2) On 03/06/20 at 9:30 AM, a request was made to the facility to provide the CMS 672 form which identifies the number of residents on 'Mechanically altered diets including pureed and all chopped food (not only meat).' Review of this list documented of the 146 current census, 32 residents were identified as receiving altered diets. On 03/06/20 at 10:10 AM, a Diet Report list of residents identified as having dysphagia was provided by the Director of Nursing (DON). The list identified 28 residents as having dysphagia requiring altered diets to meet their nutritional and swallowing safety needs. After reviewing the list, it was noted Resident #4, Resident #1's roommate, who was on a mechanical soft puree meat diet was not identified on this list. A request was made to the DON to clarify this discrepancy. The DON stated the list was generated from their electronic charting system and she will see if she can generate a different list. On 03/06/20 at 10:30 AM, the Risk Manager (RM) provided a list of facility residents identifying their diets, highlighting those residents receiving altered diets. The highlighted list identified 22 resident names. Review of the list revealed resident names who were receiving mechanical ground or puree diets however they were not highlighted. A request was made to the RM to clarify why some residents on altered diets were highlighted, while other residents were not. On 03/06/20 at 11:38 AM, an interview was conducted with the Registered Dietician (RD) who stated Resident #4 was not considered dysphagia, he was more of a chewing issue and not a swallowing issues therefore he would not be identified on the dysphagia list. She stated hs is on puree meat diet because he has difficulty chewing as some people cannot chew meat. The RD stated Resident #1 was on a puree diet with nectar thick liquids due to swallowing issues therefore would be considered dysphasic. She further stated the dysphagia list is categorized by the Speech Therapist (ST) and residents would be treated by the ST for their dysphagia and when they are discharged from ST services they are discontinued from the dysphagia list. On 03/06/20 at 12:12 PM, an interview was conducted with the ST and Director of Rehabilitation Services who stated residents with dysphagia are coded and populated by the Minimum Data Set (MDS) assessment, so they would have a list of residents with dysphagia. The ST stated they keep a list of residents they are treating for dysphagia while they are on their service but once they are discontinued from ST service, they are no longer on the list. An inquiry was made to the ST regarding Resident #1 who was on a puree diet with nectar thick liquids if a Brussel sprout was an appropriate diet item to which the ST stated he would not be able to chew or swallow a Brussel sprout. On 03/06/20 at 12:30 PM, an interview was conducted with the MDS Director who stated she generated a list of residents with dysphgia by their assessment diagnosis. Review of this list revealed 51 resident names identified with dysphagia. Resident #4 was identified on the list as having dysphagia. The 4 different lists provided were reviewed with the MDS Director. On 03/06/20 the CMS Form 672 documented 32 residents on mechanically altered diets. The DON provided a list of 28 residents with dysphagia on mechanically altered diets. The RM provided a list of 22 residents with dysphagia. The MDS Director provided a list of 51 residents identified with dysphagia. The MDS Director stated they will have to look at this and clear up the discrepancies. 3) Review of the Diet Report of dysphagia residents provided by the DON on 03/06/20 at 10:10 AM did not highlight or identify Resident #5 as having dysphagia, however documented Resident #5 as being on a mechanically altered chopped diet with thin liquids. On 03/06/20 at 12:45 PM, a random tour was conducted on the second floor of residents eating their lunch meals in their rooms. At 12:50 PM, Resident #5, who was listed as being on a mechanically altered chopped diet, but not highlighted, was observed to have an open faced turkey sandwich with 3 slices of whole turkey with gravy on a slice of white bread. Review of the meal ticket on the lunch tray documented the resident's diet as 'Regular.' (Photographic evidence was obtained.) Review of physician orders [REDACTED]. On 03/06/20 at 1:30 PM, an interview was conducted with the MDS Director who stated Resident #5 has difficulty chewing but she does not have a [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] documented Resident #5 has no chewing or swallowing issues but is on an altered diet. Review of the Care Plans documents the resident is on a therapeutic diet with mechanical altered consistency. The MDS Director was shown the photo of the open faced turkey sandwich with 3 slices of whole turkey to which she stated that is not a mechanically altered chopped diet. An inquiry was made if the resident placed too large a piece of food in her mouth and was unable to chew it due to no teeth, could this pose a choking risk, to which she had no response. On 03/06/20 at 3:45 PM, an interview was conducted with the ST and Rehabilitation Director in the presence of the RD and they were shown the photo of the open faced turkey sandwich. The ST stated the turkey is a soft meat and a slice would be alright. The ST was apprised the list of resident diets and physician orders [REDACTED]. The ST reviewed the photo again and stated 'the meal ticket says Regular.' There was no further comment. On 03/06/20 at 4:00 PM, a request was made to the RM for a copy of Resident #5's lunch meal ticket. On 03/06/20 at 4:20 PM, the RM provided a copy of the lunch meal ticket which now documented a 'Mechanical Soft' diet. An inquiry was made regarding why the meal ticket in the photo documented a 'Regular' diet and now the copy documented mechanical soft. The RM stated she will ask the RD. On 03/06/20 at 4:28 PM, the RM stated the reason the meal ticket is different is because when the RD overheard the conversation with the ST, she went to the kitchen and made the changes to reflect the resident's appropriate diet consistency. 4) Review of the Diet Report of dysphagia residents provided by the DON on 03/06/20 at 10:10 AM did not highlight or identify Resident #6 as having dysphagia, however documented Resident #6 as being on a mechanical soft diet

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F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) with nectar thick liquids. On 03/06/20 at 1:10 PM, Resident #6 was observed in his room during the lunch meal. Sitting next to the lunch tray on the overbed table was an opened bottle of an orange colored drink with a straw in the bottle. (Photographic evidence obtained.) The orange drink was regular consistency and not nectar thick. Review of the meal ticket read 'Nectar thick liquids.' An inquiry was made to Resident #6 regarding if that was his drink to which he stated he was not sure where it came from. An inquiry was made to the other resident in the room and his spouse, and 2 private duty aides in the room, where the orange drink came from to which no one could answer. On 03/06/20 at 3:45 PM an interview was conducted with the ST who confirmed Resident #6 was on therapy service and is on nectar thick liquids. The ST stated maybe the resident's spouse was visiting and brought it in. The ST was apprised during the observation of Resident #6 at 1:10 PM, the resident's spouse was not in the room. Review of Resident #6's [DIAGNOSES REDACTED].' Review of a MDS resident assessment dated [DATE], documentation under Section K - Swallowing/Nutritional Status documents 'Coughing or choking during meals or when swallowing medications - YES. Mechanically altered therapeutic diet.' The following interviews were conducted with the facility CNAs during the initial survey conducted on 02/25/20 and 02/26/20: On 02/25/20 at 12:30 PM, an observation was conducted of lunch tray delivery to the second floor resident rooms. Five residents were observed seated in the restorative dining room being assisted by 2 restorative aides CNA Staff 'L' and CNA Staff 'M' who stated they assist the residents with their meals at breakfast and lunch and after lunch assist residents with ambulation and range of motion exercises. An inquiry was made how they know what diet the residents are supposed to be on, to which both stated it is on the meal ticket. CNA Staff 'L' went up to a resident seated in the dining room and pulled up the meal ticket off the tray stating, this is their diet, it comes from the kitchen. An inquiry was made if it was not meal time and a resident came up to them asking for cookies where would they locate the information of a resident's possible dietary restrictions to which CNA Staff 'M' stated, they do not have a resident assignment, they only do restorative. On 02/25/20 at 12:40 PM, an interview was conducted with CNA Staff 'D' and an inquiry made if a resident asked her for a cookie at 2:00 PM outside of meal times, where would she find out what kind of diet that resident was on to which she stated she would ask the nurse or look at the meal ticket. An inquiry was made if the nurse was busy and it was not at meal time to refer to a meal ticket, where would she get that information, to which she stated she would get a report from the nurse if the diet has changed. On 02/25/20 at 12:45 PM an interview was conducted with CNA Staff 'E' and the same questions posed to her. CNA Staff 'E' stated with resident diets we follow the menu and meal ticket and if the resident is new she will check with the nurse to see what they can eat. An inquiry was made was there anything in their electronic record or a book of diets to refer to, to which she stated the resident's diet is on the meal ticket. On 02/26/20 at 9:55 AM an interview was conducted with CNA Staff 'F' and an inquiry made how she knows what the resident's diet is and she stated she checks the computer kiosk. She was asked to demonstrate where she would go in the electronic record and after fumbling for a minute she stated sometimes she will ask the nurse if there are any changes and sometimes the nurse will tell me if the resident's diet has changed. On 02/26/20 at 12:45 PM, an interview was conducted with CNA Staff 'G' who was currently feeding Resident #4 his lunch in his room. CNA Staff 'G' stated Resident #4 has to be totally fed and cannot do anything for himself. All that was left on the lunch tray was a bowl of sliced canned peaches and a glass of water. An inquiry was made what kind of diet Resident #4 was on and picking up the meal ticket off the lunch tray she stated he got a puree hot dog and a hot dog bun that she cut up and put in the puree and he had beans. An inquiry was made how she can find out what diet a resident is on to which she stated it's on the meal ticket and the nurse knows. She was asked what she would do if the nurse was not around to which she shrugged and said she would look on the ticket. On 02/26/20 at 2:46 PM, an interview was conducted with evening CNA Staff 'H' and an inquiry made regarding how she would know what diet her residents are on and she stated she would look in the computer. A request was made to demonstrate where she would find that information and going to the electronic kiosk charting system she brought up a random resident on the computer and was able to point out where the diet information was located. On 02/26/20 at 3:35 PM, 3 evening CNAs were observed to be exiting the second floor pantry with a cart full of cups of water and ice. Interviews were conducted with CNA Staff 'I', CNA Staff 'J' and CNA Staff 'K' and an inquiry made how they would find what diet their residents are on. They all said almost in unison, there is a Book. A request was made to see the Book. As CNA Staff 'J' and CNA Staff 'K' stood there, CNA Staff 'I' went to some binders by the nursing station and pulled out a black binder and started flipping through, stating usually the diets are in the Book but I can't seem to find it now. They were asked again how they know what diets their residents are on and they stated we can ask the nurse and we look at the ticket. CNA Staff 'J' stated the diet is on the ticket. CNA Staff 'J' was asked if a resident wanted something at 8 o'clock at night, when there was no meal ticket to refer to, where would she find that information and CNA Staff 'K' answered we would ask the nurse. An inquiry was made regarding if the nurse was not available what would they do and they all stated they would look in the Book, however nobody was able to locate and produce the Book. Of 11 interviews conducted with day shift and evening shift CNAs on 02/25/20 and 02/26/20, who are responsible for assisting and ensuring their assigned residents receive the appropriate nutrition and hydration support, only one aide, CNA Staff 'H' was able to show the information is available in their electronic charting system.