| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676472 | A. BUILDING _____ B. WING _____ | 08/04/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SUNDANCE INN HEALTH CENTER | 2034 SUNDANCE PARKWAY NEW BRAUNFELS, TX 78130 |

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) |
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| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, and record review, the facility failed to implement its written policies and procedures that prohibit and prevent abuse or neglect for 1 of 6 residents (Resident #1) whose care was reviewed, in that: The facility did not report to State Survey Agency (HHSC) that Resident #1 went into [MEDICAL CONDITION] and died shortly after being fed a wrong textured dessert by CNA A. This deficient practice could place residents at risk for abuse and neglect. The findings were: Record review of the facility's policy titled, Abuse Prohibition Policy - Identification, dated [DATE] revealed in part . All alleged violations concerning abuse, neglect or misappropriation of property are reported immediately to the Administrator and /or the designee and other enforcement agencies according to state law including the State Survey and Certification Agency. Procedures- 2. Staff members identify and assess suspected or alleged reports of abuse or neglect, focusing on objective and observable evidence. Type of abuse include: e) Neglect- failure to provided goods and services necessary to avoid physical harm, mental anguish or mental illness. Record Review of Long-Term Care Regulatory Provider Letter, PL ,[DATE], titled, Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), dated [DATE] revealed in part, A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: abuse, neglect, exploitation, death due to unusual circumstances, missing resident, misappropriation, drug theft, suspicious injuries of unknown source, fire, emergency situations that pose a threat to resident health and safety. Reporting timeframes include: Immediately, but not later than two hours after the incident occurs or is suspected for abuse (with or without serious bodily injury; or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury. Immediately, but not later than 24 hours after the incident occurs or is suspected for an incident that does not result in serous bodily injury and involves: neglect, exploitation, a missing resident, drug theft, fire emergency situations that pose a threat to resident health and safety, a death under unusual circumstances. Record review of Resident #1's face sheet, dated [DATE], revealed an admission date of [DATE] and discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 01, which indicated the resident was severely cognitively impaired. The MDS further revealed Resident #1 was on a mechanically altered diet and had signs and symptoms of possible swallowing disorder as indicated by: holding food in mouth/cheeks or residual food in mouth after meals. Record review of Resident #1's Death in facility tracking record MDS, signed [DATE], revealed a discharge date of [DATE]. Record review of Resident #1's Physician order [REDACTED]. Record review of Resident #1's Care Plan, dated [DATE], revealed the resident received a therapeutic diet, with goals to demonstrate compliance with nectar liquids and puree diet and interventions to include: during social events/activities provide snacks that comply with diet and encourage compliance with nectar thick liquids and puree heart healthy. Record review of Resident #1's progress note, dated [DATE] at 23:18 p.m. (11:18 p.m.) revealed it read in part . Patient was been assisted with dinner by cna, when patient started to gasp for air, cna hold patient in a higher up position and called for help. When this nurse enter patient's room, patient was lethargic and lips were blue. This nurse called code blue and CPR was started 18:55 p.m. (6:55 p.m.) ADON started compression(s). This nurse called 911 and gave patient information to dispatcher. Paramedics arrived to facility 19:07 (7:07 p.m.) and took over of patient care. Paramedics continue to assist Patient till 19:38 (7:38 p.m.) when Patient was pronounced dead. During an interview on [DATE] at 5:08 p.m., LVN C stated she assisted the ADON with CPR and reported that she overheard the paramedic say Resident #1 had choked on some food but did not know why that was said. LVN C stated she reported to the ADON that EMS stated Resident #1 choked on food. During an interview on [DATE] at 4:29 p.m., the ADON, stated she was informed that a small piece of fruit was found by EMS during CPR but could not recall who informed her. During an interview on [DATE] at 7:24 p.m., CNA A stated on [DATE] she fed Resident #1 his dinner meal in his room. She stated she was asking the resident yes and no after questions whether or not he liked the food. The CNA stated the resident was provided a pureed meal tray but stated the dessert was not pureed enough. She stated she was aware the dessert was not pureed to the right consistency and fed the dessert to Resident #1. She stated she provided two bites of the dessert to the resident and prior to giving a third bite, she asked the resident if he wanted more and he stated No and she heard a wheezing noise when the resident said no. She stated the resident's lips started to change to a grayish-blueish color and she called for help. CNA A reported the dessert as being 'pears with oatmeal crumbled on top and described the pears as being, small, cut into bite size and semi-mushed. The CNA stated she reported to the Administrator and DON the following day that she fed Resident #1 a dessert that was not pureed and wrote a statement. Record review of CNA A's written statement provided by the DON, read in part, I *** CNA was feeding patient in room [ROOM NUMBER]. I was asking yes or no questions about his meal. I was feeding him his dessert, pears with oatmeal crumbs. I asked patient if he wanted more when he responded NO!! he started to wheeze. I repositioned him even more to see if that would help. Immediately I called the Med Aide for help. We noticed discoloration on his lips, we called out for the nurse . Record review of CNA A's personnel file revealed a form titled, Employee Coaching and Counseling Record, which revealed CNA A was given a verbal warning for violation of policy. Under the subheading Company/Supervisor Remarks was a hand-written statement, Employee fed regular dessert to pureed diet patient. The form was signed by the DON and CNA A on [DATE] with the Administrator's signature, undated. During an interview with the Administrator on [DATE] at 10:24 a.m., the Administrator stated there was some question regarding the consistency of the dessert provided to Resident #1 on the day he coded. He stated CNA A reported that she mashed up the fruit and that she gave a very small amount on a spoon. He stated he did not know if the resident was served a regular dessert or not, stating that CNA A could not identify the consistency, but it sounded like the right one. The Administrator stated he spoke to the ADON on [DATE] and that the ADON mentioned that when EMS was performing CPR that EMS stated that something came up and stated that was why he and the DON spoke to CNA A to get clarification. The Administrator stated the incident was not reported to THHS, stating it was not reportable. He stated the resident was a very sick man, and was determined to be a full code, CPR was provided and he passed away. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to report alleged violations related to neglect or abuse, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 6 residents (Resident #1) reviewed for |

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

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| | 676472 | A. BUILDING _____ B. WING _____ | 08/04/2020 |

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| SUNDANCE INN HEALTH CENTER | 2034 SUNDANCE PARKWAY NEW BRAUNFELS, TX 78130 |

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|---|---|
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>neglect and abuse, in that: The facility did not report to State Survey Agency (HHSC) that Resident #1 went into [MEDICAL CONDITION] and died shortly after being fed a wrong textured dessert by CNA A. This deficient practice could place residents who are prescribed a pureed texture diet at risk of aspiration, choking and/or death. The findings were: Record review of Resident #1's face sheet, dated [DATE], revealed an admission date of [DATE] and discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 01, which indicated the resident was severely cognitively impaired. The MDS further revealed Resident #1 was on a mechanically altered diet and had signs and symptoms of possible swallowing disorder as indicated by: holding food in mouth/cheeks or residual food in mouth after meals. Record review of Resident #1's Death in facility tracking record MDS, signed [DATE], revealed a discharge date of [DATE]. Record review of Resident #1's Physician order [REDACTED]. Record review of Resident #1's Care Plan, dated [DATE], revealed the resident received a therapeutic diet, with goals to demonstrate compliance with nectar liquids and puree diet and interventions to include: during social events/activities provide snacks that comply with diet and encourage compliance with nectar thick liquids and puree heart healthy. Record review of Resident #1's progress note, dated [DATE] at 23:18 p.m. (11:18 p.m.) revealed it read in part . Patient was been assisted with dinner by cna, when patient started to gasp for air, cna hold patient in a higher up position and called for help. When this nurse enter patient's room, patient was lethargic and lips were blue. This nurse called code blue and CPR was started 18:55 p.m. (6:55 p.m.) ADON started compression(s). This nurse called 911 and gave patient information to dispatcher. Paramedics arrived to facility 19:07 (7:07 p.m.) and took over of patient care. Paramedics continue to assist Patient till 19:38 (7:38 p.m.) when Patient was pronounced dead. During an interview on [DATE] at 5:08 p.m., LVN C stated she assisted the ADON with CPR and reported that she overheard the paramedic say Resident #1 had choked on some food but did not know why that was said. LVN C stated she reported to the ADON that EMS stated Resident #1 choked on food. During an interview on [DATE] at 4:29 p.m., the ADON, stated she was informed that a small piece of fruit was found by EMS during CPR but could not recall who informed her. During an interview on [DATE] at 7:24 p.m., CNA A stated on [DATE] she fed Resident #1 his dinner meal in his room. She stated she was asking the resident yes and no after questions whether or not he liked the food. The CNA stated the resident was provided a pureed meal tray but stated the dessert was not pureed enough. She stated she was aware the dessert was not pureed to the right consistency and fed the dessert to Resident #1. She stated she provided two bites of the dessert to the resident and prior to giving a third bite, she asked the resident if he wanted more and he stated No and she heard a wheezing noise when the resident said no. She stated the resident's lips started to change to a grayish-blueish color and she called for help. CNA A reported the dessert as being 'pears with oatmeal crumbled on top and described the pears as being, small, cut into bite size and semi-mushed. The CNA stated she reported to the Administrator and DON the following day that she fed Resident #1 a dessert that was not pureed and wrote a statement. Record review of CNA A's written statement provided by the DON, read in part, I *** CNA was feeding patient in room [ROOM NUMBER]. I was asking yes or no questions about his meal. I was feeding him his dessert, pears with oatmeal crumbs. I asked patient if he wanted more when he responded NO!! he started to wheeze. I repositioned him even more to see if that would help. Immediately I called the Med Aide for help. We noticed discoloration on his lips, we called out for the nurse . Record review of CNA A's personnel file revealed a form titled, Employee Coaching and Counseling Record, which revealed CNA A was given a verbal warning for violation of policy. Under the subheading Company/Supervisor Remarks was a hand-written statement, Employee fed regular dessert to pureed diet patient. The form was signed by the DON and CNA A on [DATE] with the Administrator's signature, undated. During an interview with the Administrator on [DATE] at 10:24 a.m., the Administrator stated there was some question regarding the consistency of the dessert provided to Resident #1 on the day he coded. He stated CNA A reported that she mashed up the fruit and that she gave a very small amount on a spoon. He stated he did not know if the resident was served a regular dessert or not, stating that CNA A could not identify the consistency, but it sounded like the right one. The Administrator stated he spoke to the ADON on [DATE] and that the ADON mentioned that when EMS was performing CPR that EMS stated that something came up and stated that was why he and the DON spoke to CNA A to get clarification. The Administrator stated the incident was not reported to THHS, stating it was not reportable. He stated the resident was a very sick man, and was determined to be a full code, CPR was provided and he passed away. Record review of the facility's policy titled, Pureed Diet, revealed: The consistency of the pureed foods must be similar to that of smooth pudding. Record review of the facility's policy titled, Abuse Prohibition Policy - Identification, dated [DATE] revealed in part . All alleged violations concerning abuse, neglect or misappropriation of property are reported immediately to the Administrator and /or the designee and other enforcement agencies according to state law including the State Survey and Certification Agency. Procedures- 2. Staff members identify and assess suspected or alleged reports of abuse or neglect, focusing on objective and observable evidence. Type of abuse include: e) Neglect- failure to provided goods and services necessary to avoid physical harm, mental anguish or mental illness. Record Review of Long-Term Care Regulatory Provider Letter, PL ,[DATE], titled, Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), dated [DATE] revealed in part, A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: abuse, neglect, exploitation, death due to unusual circumstances, missing resident, misappropriation, drug theft, suspicious injuries of unknown source, fire, emergency situations that pose a threat to resident health and safety. Reporting timeframes include: Immediately, but not later than two hours after the incident occurs or is suspected for abuse (with or without serious bodily injury; or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury. Immediately, but not later than 24 hours after the incident occurs or is suspected for an incident that does not result in serious bodily injury and involves: neglect, exploitation, a missing resident, drug theft, fire emergency situations that pose a threat to resident health and safety, a death under unusual circumstances. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure Residents received treatment and care in accordance with professional standards of practice that met the physical, mental and psychological needs for 1 of 6 Residents (Resident #1) reviewed for quality of care, in that: CNA A provided Resident #1 a dessert (small bite size, semi-mushed pears with oatmeal crumbled on top) that was not pureed to the proper consistency. This deficient practice affected one resident and could place all residents prescribed a pureed textured diet at risk of aspiration, choking and/or death. The findings were: Record review of Resident #1's face sheet, dated [DATE], revealed an admission date of [DATE] and discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Admission MDS, dated [DATE], revealed the resident had a BIMS score of 01, which indicated the resident was severely cognitively impaired. The MDS further revealed Resident #1 was on a mechanically altered diet and had signs and symptoms of possible swallowing disorder as indicated by: holding food in mouth/cheeks or residual food in mouth after meals. Record review of Resident #1's Death in facility tracking record MDS, signed [DATE], revealed a discharge date of [DATE]. Record review of Resident #1's Physician order [REDACTED]. Record review of Resident #1's Care Plan, dated [DATE], revealed the resident received a therapeutic diet, with goals to demonstrate compliance with nectar liquids and puree diet and interventions to include: during social events/activities provide snacks that comply with diet and encourage compliance with nectar thick liquids and puree heart healthy. Record review of Resident #1's progress note, dated [DATE] at 23:18 p.m. (11:18 p.m.) revealed it read in part . Patient was been assisted with dinner by cna, when patient started to gasp for air, cna hold patient in a higher up position and called for help. When this nurse enter patient's room, patient was lethargic and lips were blue. This nurse called code blue and CPR was started 18:55 p.m. (6:55 p.m.) ADON started compression(s). This nurse called 911 and gave patient information to dispatcher. Paramedics arrived to facility 19:07 (7:07 p.m.) and took over of patient care. Paramedics continue to assist Patient till 19:38 (7:38 p.m.) when Patient was pronounced dead. During an interview on [DATE] at 5:08 p.m., LVN C stated she assisted the ADON with CPR and reported that she overheard the paramedic say Resident #1 had choked on some food but did not know why that was said. LVN C stated she reported to the ADON that EMS stated Resident #1 choked on food. During an interview on [DATE] at 4:29 p.m., the ADON, stated she was informed that a small piece of fruit was found by EMS during CPR but could not recall who informed her. During an interview on [DATE] at 7:24 p.m., CNA A stated on [DATE] she fed Resident #1 his dinner meal in his room. She stated she was asking the resident yes |

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| **SUNDANCE INN HEALTH CENTER** | **2034 SUNDANCE PARKWAY NEW BRAUNFELS, TX 78130** |

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 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>and no after questions whether or not he liked the food. The CNA stated the resident was provided a pureed meal tray but stated the dessert was not pureed enough. She stated she was aware the dessert was not pureed to the right consistency and fed the dessert to Resident #1. She stated she provided two bites of the dessert to the resident and prior to giving a third bite, she asked the resident if he wanted more and he stated No and she heard a wheezing noise when the resident said no. She stated the resident's lips started to change to a grayish-blueish color and she called for help. CNA A reported the dessert as being pears with oatmeal crumbled on top and described the pears as being, small, cut into bite size and semi-mushed. The CNA stated she reported to the Administrator and DON the following day that she fed Resident #1 a dessert that was not pureed and wrote a statement. Record review of CNA A's written statement provided by the DON, read in part, I *** CNA was feeding patient in room [ROOM NUMBER]. I was asking yes or no questions about his meal. I was feeding him his dessert, pears with oatmeal crumbs. I asked patient if he wanted more when he responded NO!! he started to wheeze. I repositioned him even more to see if that would help. Immediately I called the Med Aide for help. We noticed discoloration on his lips, we called out for the nurse . Record review of CNA A's personnel file revealed a form titled, Employee Coaching and Counseling Record, which revealed CNA A was given a verbal warning for violation of policy. Under the subheading Company/Supervisor Remarks was a hand-written statement, Employee fed regular dessert to pureed diet patient. The form was signed by the DON and CNA A on [DATE] with the Administrator's signature, undated. During an interview with the Administrator on [DATE] at 10:24 a.m., the Administrator stated there was some question regarding the consistency of the dessert provided to Resident #1 on the day he coded. He stated CNA A reported that she mashed up the fruit and that she gave a very small amount on a spoon. He stated he did not know if the resident was served a regular dessert or not, stating that CNA A could not identify the consistency, but it sounded like the right one. The Administrator stated he spoke to the ADON on [DATE] and that the ADON mentioned that when EMS was performing CPR that EMS stated that something came up and stated that was why he and the DON spoke to CNA A to get clarification. The Administrator stated the incident was not reported to THHS, stating it was not reportable. He stated the resident was a very sick man, and was determined to be a full code, CPR was provided and he passed away. Record review of the facility's policy titled, Pureed Diet, revealed: The consistency of the pureed foods must be similar to that of smooth pudding. |