STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105202	A. BUILDING _____ B. WING _____	10/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APOLLO HEALTH AND REHABILITATION CENTER	1000 24TH ST N SAINT PETERSBURG, FL 33713

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 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 interviews with facility staff and review of medical records and policies, it was determined the facility failed to provide the level of oversight and supervision needed to ensure one (#1), of a total of 16 residents on modified diets, received and consumed the prescribed modified diet. At approximately 11:00 p.m., just prior to shift change, Resident #1 was provided a peanut butter and jelly sandwich by a Registered Nurse that was unaware of a diet order change in the previous 24 hours to pureed. While eating a bedtime snack, Resident #1 began choking, but was able to report that he was choking on a sandwich, which was a food item not consistent with his Physician-ordered Pureed diet. Emergency Medical Services (EMS) arrived and were able to intubate the resident to provide an oxygen source once they dislodged the material blocking his throat which facility staff said appeared to be ham. The resident ' s Certified Nursing Assistant (C.N.A.) confirmed he served the resident ' s roommate half of a ham sandwich at about 8:30 p.m. when he served Resident #1 a pudding cup. The C.N.A. reported he discarded the empty pudding cup and saw the ham sandwich still on the bedside table next to the roommate. The resident ' s nurse, unaware that the resident had a downgrade in diet texture (from mechanical soft to pureed), served Resident #1 a peanut butter and jelly sandwich. Resident #1 was ultimately not able to be revived and was admitted to the ICU and died 13 days later. Findings included: 1. Resident #1 had [DIAGNOSES REDACTED]. and depression. He had had a stroke and had dysphagia which led to the use of a feeding tube beginning in [DATE]. According to the American Stroke Association (a division of the American Heart Association), a stroke, or Cerebral Hemorrhage, may cause a swallowing disorder called Dysphagia. If the dysphagia is not treated it can lead to poor nutrition, weight loss, choking and pneumonia. Aspiration is a common problem for people with dysphagia. It occurs when something swallowed enters the airway and lungs. Normally, aspiration causes a violent cough, but a stroke can reduce the sensation to cough which is referred to as silent aspiration. For some patients the only solution is a feeding tube. For others, the diet can be modified to allow for eating by mouth. The food items can be chopped into smaller pieces or pureed for easier eating. Sometimes beverages need to be thickened so the resident can swallow the beverage safely and ensure it doesn ' t flow into the lungs. https://www.stroke.org/en/about-stroke/effects-of-stroke/cognitive-and-communication-effects-of-stroke/difficulty-swallowing-after-stroke--dysphagia 2. On [DATE], according to a progress note located in the resident ' s medical record, around 2310 (11:10 p.m.) an aide heard the resident choke and called the nurse. His spO2 (oxygen in his blood) decreased to 70%, the [MEDICATION NAME] maneuver was performed, without much success, 911 was called. The facility provided a sequence of events that began on [DATE] at 8:30 p.m. when the C.N.A., Staff E provided evening snacks to Resident #1 and his roommate. Resident #1 received chocolate pudding and his roommate received a half of a ham sandwich. At 10:30 p.m. Staff E conducted his final rounds for his shift, saw no snack remaining for Resident #1, and the ham sandwich half still at the roommate ' s bedside. At 10:56 p.m. Staff A, RN, clocked in, was screened, and completed walking rounds while coming down to unit for shift report. Staff A noted that Resident #1 did not have a snack at the bedside, and roommate of resident did have a sandwich at the bedside. Nurse A went to the snack area and obtained a peanut butter and jelly sandwich and removed crust and gave to Resident #1. Nurse A then proceeded to the nurses station. At 11:14 p.m. on [DATE], Staff B, C.N.A., heard Resident #1 coughing. At 11:15 p.m., Staff C, a Licensed Practical Nurse (LPN) was called to the room to assess the resident who was coughing and speaking. At 11:17 p.m., Staff C, Licensed Practical Nurse (LPN) performed the [MEDICATION NAME] maneuver followed by finger sweeps. Staff A, a Registered Nurse, brought the crash cart and applied oxygen to the resident. At 11:19 p.m., Staff F, LPN, called 911 and called a code blue. The resident ' s fingers were turning blue and he could not speak. At 11:20 p.m., Staff D, RN performed the [MEDICATION NAME] maneuver and a small amount of food particles were dislodged. Staff G, LPN, recorded a heart rate of 107 and oxygen saturation of 64%. At 11:28 p.m., Staff F, LPN, and Staff G, LPN, reported the arrival of EMS to Resident #1 ' s room. At 11:30 p.m., Staff F LPN and Staff G, LPN recorded oxygen saturation of 80% and heart rate of 36 with respirations and Resident #1 was unconscious. At 11:30 p.m., EMS assumed care of Resident #1. Staff H, LPN stated food, appearing to be ham was removed from Resident #1 ' s airway by EMS using forceps. At 11:40 p.m., Staff G LPN records Cardiopulmonary Resuscitation (CPR) initiated by EMS who continued while exiting the facility with Resident #1. 3. On [DATE] at 8:10 PM, a telephone interview with Staff A, RN, revealed that when he arrived for his shift the evening of [DATE] (at 10:56 p.m. according to time card entry), he was concerned about Resident #1 getting a snack before he fell asleep because Resident #1 was known to be a diabetic resident whose blood sugar would get low overnight. Staff A, RN, stated he remembered that Resident #1 was on a mechanical soft diet and gave him a peanut butter and jelly sandwich after cutting off the crusts. Staff A, RN, stated that he was not aware that Resident #1 ' s diet was downgraded the day before on [DATE] to a pureed diet. Staff A, RN, confirmed that he should have verified Resident #1 ' s diet before giving him the sandwich. Review of the statement documented on [DATE] by Staff E, CNA, after the incident with Resident #1 on [DATE], indicated, On the evening of this event, both Resident #1 and his roommate were given snacks according to their diets. Resident #1 ' s roommate received a ham sandwich which laid on his bedside table which is very common as he doesn ' t eat right away as both residents are night owls and like to move around at night. On [DATE] at approximately 2:00 p.m., Staff E, CNA, confirmed that he completed his walking rounds at 10:30 p.m. on [DATE] prior to leaving the facility after his shift (3:00 p.m. - 11:00 p.m.). Staff E, CNA stated that during his walking rounds, he observed half of a ham sandwich on the bedside table of the roommate. Staff E, CNA, confirmed that he had delivered that half of a ham sandwich to the roommate earlier in the shift. He also confirmed that he had delivered a chocolate pudding to Resident #1 at that same time. Review of the statement documented on [DATE] at 11:10 p.m., related to the event of [DATE] concerning Resident #1, Staff B, CNA, revealed, I was standing at South station when I heard a vomiting noise like someone was trying to throw up. I walked . to hear where the noise was coming from and it was Resident #1. I walked into his room, asked him if he was okay, he stated he was eating a sandwich. He was acting like he was trying to throw up. I looked into his mouth and tried to get him to spit the rest of what he was eating out. I asked the West evening nurse, ' What diet is he on? ' She said pureed and then I asked, ' Well who gave him a sandwich? ' Night nurse came to the room examine(d) him (Resident #1) left out. I asked South nurse to come here and he did. Noticed patient fingers was turning blue. South nurse checked his mouth and started doing the [MEDICATION NAME]. West evening nurse came into the room and started asking questions then went to call 911. Night nurse checked his (Resident #1) blood sugar. By that time the supervisor and the other nurses were in the room and I stepped out of their way. Review of the statement documented on [DATE], completed by Staff C, LPN, found, At about 11:10 p.m. responded to check on the patient who was choking (Resident #1). Checked the mouth and airway to see if there was any visible object. At that time there was nothing showing. Patient was having difficulty breathing and trying to throw up. Head of the bed was raised, turned patient with his back towards

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) the writer and performed the [MEDICATION NAME] maneuver. After couple of times performing the [MEDICATION NAME] maneuver two nurses came. Patient became non-responsive. Patient had pulse and respirations. Airway was checked again. Patient had food particles coming out of his mouth. The supervisor cleared his airway by passing finger sweeps. The Emergency Medical Technician (EMT) arrived couple of minutes later. Patient was taken to the hospital. Review of the statement documented by Staff G, LPN, dated [DATE] revealed, I (Staff G) was in the therapy room checking in 11:00 p.m.-7:00 a.m. staff and was made aware that a resident needed assistance. Nursing staff responded quickly to assist in his room. When approached the room [ROOM NUMBER]:00 p.m.-7:00 a.m. supervisor was in the room with an 11:00 p.m.-7:00 a.m. nurse assisting with [MEDICATION NAME] maneuver. Nurse that came on duty for 11:00 p.m.-7:00 a.m. shift had apparently given resident sandwich. Crash cart was in the room at the time. Resident had a pulse and oxygen level was at 64%. 02 (oxygen) mask rebreather was on resident. Paramedics arrived and initiated intubation and CPR and begin to retrieve chunks of ham. Resident was sent to . Hospital. Son and MD (Medical Doctor) was notified via 11:00 p.m.-7:00 a.m. nurse on duty. Review of the statement documented on [DATE] by Staff D, RN, stated, Around 23:15 (11:15 p.m.), West nurse alerted me that . (Resident #1) was choking. Upon entering the room patient was seen in a high Fowler ' s position (head of the bed needs to be elevated as high as possible, upper half of the body is between 60 degrees and 90 degrees in relation to the lower half of the body) with non-rebreather applied. Initial 02 at 64% and Heart Rate (HR) 107. Sat patient to the side of the bed to approach from behind to attempt the [MEDICATION NAME] maneuver then turned on his side and finger sweep completed with small chunks of bread being dislodged. Patient was seen gasping for air, so several abdominal thrusts were completed with minimal food being dislodged each time. Reassessed 02 now 80% but HR 36. Paramedics arrived and immediately intubated and took over. Afterwards I had been informed patient was recently downgraded to a puree diet, but this evening had been given a ham sandwich by the oncoming nurse. Review of the statement documented by Staff H, LPN, on [DATE] pertaining to the event of [DATE] for Resident #1 revealed, This nurse went in to assist a fell ow nurse after receiving word that patient (Resident #1) was choking on a ham sandwich. This nurse went into the room while other nurses were performing [MEDICATION NAME] maneuver and monitoring vitals, offering assistance. 911 was already called, waiting arrival of EMS, monitoring vitals, immediately intubating and then EMS started CPR. Nurse witnessed EMS removing sandwich matter from patient and still continuing CPR. EMS then took the patient to hospital shortly after. The Hospital History and Physical, Final report, for an admission date of [DATE], provided The patient . presenting with cardiopulmonary arrest after apparent choking episode. Resident #1 was evaluated at the hospital upon arrival by a Neurologist who discussed his findings with the resident ' s son. The evaluation indicated the patient had pinpoint pupils that were nonreactive, no corneal reflexes, flaccid, no response to noxious stimuli, no cough reflex which the Neurologist made clear to the son that there was an extremely poor neurological prognosis to a meaningful recovery. Per the hospital progress notes dated [DATE], Contacted the patient ' s Extended Care Facility (ECF). The patient was bed and wheelchair bound for quite some time. Was at the facility for about the last 4 years. There has been a gradual and progressive decline in overall and more so this year. Approximately 1-,[DATE]-2 months ago when he came down with COVID he had a more dramatic decline in his overall function. Was no longer able to move himself around in bed, eating less and also less verbal interaction with the staff. Variably ate some days feeding himself and other days needing assistance. He used to be (able to) propel himself around (in) a wheelchair but had stopped doing that. He frequently because of his pureed diet and honey thickened liquids would grab things from other trays. Anything within reach. Overall, though his cognitive and physical functional level had declined significantly over this year and more so since COVID 19 infection. The resident expired on [DATE] at 5:30 p.m. An interview was conducted on [DATE] at 10:41 a.m. with Resident #1 ' s Attending Physician. She confirmed that Resident #1 had been her patient for one year and she was knowledgeable about him. She stated that the resident had improved somewhat during the time she followed him, but he had issues with his health. She initiated Resident #1 ' s diet change on [DATE] from mechanical soft to pureed. She remembered an incident a couple weeks prior where Resident #1 consumed a carrot ([DATE]) resulting in some choking and so to be certain, his diet was downgraded to pureed, but perhaps the carrot was not properly softened. They continued to follow the Resident and he followed the pureed diet until he was given a sandwich by a nurse. The physician said, to her understanding he was given a sandwich that he should not have had resulting in a respiratory arrest. She said, I have been doing this long enough to know that eating the wrong foods can lead to a respiratory arrest. As a precaution I gave an order, and that order was not followed. That nurse should be educated, and the facility needs to do all out checks and balances. Instructions were not followed. That ' s the bottom line. This happened in the course of a week. She had been notified that the resident was transferred to the hospital. She had been informed that Resident #1 ' s code time was around 12 minutes and usually after 5 minutes when the brain is deprived of oxygen, the patient remains quite ill. The physician continued by saying she observed Resident #1 ' s roommate, weeks ago, giving Resident #1 coffee and he shouldn ' t have been doing that due to the sugar in the coffee. She educated people on this problem and since then she did not have any issues. A Psychotherapy Note dated [DATE] summarized the visit with Resident #1 as: I spoke with the current speech therapist who reported the patient was impulsive and forgetful, but always positive. He was disoriented but would remember things he was told if prompted. The Psychotherapist provided support and positive reinforcement and reinforced positive coping skills. In an interview that was conducted with the resident ' s usual day C.N.A., Staff J, on [DATE] beginning at 12:00 p.m., she reported that when she came to work on [DATE] she heard the news and went to the resident ' s roommate and asked him what had happened. She reported that the roommate told her that the nurse had given the resident a sandwich and he choked. She confirmed that the roommate liked to keep food items from his meal to eat later on his bedside table. She suggested that maybe he had kept his bedtime sandwich around and somehow Resident #1 got it. She reported that other aides had told her that they had seen the roommate give Resident #1 food and drinks. She said that she never saw the roommate do that, and never told the nurses what she was told, but she said she told the other aides they needed to explain to the roommate that he shouldn ' t do that. She reported that she tells her residents not to share with the other residents, as you don ' t know their allergies [REDACTED]. She said by the end of her shift she would probably discard the food item and let the nurse and incoming aide know that the resident might be looking for his snack. When asked about the resident ' s room configuration, she reported that the beds had always been against the wall, perpendicular to each other. One bed was under the window and the other was against the side wall of the room. She confirmed that the over the bed table of the roommate was usually parallel to his bed, which meant that the short side of the table may have been near Resident #1. 4. Resident #1 had multiple re-admissions to the facility after hospital stays. On [DATE] the resident was readmitted to the facility after having a feeding tube inserted. A review of the quarterly nursing readmission evaluation, dated [DATE], revealed that Resident #1 was able to make his needs known, with the plan to remain long term in the facility. He was described during the assessment as verbally denying pain, smiling, and talking. He was admitted with a feeding tube for the [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) Assessment, completed on [DATE] did not include a BIMS (Brief Interview for Mental Status) score as the resident was identified as rarely or never understood. On [DATE], a quarterly MDS was completed and the BIMS was attempted with the resident, but he scored a 00, indicating severe cognitive impairment. A significant change MDS, related to the resident ' s COVID-19 positive status, was completed on [DATE] which identified the resident ' s BIMS score as 6, indicating severe cognitive impairment. The resident ' s short- and long-term memory were not assessed at that time. The resident had no signs of [MEDICAL CONDITION] or any behaviors or moods identified. The resident continued to require extensive assistance with two staff for bed mobility and transferring. He was able to walk in his room and the corridor, or use a wheelchair or walker, but with extensive assistance with one staff. He was frequently incontinent of bladder and always incontinent of bowel and required extensive assistance by two staff for toilet use. His balance was not steady but would stabilize with staff assistance. He had no range of motion limitations. The MDS included [DIAGNOSES REDACTED]. anxiety and depression. He had a stroke and had dysphagia following the cerebral infarction and was at risk for malnutrition. In [DATE], the resident was 65 tall and weighed 146 lbs. There had been no change in his weight during the past six months. The MDS assessed the resident as having no swallowing disorders (no loss or liquids or solids from the mouth when eating or drinking; no holding food in his mouth or cheeks; no coughing or choking during meals or when swallowing medications, and no complaints of difficulty or pain when swallowing.) His eating ability was assessed as needing limited assistance by one staff. The MDS indicated the resident did not have a feeding tube but was receiving a therapeutic, mechanically altered diet. The resident was assessed as having no dental concerns - no broken or loosely fitting full or partial dentures, having teeth, no abnormal mouth tissue, no obvious cavities, no inflamed or bleeding gums, no loose natural teeth and no mouth or facial pain or discomfort or difficulty chewing. Therapies (Physical, Occupational, Speech) were not working with the resident in August, but the MDS documented that he had been seen by the Speech Therapist from ,[DATE] - [DATE]; and the Physical and Occupational Therapists from ,[DATE]- [DATE]. A restorative

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) program for passive range of motion was identified for this resident. 5. An interview was conducted with the Speech Therapist on [DATE] beginning at 12:45 p.m. She confirmed that she was involved with Resident #1 ' s care related to eating. She reported that he usually just needed a reminder about sitting up, to go slow and take his time, as he ate fast. She reported that she had asked the resident ' s aides to remind him of that and he was usually pretty good at following the reminders. She reported that he didn ' t always tolerate his thickened water, adding that she had seen him go back to the therapy room to drink water out of their water fountain. She reported that at first, he didn ' t like the chopped meat (received on a Mechanical Soft diet) and wanted a regular diet. She said that over time he seemed to accept the consistency changes as his condition progressed, but, at times, he requested regular foods. She added that his safety awareness fluctuated as sometimes he needed direction and sometimes, he was fine. The Speech Therapist reported that she discussed her recommendations with the direct care staff numerous times, including the need for more supervision as all of his meals were in his room, not the dining room. She confirmed that she was not aware how her recommendations were documented on the care plan for staff to refer to, but thought it was probably nursing who added them. A second interview was conducted with the Speech Therapist and Rehab Director on [DATE] beginning at 1:20 p.m. The Rehab Director reported that she was familiar with Resident #1 from his sessions with the Therapy department. She described him as a very social guy. She said she would see him in the halls, in his wheelchair, pulling himself along using the handrails. She didn ' t know him to ever ambulate, even from admission. She knew that last Fall he went out for a Percutaneous Endoscopic Gastrostomy (PEG) tube placement and when he returned, he was lethargic and just wanted to sleep. The Rehab Director reported that she saw Resident #1 a week or two before his incident and he called her by name. She said it surprised her that he remembered her and her name. She described him as having a great personality and a great attitude. She knew he didn ' t remember his limitations, such as not locking his wheelchair and then trying to get into bed from it. He didn ' t remember that he couldn ' t do some things anymore. She confirmed that she was aware his cognition was impaired and his ADLs and ability to perform them had started to decline. She stated that she was not aware that he had problems eating and only when he choked on the carrot ([DATE]) and speech got involved did, she become aware of his history. The Rehab Director reviewed therapy screenings that were conducted in [DATE] and reported that the Speech screening identified deficits for Resident #1 with oral motor strength, the resident ' s ability to swallow liquids, and difficulty with mastication (chewing). Speech Therapy was provided to Resident #1 from [DATE] - [DATE] and the recommendations made by the Speech Therapist in her report were compared to the approaches on the care plan. When it was noted that the recommendations were not included in the care plan, the reason given was that the recommendations were standards of care that should be provided to all residents. The Speech Therapist reiterated that the resident wasn ' t referred to the Restorative Dining Program in July as he did well by the end of therapy and remembered his cues. She reported that over time, with his progressing dementia, the carry over from the sessions would wane and he would be referred to therapy again. The Speech Therapist confirmed that she knew his roommate as a friendly guy. She was aware that he tried to give away what he had, would offer staff food from his meals, or ask staff for a snack. The resident had been followed by the Speech Therapist in [DATE] with her clinical impression as, Patient has had success with mechanical soft trials, diet progressed to three meals a day with mechanical soft. Patient has declined trials with the nectar liquids, continues to request regular water. Patient educated regarding risks and consequences of aspiration, choking, pneumonia and death. The section of the ST progress and updated plan of care notes entitled, ' Updates to Treatment Approach ' read, Caregiver education to include instructions for setup, aspiration precautions, and recommended diet textures to include mechanical soft with regular liquids. The Impact on Burden of Care/Daily Life section read, Complicating factors that prevented the patient from achieving all established goals include decreased compliance with liquids, aspiration risk with regular liquids. The Updated Standardized Tests section of the document read, Patient has a history of dislike and refusing modified textures, often declines honey liquids. Patient had few natural teeth, poor condition, some broken, has partial (plate) - inconsistent wearing. A review was conducted of the Speech Therapists evaluation and treatment notes for the [DATE] sessions. A note by the Speech Therapist (ST) dated [DATE] read, Referral received from occupational therapy, patient eating at a very fast rate and choking observed. Patient has a PEG (percutaneous endoscopic gastrostomy) tube and had been tolerating PO (by mouth) meals three times a day with mechanical soft and nectar liquids. Noted recent downgrade to honey thick liquids by nursing. The Current Level of Function for the start of care on [DATE], read, The patient exhibits poor compliance with safe eating strategies exhibiting increased poor safety, impulsive eating and coughing during meals for pleasure. The Rehab potential was good due to able to follow one step directions. Demonstrated higher functional level compared to current condition. Positive results from previous treatment. A review of the end of care notes, dated [DATE], found the resident had not met many of the goals set by the ST for the therapy, which included mastication of food, a safe swallow, and progressing the texture of the diet and liquids. The ST Clinical Impression read: Patient had new [DIAGNOSES REDACTED]. Liquids had been downgraded following PEG dislocation and removal. Patient has a history of poor safety awareness during PO intake, fast intake pace, spillage, overfills mouth, sleepiness, decreased positioning and resistance at times. Therapy focused on improving tolerance of the current diet, possible progression to regular textures and improving compliance with protocol strategies. Patient requires 50 - 75% cues with positioning, meal set up, cues for strategies and carryover. Patient has had some weight loss since PEG removal. Discussed with MD. The Discharge Plan and Instructions included: Patient discharged to nursing with recommendations including assist with positioning, meal set up, adaptive equipment, assist, cueing, and extra time. The Discharge Summary read: Current - increase tolerance of the current diet, mechanical soft with honey thick liquids, needs positioning and tray set up, adaptive equipment, Numerous missing and/or broken teeth, poor condition, partials present, not utilized, decreased anchor on remaining teeth. PLOF (prior level of functioning) diet was mechanical soft with nectar liquids, nurse downgraded to honey liquid, increased coughing episodes during PO, fast intake rate, often refuses nectar liquid, needs assist with positioning, impulsive and decreased safety awareness, decreased carry over of strategies learned during prior therapy. History of aspiration during Modified [MEDICATION NAME] Swallow (MBS), not a candidate for regular liquids at this time. In an interview conducted with a Unit Manager (UM), on [DATE] beginning at 2:00 p.m., an incident where Resident #1 choked on a carrot at lunch was discussed. The UM reported that on [DATE], she heard the resident coughing and saw him cough up a piece of carrot that he had tried to swallow whole. The piece of carrot had no teeth marks on it indicating he had not chewed before attempting to swallow. The UM reported that she reminded him to chew his food and tried to remove the piece of carrot from his plate, but the resident asked for it back before chewing and swallowing it. The UM reported that she told the nurse and the resident ' s diet was downgraded to Pureed and an order for [REDACTED]. She reported that she had not heard him cough before and didn ' t know him to have any other food problems. The Speech Therapist treated the resident, again, from [DATE] until [DATE] with the reason for the referral as, (taken from the progress notes), Choking episode reported during the noon meal yesterday. MD visited today; dysphagia evaluation/treatment order received. Discussed patient possibility being eligible for dentures/partials with unit manager and doctor. Current partials have poor connection due to missing and partial teeth. Nursing downgraded diet to puree, continue to have honey thick liquids. The Speech Therapist, on the Evaluation Form, documented the previous therapy as The patient has had previous speech therapy initiated on [DATE] for oropharyngeal dysphagia during episode of COVID-19. Patient had positive outcomes, returning to a modified diet, mechanical soft with honey thick liquid. Patient has a history of refusing modified textures and increased signs and symptoms of aspiration with regular and nectar liquids. Precautions listed: HOB (head of bed) elevated for all PO (by mouth) due to aspiration risk, oxygen 2 liters nasal cannula, fall risk, poor safety awareness due to cognitive deficits, needs assist with positioning. The assessment of the resident ' s swallowing abilities indicated; Choking episode, patient doesn ' t remember, was on mechanical soft, nursing downgraded to pureed, full assist with positioning, poor dentition, missing and broken teeth, partials do not attach to remaining teeth. Patient has poor safety awareness during intake, eating at a fast pace, large bites, delayed coughs, stating he ' s hungry. Discussed with nurse manager and MD possible eligibility for new partials/dentures could greatly impact thoroughness of mastication and decrease choking potential. The Rehab potential was indicated as Good due to demonstrated higher functional level compared to current condition. Positive results from previous treatment, responsive to cueing. Both the July and [DATE] Speech Evaluations indicated similar concerns that the resident was experiencing during eating. The resident was identified as having poor safety awareness during eating, he needed full assistance for positioning when eating, he ate at a fast pace, and overfilled his mouth or took large bites. 6. A review was conducted of the care plans developed for Resident #1 and no specific care plan for the resident ' s need for specific interventions recommended by the Speech Therapist during her July or [DATE] evaluations was located. Care plan focus, included ADL self-care performance deficit related [MEDICAL CONDITION], and limited mobility and weakness, included the intervention added on [DATE] for resident up in wheelchair for lunch and

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