STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676423	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HALLMARK	**4718 HALLMARK DR HOUSTON, TX 77056**

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 0580

Level of harm - Actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is - (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention and (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 residents (CR #1) reviewed for notification of changes. - The facility failed to immediately notify and consult with CR #1's physician when the resident choked during an event that lasted approximately 17 minutes to one hour. CR #1 died . This failure placed all residents receiving respiratory care or difficulty swallowing at risk of delayed intervention and of Physician not being consulted to provide timely orders for interventions which could result in delayed treatment, inadequate treatment, hospitalization , or death. Findings Include: Record review of CR #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 04 out of 15 indicating severe cognitive impairment. He required two-person assistance with bed mobility, transfer, dressing and toile use. He required one-person assistance with locomotion on unit, eating and personal hygiene. He was coded as always incontinent for urinary and bowel. He was coded as having shortness of breath. Section K: Swallowing/Nutritional Status was coded as C. Coughing or choking during meals or when swallowing medications. Record review of CR #1's care plan initiated on [DATE] and revised on [DATE] revealed the following: -Focus: CR #1 admitted to hospice with dx of Alzheimer's with comorbidities of [MEDICAL CONDITION] and dysphagia. Goal: Will maintain CR #1's quality of life through integrated care provided by Hospice and nursing staff. Interventions: Family/ Hospice/ IDT to coordinate plan of care and reach common goals for CR #1; Monitor for any changes in condition and notify hospice; No labs, Diagnostic testing or hospitalization ; Provide comfort care; and Refer to chart for hospice plan of care. -Focus: Resident has an ADL self-care performance deficit r/t Activity Intolerance, Alzheimer's Date initiated: [DATE] Goal: Reduce the risk of a decline in current participation. Date initiated [DATE] Intervention: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Requires total assistance with 2 staff members for his showers Date Initiated: [DATE]. Bed mobility: Resident requires moderate assistance by 1 staff to turn and reposition in bed frequently and as necessary. Date Initiated: [DATE]. Dressing: Resident is totally dependent on 1 staff for dressing. Date Initiated: [DATE]. EATING: Resident is able to feed self with 1:1 supervision to monitor pace/rate. Diet is regular-mechanical soft consistency with thin liquids. Date Initiated: [DATE]. Personal Hygiene/Oral Care: Resident requires moderate assistance of 1 staff member for his hygiene. Date Initiated: [DATE]. Transfer: Resident requires 2-person assist with Hoyer lift transfers. Date initiated: [DATE]. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of CR #1's DNR, Do Not Resuscitate, Order revealed it was dated [DATE]. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED].@ 2lpm via nc as needed for spo2 < 92% as needed. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician order [REDACTED].#1's progress notes written by RN on [DATE] read in part, 6 pm, sitter reported that the resident had been coughing during meals since this morning, resident has a communication deficit due to dementia, continues on aspiration precaution, HOB was kept on 90% (sic) during eating, VSS, no fever, temp 96.7 F, safety was maintained, call bell within reach, bed in low position, all needs attended. . Record review of CR #1's progress notes written by LVN A on [DATE] read, Resident was [MEDICAL CONDITION] a 114 pulse, rechecked the pulse and it was 58. His O2 saturation was 90% on room air, prn duo-nebulizer treatment was given. His oxygen increased to 97% on room air. Continued monitoring. No pain, a-febrile, skin warm to touch, no sob, no signs/symptoms of COVID. Record review of CR #1's progress note written by LVN D on [DATE] read in part, .Suction patient PRN DX congestion as needed. PRN Administration was: Effective. No coughing at this time. Will continue to monitor . Record review of CR #1's progress note written by RN on [DATE] read in part, Resident remains alert and responsive to all stimuli, not in distress, not able to make needs known, noted coughing this shift during meds administration, aspiration precaution maintained, HOB was kept elevated, dependent to all ADL's., incontinent care provided, noted staring at the ceiling, smiling, VSS, no SOB noted, afebrile, temperature 96.5 f, incontinent care provided, will continue to monitor. . Record review of CR #1's Orders-Administration note dated [DATE] written by LVN D revealed the following: Suction patient PRN DX congestion as needed. Resident coughing, unable to clear throat, suctioned at this time. Tolerated well. Oxygen saturation 95% to room air. HOB up 90-degrees. Record review of CR #1's progress note written by LVN D on [DATE] read in part, RN with Hospice here to evaluate resident. States 'resident may be transitioning.' Resident stable at this time, no productive cough at this time b/p ,[DATE], respirations 20, temperature 97.6, oxygen saturation 92% with oxygen at 2L/min via NC. New order obtained, [MEDICATION NAME] Tablet 0.125 mg give 1 tab SL for increased secretions. (Staff Name) will be back to evaluate in 2 days and if any further decline he will coordinate with the family for a visit. . Record review of CR #1's Health Status note written by RN on [DATE] read in part, .625 pm, called by the sitter to check on the resident because he's unable to respond verbally and choking on the sandwich that he's eating. In the room resident was on his bed on upright 90-degree position, unresponsive, not breathing and cyanotic, he was placed immediately on side lying position and was suctioned and was able to take out some of the liquified food that was stuck on his throat, O2 on @ ,[DATE] LPM via NC. Resident was trying to cough out but unable to do so, BP ,[DATE] HR 126 respiratory 0, still cyanotic (blue due to lack of oxygen), suctioning continued until vital signs was unappreciated, unresponsive, no breathing, no heart sound, pupil-dilated and the time was noted 642 pm. Hospice Care was made aware, RP and MD. Record review of CR #1's progress notes for [DATE] revealed no documentation of RN or other staff making notification of change in condition to Hospice or Attending Physician during the change of condition for CR #1. In an interview on [DATE] at 4:15 pm with RN, he said he worked at the facility for almost 3 years. He said he was familiar with CR #1. He said the resident passed (died). He said CR #1 had been at the facility since he had been working at the facility, so he knew him very well. He said on [DATE] he was charting for medications and the CNA for CR #1 was yelling and was calling his name to respond. He said he went over to CR #1's room and he saw the resident with both hands on his neck. He said he assumed he was choking. He said he asked the CNA if he was eating something. He said the CNA said the resident was eating a sandwich. He said he opened CR #1's mouth to assess and he saw a thick mucus. He said he did a finger sweep to clear his mouth and he retrieved some sticky mucous substance from his mouth and throat. He said it did not look like liquified bread. He said, It just looked thick like mucus. He said, I didn't see the sandwich. He said he lowered the bed to put the resident in a supine (lying flat face up) position. He said he gave the resident abdominal thrusts and nothing was coming out. He said he just used his judgement and told CNA to place the resident immediately on his side to drain the mucus. He said some secretions drained when he placed the resident on his side. He said he used the suction machine by the resident side table. He said he started to suction his mouth. He said there was some secretions post suctioning. He said the resident tried to gasp for air but, he was unable to continue to breathe on his own. He said he told the CNA to get CR #1's vitals while he was suctioning. He said at that point, the resident's blood pressure was low. He said he could not recall exactly how low. He said his heart was elevated. He said the resident was turning blue due to lack of oxygen. He said he continued suctioning because the resident was DNR, so he was unable to give him artificial ventilation. He said he kept suctioning because he knew they could not call 911 or use CPR because of the resident's DNR status. He said he wished he could have but, he knew that he needed to respect the resident's choice. He said it was past dinner time around 6:20 pm. He said the resident most likely got the sandwich from the kitchen but, he was not sure because he did not see it. He said the resident was on a restrictive diet. He said the resident's diet called for mechanical soft. He said the CNA knew the resident was on a mechanical diet. He said the CNA stayed to assist with post mortem care. He said he was the one that notified the family. He said he notified hospice, MD and the DON. He said he did not call the physician during the choking episode. In an interview on [DATE] at 4:38 pm with CNA, she said she worked for the department where sitters were assigned. She said she was a certified CNA. She said she went inside the restroom and when she came out, CR #1 was choking. She said the resident had mucus and foam coming out of his mouth. She said she hollered for the RN. She said he arrived and told her to turn the resident on his side, so he could use the suction machine. She said the RN tried to use the suction machine but, it was not plugged in. She said the RN was sitting on the side trying to get the suction machine to work, but it was not working because it was unplugged so she had to tell him that it was not plugged. She said she tried to plug it in. She said she did her best to help the RN get the suction machine going but she did not know how to use the facility's equipment. She said she spent time trying to plug the suction machine and the tubing. She said after she got the suction machine plugged in, the RN tried to suction CR #1's mouth but, it was too late, the resident had already passed. She said the RN pronounced him dead. She said she fed CR #1 a sandwich that she ordered from the facility's kitchen. She said she cut it up into bite size pieces for the resident. She said she fed him the sandwich about 5:10 pm on that day. She said the incident occurred about 5:45 pm because the resident passed around 6:45 pm. She said she worked with CR #1 for 2 years. She said she worked almost every day. She said the facility was saying that he choked on the sandwich but, he choked on mucous. She said he would have episodes where the resident would have increased amount of mucus coming out of his mouth and the nursing staff would suction it out. She said it happened frequently. She said the resident used to spit it out on the floor and she always gave him tissue. She said she did not know why the facility was saying the resident choked on a sandwich because she had already fed him and gave him water behind the sandwich and he was doing fine. She said she was suspended because the facility told her they had to investigate the matter. In an interview on [DATE] at 5:13 pm with DON, she said the CNA's role was to know equipment. She said it was the nurse's responsibility to ensure the equipment, like the suctioning machines, were in good repair and plugged in, so they were ready to go. She said she was not aware the suctioning machine was not plugged in. In a follow up interview on [DATE] at 5:20 pm with RN, he said the suction machine was not plugged in because there were only two outlets; one had the nebulizer plugged in and the other had the oxygen concentrator plugged in. He said he forgot to tell this Surveyor he used oxygen on the resident because it was right there next to his bedside. He said he was the one that unplugged the oxygen, so he could plug the suction machine. He could not recall if the CNA helped him plug in the suctioning machine because it happened so quickly. In an interview on [DATE] at 12:19 pm with Executive Chef, he said he had worked for the facility for 1 year and 3 months. He said he was not at the facility at the time the sandwich was ordered. He said the next day he spoke with the Dietician. He said she told him what had happened with the sandwich. She said a resident choked the night before, (CR #1). He said the sandwich was not ordered as mechanical chop. He said that's why the sandwich was not mechanically chop. He said kitchen staff were in-serviced on the same day he found out. He said the facility changed the process on mechanical chop orders. He said the different diets were now color coded. He said staff had to keep their mask on at all times. He said staff also had to wear masks properly. He said properly was to cover nose, mouth and chin. He said staff always gave him excuses about the kitchen being hot but, he was trying to get them out of that mindset. In an interview on [DATE] at 12:51 pm with DON, she said the suctioning machine should have been plugged in and ready to go especially with CR #1 having a history of mucus in his throat. She said she did not feel the suction machine being unplugged and not ready to go contributed to CR #1's passing because the RN did all he could to preserve the resident's life. She said the RN did abdominal thrusts and gave him oxygen prior to suctioning. She said the resident was on hospice and he had been exhibiting a decline in respiratory functioning. She said he was having episodes where he had mucus buildup in his throat that had to be constantly suctioned. He said the RN was experienced with working with CR #1 so most of the time, the RN did not have to use the suction machine. In an interview on [DATE] at 1:10 pm with the Administrator, he said he questioned if the suction machine not being plugged in was the cause of death. He said he never got a clear answer. In a telephone interview on [DATE] at 1:42 pm with Hospice RN, he said CR #1 was one of his

patients. He said he had not seen the death certificate because it was a duty of the funeral home. He said what happened in the hospice process was that there were two physician medical opinions and both certified a patient as hospice appropriate. He said they reviewed the case and selected the [DIAGNOSES REDACTED]. He said CR #1 was at end of life [MEDICAL CONDITION] with [MEDICAL CONDITION]. He said CR #1 was on PRN oxygen. He said he also had severe dysphagia (difficulty swallowing). He said prior to hospice and while on hospice CR #1 was exhibiting several episodes of severe dysphagia and choking but, it was usually handled appropriately with hospice interventions. He said his interventions were suctioning and PRN oxygen. He said CR #1 was also receiving scheduled [MEDICATION NAME]. He said what probably happened was that he had a choking episode and that was to be expected. He said the resident was declining already. He said, it was super sad. He said he did not believe that the delay in using the suction machine was the cause of death because the resident was already declining, and it was expected. In an interview on [DATE] at 9:38 am with LVN C, she said she worked 7 am to 3 pm. She said she had worked at the facility for 3 weeks. She said she was not familiar with CR #1. She said she was aware that he passed. She said the nurses were talking about it and that was how she became aware. She said the only thing she knew was that he had a sandwich and he choked on the sandwich. She said her understanding of DNR orders were to not resuscitate. She said DNR meant no life saving measures. She said she would probably use abdominal thrusts and back blows if she needed. She said she would not use CPR on a resident with DNR orders. She said her understanding of full code was CPR, oxygen and anything else that could preserve the resident's life. She said if a resident had a DNR on his medical record and he was choking, her approach would be to try to clear his airway to get the obstruction out. She said she would use oxygen. She said she would suction if oxygen did not work. She said if the resident had a history of [REDACTED]. She said she needed a physician's orders [REDACTED]. She said she would call 911 only if instructed by the physician. In a follow-up interview on [DATE] at 9:53 am with CNA, she said CR #1 finished eating the sandwich about 5:30 pm or 5:45 pm or close to 6:00 pm because he ate slow. She said CR #1 ate the whole sandwich. She said the sandwich did not have any ends on it. She said it was a turkey sandwich with cheese. In an interview on [DATE] at 9:57 am with ADON, she said her understanding of DNR was not to perform any CPR, cardiac pacing and AED. She said nursing staff was not prohibited from performing, [MEDICATION NAME], any type of suctioning or any other comfort measures. She said her understanding of full code was to use any kind of life sustaining measures, i.e. AED, CPR, airway management, call 911 and continue CPR until emergency paramedics arrived at the facility. She said her approach to CR #1's situation would be to observe if there was something physically lodged. Perform the [MEDICATION NAME], if unsuccessful, turn him on his side, and then try suctioning. She said since CR #1 was a DNR, her next step would be to call hospice. She said she was uncertain what to do when a resident was DNR and on hospice, so she would call hospice to get further instructions. She said if the resident had a history of [REDACTED]. She said physician orders [REDACTED]. She said, most times, the suctioning orders are PRN. She said she was told CR #1 had aspirated. She said she assumed it was related to the mucus episodes CR #1 kept experiencing. She said she went into the chart to read what the RN had documented. She said the RN's story and the CNA's were inconsistent and not adding up. She said she had not been involved in the facility's investigation. She said if the sandwich did not have the edges, the bread gets kind of liquified. She said if CR #1 finished the sandwich around 6 pm, she did not believe the sandwich could still be lodged in CR #1's throat. She said if CR #1 had [MEDICAL CONDITION] reflux there was a possibility that the sandwich could come back up. She said CR #1 had already had a lot of episodes where he would decline, become lethargic, loss of appetite, confusion, and mucus build up in his mouth and perk right up the next day. In an interview on [DATE] at 10:42 am with Prep Cook, he said he had been with the facility about one year. He said the staff from the healthcare side come to the kitchen to ask for sandwiches. He said they gave them specifics for how they wanted the sandwich made, i.e, bread with no crust or with no condiments or choking hazards. He said he made the sandwich for CR #1. He could not recall what type of meat. He said it could have been turkey. He said some staff were very specific when placing orders and some just placed the ticket on the service counter. He said on the day when CR #1 passed a staff person from healthcare approached him with an order for [REDACTED]. He said he did not remember if he cut the crust off. He said if the ticket said to cut the crust, then he cut it. He said he would only chop sandwiches upon request. He said the next day he found out that a resident passed from choking on a sandwich because the supervisor in charge of the servers along with the Executive Chef got cooks and servers in a huddle to let them know that whoever made the sandwiches last night caused the resident to choke on the sandwich. He said he defended himself because he said there were no instructions on the meal ticket that called for the sandwich to be mechanically chopped. He said an in-service training occurred next day. He said the facility's kitchen has a color-coded system now to identify mechanical chop, puree and ground. He said because before they would just go by whatever the healthcare staff told them to do. He said the pantry did not have any system like the hot food area had. He said they had a list of the residents with their diets. In an interview on [DATE] at 2:27 pm with Dietary Wait Staff, she said she had worked at the facility for two years. She said she put everyone's menu on serving line and for CR #1, staff ordered a turkey and cheese sandwich with the ends cut off. She said staff would order turkey and cheese sandwich a lot because that's what CR #1 liked. She said if they gave him his mechanical chop he would not eat it. She said he would just leave it there. She said the dishes got picked up about 6 pm. She said dinner usually started about 5:15 pm. She said around 5:45 pm they would bring CR #1's tray back to the kitchen and staff would say he didn't eat anything. She said on [DATE], the day the resident passed, the CNA forgot to tell the kitchen that the turkey and cheese sandwich order was for CR #1 (who was on mechanical chop). She said she delivered the sandwich to resident's room. She said she came back to work the next day and other staff that didn't work the evening before were saying CR #1 choked on a sandwich. She said her supervisor had a meeting with the kitchen staff to tell them if someone was on mechanical chop and they were going to order sandwiches, they had to be mechanically chopped. She said her supervisor developed a color-coded system to identify mechanical chop, puree and ground moving forward. Telephone interview on [DATE] at 12:31 pm with Physician, she said the facility notified her of CR #1's incident after he passed. She said they told her he choked on a sandwich. She said they told her they did everything they could for the resident while respecting his DNR status. She said she was told it happened so fast so there were no other interventions that they could have done while respecting his wishes. Observation on [DATE] at 1:00 pm revealed CR #1's past room had 1 outlet behind his end table located to the left as you entered the room. It had two plugs. There was another outlet behind the bed. It had two plugs. The bed was plugged into one plug. In an interview on [DATE] at 2:23 pm with DON, she said if a resident had signs of an obstructed airway or had a need for suctioning, the staff was expected to do the following: first, staff needed to make sure there was an order in place. She said if there was a suction machine in the room, there had to be an order. She said nurses would do a resident assessment and would suction as needed/accordingly. She said the facility did not have any residents with continuous suctioning orders. She said any resident with orders for suctioning should have the suctioning machine available for immediate use. She said when nurses conducted their rounds and assessed their resident's, O2 saturations were checked, they should be checking that all other emergency equipment was ready to go. She said if residents were on oxygen, they paid closer attention for the need to suction. She said O2 saturations gave nurses an idea of resident's condition. She said if O2 saturation dropped, the nurses would look into why. She said, the CNA's did vital signs at every shift. She said CNA's reported any change of condition to nurses. She said the nurses were responsible to ensure that machines or equipment used for respiratory care were properly working, maintained, and cleaned with a disinfectant. She said if the resident had a 24-hour CNA they too were responsible to ensure machines or equipment used for suctioning was plugged in, working and ready to go. She said CNA's sometimes used the electrical outlets for their personal use i.e. plug in cell phones. She said she had to constantly check on them to ensure they were not doing it. She said sometimes, they unplugged resident's equipment to charge their cell phones. She said the charge nurses were responsible to ensuring supervision of residents. She said the charge nurses gave direction to CNA's. She said, in my own opinion, I believed the resident had already passed at the time the CNA called for help. She said she could not explain the inconsistencies with the narratives provided by the RN and CNA because they were conflicting. She said the event occurred toward the end of the week and she did not find out what kind of sandwich until Monday. She said it was reported that the resident ate sandwiches every night. She said the resident could have had a sandwich just not turkey and cheese. She said the CNA gave the resident whatever he wanted. She said the CNA never told her she cut the sandwich up for the resident. Record review of the facility's policy titled: Physician Services revised ,[DATE] read in part . The medical care of each resident is under the supervision of a licensed physician. 1. The resident's attending physician participate in the resident's assessment and care planning, monitoring, changes in resident's medical status, providing consultation or treatment when called by the facility, and overseeing a relevant plan of care for the resident. 2. The attending physician will determine the relevance of any recommended interventions from any discipline . Record review of the facility's policy titled: Policy for Notifying Physicians for Change of Condition, revised on [DATE] read in part . It is the policy of The Hallmark Anderson Healthcare Facility that the resident's physician and family members be notified of changes in a resident's condition that affect the resident's health. The following are examples of times when the physician must be immediately notified of a change in condition: Any episode of vomiting with change in vital signs or evidence of dehydration; shortness of breath that is sudden in onset, with chest pain, and/or with change in vital signs; and vital sign changes such as increase or decrease in systolic blood pressure, increase in pulse by 20 beats per minute, pulse below 50 beats per minute, increase or decrease in respirations by 6 breaths per minute, and oxygen saturation less than 90% .

F 0609

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, 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 and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 5 residents (CR #1) reviewed for reporting: - The facility failed to immediately report (within 2 hours) an incident involving Resident # 1's passing to the state agency. This failure could affect all residents and place them at risk of abuse, neglect, and exploitation or mistreatment not being reported for investigation which could result in serious incidents not being investigated. Findings include: Record review of CR #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 04 out of 15 indicating severe cognitive impairment. He required two-person assistance with bed mobility, transfer, dressing and toile use. He required one-person assistance with locomotion on unit, eating and personal hygiene. He was coded as always incontinent for urinary and bowel. He was coded as having shortness of breath. Section K: Swallowing/Nutritional Status was coded as C. Coughing or choking during meals or when swallowing medications. Record review of CR #1's care plan initiated on [DATE] and revised on [DATE] revealed the following: Focus: CR #1 admitted to Vantage Hospice with dx of Alzheimer's with comorbidities of [MEDICAL CONDITION] and dysphagia. Goal: Will maintain CR #1's quality of life through integrated care provided by Hospice and nursing staff. Interventions: Family/ Hospice/ IDT to coordinate plan of care and reach common goals for CR #1; Monitor for any changes in condition and notify Vantage Hospice; No labs, Diagnostic testing or hospitalization ; Provide comfort care; and Refer to chart for hospice plan of care. Record Review of the Facility's Incident/Accident log for [DATE] revealed no incidents documented for CR #1. Record review of Resident's Health Status notes entered by RN on [DATE] read, 625pm, called by the sitter to check on the resident because he's unable to respond verbally and choking on the sandwich that he's eating. In the room resident was on his bed on upright 90-degree position, unresponsive, not breathing and cyanotic, he was placed immediately on side lying position and was suctioned and was able to take out some of the liquified food that was stuck on his throat, O2 on @ ,[DATE]LPM via NC. Resident was trying to cough out but unable to do so, BP ,[DATE] HR126 respiratory 0, still cyanotic, suctioning continued until vital signs was unappreciated, unresponsive, no breathing, no heart sound, pupil- dilated and the time was noted 642pm. Hospice Care was made aware, RP and MD. Record review of CR #1's DNR revealed it was dated [DATE]. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED]. Record review of physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED].@ 2lpm via nc as needed for spo2 < 92% as needed. Record review of CR #1's physician order [REDACTED]. He said was familiar with CR #1. He said the resident passed. He said he had been at the facility since he had been working at the facility, so he knew him very well. He said he was charting for medications and the CNA for CR #1 was yelling and was calling his name to respond. He said he went over to CR #1's room and he saw the resident with both hands on his neck. He said he assumed he was choking. He said he asked the CNA if he was eating something. He said the CNA said the resident was eating a sandwich. He said he opened his mouth to assess and he saw a thick mucus. He said he did a finger sweep to clear his mouth and he retrieved some sticky mucous substance from his mouth and throat. He said it did not look like liquified bread. He said, it just looked thick like mucus. He said, I didn't see the sandwich. He said he lowered the bed to put the resident in a supine position. He said he gave the resident abdominal thrust and nothing was coming out. He said he just used his judgement and told CNA to place the resident immediately on his side to drain the mucous. He said some secretion drained when he placed the resident on his side. He said he used the suction machine by the resident side table. He said he started to suction his mouth. He said there was some secretion post suctioning. He said the resident tried to grasp air but, he was unable to continue to breathe on his own. He said he told the CNA to get CR #1's vitals while he was suctioning. He said at that point, the resident's blood pressure was low. He said he could not recall exactly how low. He said his heart was elevated. He said the resident was turning blue due to lack of oxygen. He said he continued suctioning because the resident was DNR, so he was unable to give him artificial ventilation. He said he kept suctioning because he knew they could not call 911 or use CPR because of the resident's DNR status. He said he wished he could have but, he knew that he needed to respect the resident's choice. He said it was past dinner time around 6:20 pm. He said the resident most likely got the sandwich from the kitchen but, he was not sure because he didn't see it. He said the resident was on a restrictive diet. He said the resident's diet called for mechanical soft. He said the CNA knew the resident was on a mechanical diet. He said the CNA stayed to assist with post mortem care. He said he was the one that notified the family. He said he notified hospice, MD and the DON. He said he did not call the physician or during the choking episode. In an interview on [DATE] at 4:38 pm with CNA in the role of a sitter. She said she worked for IHA; the department where sitters are assigned. She said she was a certified CNA. She said she went inside the restroom and when she came out, CR #1 was choking. She said the resident had mucous and foam coming out of his mouth. She said she hollered for the RN. She said he arrived and told her to turn the resident on his side, so he could use the suction machine. She said the RN tried to use the suction machine but, it was not plugged in. She said the RN was sitting on the side trying to get the suction machine to work, but it was not working because it was unplugged so she had to tell him that it was not plugged. She said she tried to plug it in. She said she did her best to help the RN get the suction machine going but she did not know how to use the facility's equipment. She said she spent time trying to plug the suction machine and the tubing. She said after she got the suction machine plugged in, the RN tried to suction CR #1's mouth but, it was too late, the resident had already passed. She said the RN pronounced him dead. She said she fed CR #1 a sandwich that she ordered from the facility's kitchen. She said she cut it up into bite size pieces for the resident. She said she fed him the sandwich about 5:10 pm on that day. She said the incident occurred about 5:45 pm because the resident passed around 6:45 pm. She said she worked with CR #1 for 2 years. She said she worked almost every day. She said the facility was saying that he choked on the sandwich but, he choked on mucous. She said he would have episodes where the resident would have increased amount of mucous coming out of his mouth and the nursing staff would suction it out. She said it happened frequently. She said the resident used to spit it out on the floor and she always gave him tissue. She said she did not know why the facility was saying the resident choked on a sandwich because she had already fed him and gave him water behind the sandwich and he was doing fine. She said she was suspended because the facility told her they had to investigate the matter. In an interview on [DATE] at 5:07 pm with Executive Director, he said the facility reported CR #1's passing as a death. He said the reason why the facility was investigating CR #1's passing was because there were too many inconsistencies with the events and that's what led them to investigate. He said, originally it was reported as a natural death. He said, different staff were saying different things about who was there and what happened, so, that's what led to the investigation. He said he discovered the inconsistencies about a few days after the fact. He said the leadership team was having a meeting and he brought up if the incident was something they needed to bring up to the State and leadership said no. He said he was told the resident was on hospice and he had passed so it was not a reportable event. The CNA was suspended because there was a question of whether she was in the room or not. He said, the CNA said she was in the room but, her terminology was very inconsistent. In an interview on [DATE] at 5:13 pm with DON, she said the CNA's role was to know equipment. She said it was the nurse's responsibility to ensure the equipment like the suctioning machines were in good repair and plugged in, so they were ready to go. She said she was not aware the suctioning machine was not plugged in. In a follow up interview on [DATE] at 5:20 pm with RN, he said the suction machine was not plugged in because there were only two outlets; one had the nebulizer plugged in and the other had the oxygen concentrator plugged in. He said he forgot to tell this Surveyor he used oxygen on the resident because it was right there next to his bedside. He said he was the one that unplugged the oxygen, so he could plug the suction machine. He could not recall if the CNA helped him plug in the suctioning machine because it happened so quickly. In an interview on [DATE] at 12:19 pm with Executive Chef, he said he had worked for the facility for 1 year and 3 months. He said he was not at the facility at the time the sandwich was ordered. He said the next day he spoke with the Dietician. He said she told him what had happened with the sandwich. She said a resident choked the night before, (CR #1). He said the sandwich was not ordered as mechanical chop. He said that's why the sandwich was not mechanically chop. He said kitchen staff were in-serviced on the same day he found out. He said the facility changed the process on mechanical chop orders. He said the different diets were now color coded. He said staff had to keep their mask on at all times. He said staff also had to wear masks properly. He said properly was to cover nose, mouth and chin. He said staff always gave him excuses about the kitchen being hot but, he was trying to get them out of that mindset. In an interview on [DATE] at 2:27 pm with Dietary Wait Staff, she said she had worked at the facility for two years. She said she put everyone's menu on serving line and for CR #1, staff ordered a turkey and cheese sandwich with the ends cut off. She said staff would order turkey and cheese sandwich a lot because that's what CR #1 liked. She said if they gave him his mechanical chop he would not eat it. She said he would just leave it there. She said the dishes got picked up about 6 pm. She said dinner usually started about 5:15 pm. She said around 5:45 pm they would bring CR #1's tray back to the kitchen and staff would say he didn't eat anything. She said on [DATE], the day the resident passed, the CNA forgot to tell the kitchen that the turkey and cheese sandwich order was for CR #1 (who was on mechanical chop). She said she delivered the sandwich to resident's room. She said she came back to work the next day and other staff that didn't work the evening before were saying CR #1 choked on a sandwich. She said her supervisor had a meeting with the kitchen staff to tell them if someone was on mechanical chop and they were going to order sandwiches, they had to be mechanically chopped. She said her supervisor developed a color-coded system to identify mechanical chop, puree and ground moving forward. In an interview on [DATE] at 12:51 pm with DON, she said nursing staff did not use chest compressions (CPR) and they did not call 911 because of CR #1's DNR. She said her understanding of the DNR was they were not supposed to use artificial ventilation or CPR. She said for full code, they would perform CPR, call 911 and do everything that nursing license could do to preserve the residents. She said a resident on hospice with a DNR on record was provided with palliative care only. She said the suctioning machine should have been plugged in and ready to go especially with CR #1 having a history of mucus in his throat. She said she did not feel the suction machine being unplugged and not ready to go contributed to CR #1's passing because the RN did all he could to preserve the resident's life. She said the RN did abominable thrusts and gave him oxygen prior to suctioning. She said the resident was on hospice and he had been exhibiting a decline in respiratory functioning. She said he was having episodes where he had mucus buildup in his throat that had to be constantly suctioned. He said the RN was experienced with working with CR #1 so most of the time, the RN did not have to use the suction machine. In a follow-up interview on [DATE] at 9:53 am with CNA, she said CR #1 finished eating the sandwich about 5:30 pm or 5:45 pm or close to 6:00 pm because he ate slow. She said CR #1 ate the whole sandwich. She said the sandwich did not have any ends on it. She said it was a turkey sandwich with cheese. In an interview on [DATE] at 9:57 am with ADON, she said her understanding of DNR was not to perform any CPR, cardiac pacing and AED. She said nursing staff was not prohibited from performing, [MEDICATION NAME], any type of suctioning or any other comfort measures. She said her understanding of full code was to use any kind of life sustaining measures, i.e. AED, CPR, airway management and call 911 and continue CPR until emergency paramedics arrived at the facility. She said her approach in CR #1's situation would be to observe if there was something physical lodged. Perform the [MEDICATION NAME] if unsuccessful, turn him on his side, and then try the suctioning. She said since CR #1 was a DNR, her next step would be to call hospice. She said she was uncertain what to do when a resident was DNR and on hospice,

so she would call hospice to get further instructions from hospice. She said if the resident had a history of [REDACTED]. She said physician orders [REDACTED]. She said if secretion were noted maybe there should have been at every shift order. But, most times the suctioning orders were PRN. She said she became aware that CR #1 had passed because she saw the 24-hour report the next day at the beginning of her shift. She said she did not speak with the RN about it because her shift had ended. She said in the resident review meeting she found out that CR #1 had passed. She said she was told he had aspirated. She said she assumed it was related to the mucus episodes the resident had been experiencing. She said she went into the chart to read what the RN had documented. She said the RN's story and the CNA's were inconsistent and not adding up. She said she had not been involved in the facility's investigation. She said if the sandwich did not have the edges, the bread gets kind of liquified. She said if CR #1 finished the sandwich around 6 pm, she did not believe the sandwich could still be lodged in CR #1's throat. She said if CR #1 had gastro reflux there was a possibility that the sandwich could come back up. She said CR #1 had already a lot of episodes where he would decline (become lethargic, loss of appetite, confusion, and mucus build up in his mouth) and perk right up the next day. In an interview on [DATE] at 10:42 am with Prep Cook, he said he had been with the facility about one year. He said the staff from the healthcare side come to the kitchen to ask for sandwiches. He said they gave them specifics for how they wanted the sandwich made, i.e, bread with no crust or with no condiments or choking hazards. He said he made the sandwich for CR #1. He could not recall what type of meat. He said it could have been turkey. He said some staff were very specific when placing orders and some just placed the ticket on the service counter. He said on the day when CR #1 passed a staff person from healthcare approached him with an order for [REDACTED]. He said he did not remember if he cut the crust off. He said if the ticket said to cut the crust, then he cut it. He said he would only chop sandwiches upon request. He said the next day he found out that a resident passed from choking on a sandwich because the supervisor in charge of the servers along with the Executive Chef got cooks and servers in a huddle to let them know that whoever made the sandwiches last night caused the resident to choke on the sandwich. He said he defended himself because he said there were no instructions on the meal ticket that called for the sandwich to be mechanically chopped. He said an in-service training occurred next day. He said the facility's kitchen has a color-coded system now to identify mechanical chop, puree and ground. He said because before they would just go by whatever the healthcare staff told them to do. He said the pantry did not have any system like the hot food area had. He said they had a list of the residents with their diets. Telephone interview on [DATE] at 12:31 pm with Physician, she said the facility notified her of CR #1's passing after he passed. She said they told her he choked on a sandwich. She said they told her they did everything they could for the resident while respecting his DNR status. She said she was told it happened so fast so there were no other interventions that they could have done while respecting his wishes. Observation on [DATE] at 1:00 pm revealed CR #1's past room had 1 outlet behind his end table located to the left as you entered the room. It had two plugs. There was another outlet behind the bed. It had two plugs. The bed was plugged into one plug. In an interview on [DATE] at 2:23 pm with DON, she said if a resident had signs of an obstructed airway or had a need for suctioning, the staff was expected to do the following: first, staff needed to make sure there was an order in place. She said if there was a suction machine in the room, there has to be an order. She said nurses would do a resident assessment and would suction as needed/accordingly. She said the facility did not have any resident with continuous suctioning orders. She said any resident with orders for suctioning should have the suctioning machine available for immediate use. She said when nurses conducted their rounds and assessed their resident's, 02 saturations were checked. She said if residents were on oxygen, they paid closer attention for the need to suction. She said 02 saturations would gave nurses an idea of resident's condition. She said if 02 sat dropped, the nurses would look into why. She said, the CNA's did vital signs at every shift. She said CNA's reported any change of condition to nurses. She said the nurses were responsible to ensure that machines or equipment used for respiratory care were properly working, maintained, and cleaned with a disinfectant. She said if the resident had a 24-hour CNA they too were responsible to ensure machines or equipment used for suctioning was plugged in, working and ready to go. She said CNA's sometimes used the electrical outlets for their personal use i.e. plug in cell phones. She said she had to constantly check on them to ensure they were not doing it. She said sometimes, they unplugged resident's equipment to charge their cell phones. She said the charge nurses were responsible to ensuring supervision of residents. She said the charge nurses gave direction to CNA's. She said in her own opinion, she said she believed the resident had already passed at the time the CNA called for help. She said she could not explain the inconsistencies with the narratives provided by the RN and CNA because they were conflicting. She said the event occurred toward the end of the week and she did not find out what kind of sandwich until Monday. She said it was reported that the resident ate sandwiches every night. She said the resident could have had a sandwich just not turkey and cheese. She said the CNA gave the resident whatever he wanted. She said the CNA never told her that she cut the sandwich up for the resident. In an interview on [DATE] at 2:27 pm with Dietary Wait Staff, she said she had worked at the facility for two years. She said she put everyone's menu on serving line and for CR #1, staff ordered a turkey and cheese sandwich with the ends cut off. She said staff would order turkey and cheese sandwich a lot because that's what CR #1 liked. She said if they gave him his mechanical chop he would not eat it. She said he would just leave it there. She said the dishes got picked up about 6 pm. She said dinner usually started about 5:15 pm. She said around 5:45 pm they would bring CR #1's tray back to the kitchen and staff would say he didn't eat anything. She said on [DATE], the day the resident passed, the CNA forgot to tell the kitchen that the turkey and cheese sandwich order was for CR #1 (who was on mechanical chop). She said she delivered the sandwich to resident's room. She said she came back to work the next day and other staff that didn't work the evening before were saying CR #1 choked on a sandwich. She said her supervisor had a meeting with the kitchen staff to tell them if someone was on mechanical chop and they were going to order sandwiches, they had to be mechanically chopped. She said her supervisor developed a color-coded system to identify mechanical chop, puree and ground moving forward. Record review of the facility's policy titled, Policy for Reporting Incidents to THHS dated [DATE] read in part . Objective: To comply with Texas Health and Human Services LTC regulatory provider letter ,[DATE] issued [DATE] that states: A provider must submit a provider investigation report to HHSC, complete an incident intake, using HHSC form 3613-A. The provider investigation report must include all information from the initial incident report and any additional information the provider has obtain since making the initial report, including witness statements. The provider must submit the provider investigation report within the applicable required time frame as follows: five working days for a NF or skilled NF. Initially providing as much information as possible is very important, as it facilitates the processing and management of the self-reported incidence and helps provide complaint and incident intake with enough information to review and accurately prioritize the incidents. Policy: The Hallmark will comply with the above LTC regulatory provider letter. Definitions: incident: an abnormal event, including accidents or injury to staff, residents, which is documented in facility reports. An occurrence in which the resident may have been subject to abuse, neglect or exploitation. Neglect: the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical emotional harm or pain or the failure of the caregiver to provide such goods and services. Reportable: staff who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or expectation or that the resident has died due to abuse or neglect. Other incidents that may also need to be reported are deaths, misappropriation of funds, drug divergence, missing persons, injuries of unknown source, fires, and situations that pose a threat to residence, employees or the public. Procedures: facilities will: 1. Call in all reportable incidents to HHSC complaint and intake incident at [PHONE NUMBER] immediately upon learning of a reportable incident .

F 0658

Level of harm - Actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676423	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HALLMARK	**4718 HALLMARK DR HOUSTON, TX 77056**

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 0658

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to ensure the services provided by the facility meet professional standards of quality for 1 of 5 residents (CR #1) reviewed for professional standards. -The facility failed to ensure CR #1 did not have a delay in receiving emergency treatment. CR #1 died . -The facility failed to ensure staff immediately consulted with CR #1's Physician when the resident had a change in condition. These failures could place all residents with dysphagia and respiratory care needs at risk of a delay in treatment during an emergency and could result in injury, hospitaliation and death. Findings include: Record review of CR #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 04 out of 15 indicating severe cognitive impairment. He required two-person assistance with bed mobility, transfer, dressing and toilet use. He required one-person assistance with locomotion on unit, eating and personal hygiene. He was coded as always incontinent for urinary and bowel. He was coded as having shortness of breath. Section K: Swallowing/Nutritional Status was coded as C. Coughing or choking during meals or when swallowing medications. Record review of CR #1's care plan initiated on [DATE] and revised on [DATE] revealed the following: -Focus: CR #1 admitted to hospice with dx of Alzheimer's with comorbidities of [MEDICAL CONDITION] and dysphagia. Goal: Will maintain CR #1's quality of life through integrated care provided by Hospice and nursing staff. Interventions: Family/ Hospice/ IDT to coordinate plan of care and reach common goals for CR #1; Monitor for any changes in condition and notify hospice; No labs, Diagnostic testing or hospitalization ; Provide comfort care; and Refer to chart for hospice plan of care. -Focus: Resident has an ADL self-care performance deficit r/t Activity Intolerance, Alzheimer's Date initiated: [DATE] Goal: Reduce the risk of a decline in current participation. Date initiated [DATE] Intervention: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Requires total assistance with 2 staff members for his showers Date Initiated: [DATE]. Bed mobility: Resident requires moderate assistance by 1 staff to turn and reposition in bed frequently and as necessary. Date Initiated: [DATE]. Dressing: Resident is totally dependent on 1 staff for dressing. Date Initiated: [DATE]. EATING: Resident is able to feed self with 1:1 supervision to monitor pace/rate. Diet is regular-mechanical soft consistency with thin liquids. Date Initiated: [DATE]. Personal Hygiene/Oral Care: Resident requires moderate assistance of 1 staff member for his hygiene. Date Initiated: [DATE]. Transfer: Resident requires 2-person assist with Hoyer lift transfers. Date initiated: [DATE]. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of CR #1's DNR, Do Not Resuscitate, Order revealed it was dated [DATE]. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED].@ 2lpm via nc as needed for spo2 < 92% as needed. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician order [REDACTED].#1's progress notes written by RN on [DATE] read in part, 6 pm, sitter reported that the resident had been coughing during meals since this morning, resident has a communication deficit due to dementia, continues on aspiration precaution, HOB was kept on 90% (sic) during eating, VSS, no fever, temp 96.7 F, safety was maintained, call bell within reach, bed in low position, all needs attended. . Record review of CR #1's progress notes written by LVN A on [DATE] read, Resident was [MEDICAL CONDITION] a 114 pulse, rechecked the pulse and it was 58. His O2 saturation was 90% on room air, prn duo-nebulizer treatment was given. His oxygen increased to 97% on room air. Continued monitoring. No pain, a-febrile, skin warm to touch, no sob, no signs/symptoms of COVID. Record review of CR #1's progress note written by LVN D on [DATE] read in part, .Suction patient PRN DX congestion as needed. PRN Administration was: Effective. No coughing at this time. Will continue to monitor . Record review of CR #1's progress note written by RN on [DATE] read in part, Resident remains alert and responsive to all stimuli, not in distress, not able to make needs known, noted coughing this shift during meds administration, aspiration precaution maintained, HOB was kept elevated, dependent to all ADL's., incontinent care provided, noted staring at the ceiling, smiling, VSS, no SOB noted, afebrile, temperature 96.5 f, incontinent care provided, will continue to monitor. . Record review of CR #1's Orders-Administration note dated [DATE] written by LVN D revealed the following: Suction patient PRN DX congestion as needed. Resident coughing, unable to clear throat, suctioned at this time. Tolerated well. Oxygen saturation 95% to room air. HOB up 90-degrees. Record review of CR #1's progress note written by LVN D on [DATE] read in part, RN with Hospice here to evaluate resident. States 'resident may be transitioning.' Resident stable at this time, no productive cough at this time b/p ,[DATE], respirations 20, temperature 97.6, oxygen saturation 92% with oxygen at 2L/min via NC. New order obtained, [MEDICATION NAME] Tablet 0.125 mg give 1 tab SL for increased secretions. (Staff Name) will be back to evaluate in 2 days and if any further decline he will coordinate with the family for a visit. . Record review of CR #1's Health Status note written by RN on [DATE] read in part, .625 pm, called by the sitter to check on the resident because he's unable to respond verbally and choking on the sandwich that he's eating. In the room resident was on his bed on upright 90-degree position, unresponsive, not breathing and cyanotic, he was placed immediately on side lying position and was suctioned and was able to take out some of the liquified food that was stuck on his throat, O2 on @ ,[DATE] LPM via NC. Resident was trying to cough out but unable to do so, BP ,[DATE] HR 126 respiratory 0, still cyanotic (blue due to lack of oxygen), suctioning continued until vital signs was unappreciated, unresponsive, no breathing, no heart sound, pupil- dilated and the time was noted 642 pm. Hospice Care was made aware, RP and MD. Record review of CR #1's progress notes for [DATE] revealed no documentation of RN or other staff making notification of change in condition to Hospice or Attending Physician during the change of condition for CR #1. In an interview on [DATE] at 4:15 pm with RN, he said he worked at the facility for almost 3 years. He said he was familiar with CR #1. He said the resident passed (died). He said CR #1 had been at the facility since he had been working at the facility, so he knew him very well. He said on [DATE] he was charting for medications and the CNA for CR #1 was yelling and was calling his name to respond. He said he went over to CR #1's room and he saw the resident with both hands on his neck. He said he assumed he was choking. He said he asked the CNA if he was eating something. He said the CNA said the resident was eating a sandwich. He said he opened CR #1's mouth to assess and he saw a thick mucus. He said he did a finger sweep to clear his mouth and he retrieved some sticky mucous substance from his mouth and throat. He said it did not look like liquified bread. He said, It just looked thick like mucus. He said, I didn't see the sandwich. He said he lowered the bed to put the resident in a supine (lying flat face up) position. He said he gave the resident abdominal thrusts and nothing was coming out. He said he just used his judgement and told CNA to place the resident immediately on his side to drain the mucus. He said some secretions drained when he placed the resident on his side. He said he used the suction machine by the resident side table. He said he started to suction his mouth. He said there was some secretions post suctioning. He said the resident tried to gasp for air but, he was unable to continue to breathe on his own. He said he told the CNA to get CR #1's vitals while he was suctioning. He said at that point, the resident's blood pressure was low. He said he could not recall exactly how low. He said his heart was elevated. He said the resident was turning blue due to lack of oxygen. He said he continued suctioning because the resident was DNR, so he was unable to give him artificial ventilation. He said he kept suctioning because he knew they could not call 911 or use CPR because of the resident's DNR status. He said he wished he could have but, he knew that he needed to respect the resident's choice. He said it was past dinner time around 6:20 pm. He said the resident most likely got the sandwich from the kitchen but, he was not sure because he did not see it. He said the resident was on a restrictive diet. He said the resident's diet called for mechanical soft. He said the CNA knew the resident was on a mechanical diet. He said the CNA stayed to assist with post mortem care. He said he was the one that notified the family. He said he notified hospice, MD and the DON. He said he did not call the physician during the choking episode. In an interview on [DATE] at 4:38 pm with CNA, she said she worked for the department where sitters were assigned. She said she was a certified CNA. She said she went inside the restroom and when she came out, CR #1 was choking. She said the resident had mucus and foam coming out of his mouth. She said she hollered for the RN. She said he arrived and told her to turn the resident on his side, so he could use the suction machine. She said the RN tried to use the suction machine but, it was not plugged in. She said the RN was sitting on the side trying to get the suction machine to work, but it was not working because it was unplugged so she had to tell him that it was not plugged. She said she tried to plug it in. She said she did her best to help the RN get the suction machine going but she did not know how to use the facility's equipment. She said she spent time trying to plug the suction machine and the tubing. She said after she got the suction machine plugged in, the RN tried to suction CR #1's mouth but, it was too late, the resident had already passed. She said the RN pronounced him dead. She said she fed CR #1 a sandwich that she ordered from the facility's kitchen. She said she cut it up into bite size pieces for the resident. She said she fed him the sandwich about 5:10 pm on that day. She said the incident occurred about 5:45 pm because the resident passed around 6:45 pm. She said she worked with CR #1 for 2 years. She said she worked almost every day. She said the facility was saying that he choked on the sandwich but, he choked on mucous. She said he would have episodes where the resident would have increased amount of mucus coming out of his mouth and the nursing staff would suction it out. She said it happened frequently. She said the resident used to spit it out on the floor and she always gave him tissue. She said she did not know why the facility was saying the resident choked on a sandwich because she had already fed him and gave him water behind the sandwich and he was doing fine. She said she was suspended because the facility told her they had to investigate the matter. In an interview on [DATE] at 5:13 pm with DON, she said the CNA's role was to know equipment. She said it was the nurse's responsibility to ensure the equipment, like the suctioning machines, were in good repair and plugged in, so they were ready to go. She said she was not aware the suctioning machine was not plugged in. In a follow up interview on [DATE] at 5:20 pm with RN, he said the suction machine was not plugged in because there were only two outlets; one had the nebulizer plugged in and the other had the oxygen concentrator plugged in. He said he forgot to tell this Surveyor he used oxygen on the resident because it was right there next to his bedside. He said he was the one that unplugged the oxygen, so he could plug the suction machine. He could not recall if the CNA helped him plug in the suctioning machine because it happened so quickly. In an interview on [DATE] at 12:19 pm with Executive Chef, he said he had worked for the facility for 1 year and 3 months. He said he was not at the facility at the time the sandwich was ordered. He said the next day he spoke with the Dietician. He said she told him what had happened with the sandwich. She said a resident choked the night before, (CR #1). He said the sandwich was not ordered as mechanical chop. He said that's why the sandwich was not mechanically chop. He said kitchen staff were in-serviced on the same day he found out. He said the facility changed the process on mechanical chop orders. He said the different diets were now color coded. He said staff had to keep their mask on at all times. He said staff also had to wear masks properly. He said properly was to cover nose, mouth and chin. He said staff always gave him excuses about the kitchen being hot but, he was trying to get them out of that mindset. In an interview on [DATE] at 12:51 pm with DON, she said the suctioning machine should have been plugged in and ready to go especially with CR #1 having a history of mucus in his throat. She said she did not feel the suction machine being unplugged and not ready to go contributed to CR #1's passing because the RN did all he could to preserve the resident's life. She said the RN did abdominal thrusts and gave him oxygen prior to suctioning. She said the resident was on hospice and he had been exhibiting a decline in respiratory functioning. She said he was having episodes where he had mucus buildup in his throat that had to be constantly suctioned. He said the RN was experienced with working with CR #1 so most of the time, the RN did not have to use the suction machine. In an interview on [DATE] at 1:10 pm with the Administrator, he said he questioned if the suction machine not being plugged in was the cause of death. He said he never got a clear answer. In a telephone interview on [DATE] at 1:42 pm with Hospice RN, he said CR #1 was one of his patients. He said he had not seen the death certificate because it was a duty of the funeral home. He said what happened in the hospice process was that there were two physician medical opinions and both certified a patient as hospice appropriate. He said they reviewed the case and selected the [DIAGNOSES REDACTED]. He said CR #1 was at end of life [MEDICAL CONDITION] with [MEDICAL CONDITION]. He said CR #1 was on PRN oxygen. He said he

also had severe dysphagia (difficulty swallowing). He said prior to hospice and while on hospice CR #1 was exhibiting several episodes of severe dysphagia and choking but, it was usually handled appropriately with hospice interventions. He said his interventions were suctioning and PRN oxygen. He said CR #1 was also receiving scheduled [MEDICATION NAME]. He said what probably happened was that he had a choking episode and that was to be expected. He said the resident was declining already. He said, it was super sad. He said he did not believe that the delay in using the suction machine was the cause of death because the resident was already declining, and it was expected. In an interview on [DATE] at 9:38 am with LVN C, she said she worked 7 am to 3 pm. She said she had worked at the facility for 3 weeks. She said she was not familiar with CR #1. She said she was aware that he passed. She said the nurses were talking about it and that was how she became aware. She said the only thing she knew was that he had a sandwich and he choked on the sandwich. She said her understanding of DNR orders were to not resuscitate. She said DNR meant no life saving measures. She said she would probably use abdominal thrusts and back blows if she needed. She said she would not use CPR on a resident with DNR orders. She said her understanding of full code was CPR, oxygen and anything else that could preserve the resident's life. She said if a resident had a DNR on his medical record and he was choking, her approach would be to try to clear his airway to get the obstruction out. She said she would use oxygen. She said she would suction if oxygen did not work. She said if the resident had a history of [REDACTED]. She said she needed a physician's orders [REDACTED]. She said she would call 911 only if instructed by the physician. In a follow-up interview on [DATE] at 9:53 am with CNA, she said CR #1 finished eating the sandwich about 5:30 pm or 5:45 pm or close to 6:00 pm because he ate slow. She said CR #1 ate the whole sandwich. She said the sandwich did not have any ends on it. She said it was a turkey sandwich with cheese. In an interview on [DATE] at 9:57 am with ADON, she said her understanding of DNR was not to perform any CPR, cardiac pacing and AED. She said nursing staff was not prohibited from performing, [MEDICATION NAME], any type of suctioning or any other comfort measures. She said her understanding of full code was to use any kind of life sustaining measures, i.e. AED, CPR, airway management, call 911 and continue CPR until emergency paramedics arrived at the facility. She said her approach to CR #1's situation would be to observe if there was something physically lodged. Perform the [MEDICATION NAME], if unsuccessful, turn him on his side, and then try suctioning. She said since CR #1 was a DNR, her next step would be to call hospice. She said she was uncertain what to do when a resident was DNR and on hospice, so she would call hospice to get further instructions. She said if the resident had a history of [REDACTED]. She said physician orders [REDACTED]. She said, most times, the suctioning orders are PRN. She said she was told CR #1 had aspirated. She said she assumed it was related to the mucus episodes CR #1 kept experiencing. She said she went into the chart to read what the RN had documented. She said the RN's story and the CNA's were inconsistent and not adding up. She said she had not been involved in the facility's investigation. She said if the sandwich did not have the edges, the bread gets kind of liquified. She said if CR #1 finished the sandwich around 6 pm, she did not believe the sandwich could still be lodged in CR #1's throat. She said if CR #1 had [MEDICAL CONDITION] reflux there was a possibility that the sandwich could come back up. She said CR #1 had already had a lot of episodes where he would decline, become lethargic, loss of appetite, confusion, and mucus build up in his mouth and perk right up the next day. In an interview on [DATE] at 10:42 am with Prep Cook, he said he had been with the facility about one year. He said the staff from the healthcare side come to the kitchen to ask for sandwiches. He said they gave them specifics for how they wanted the sandwich made, i.e, bread with no crust or with no condiments or choking hazards. He said he made the sandwich for CR #1. He could not recall what type of meat. He said it could have been turkey. He said some staff were very specific when placing orders and some just placed the ticket on the service counter. He said on the day when CR #1 passed a staff person from healthcare approached him with an order for [REDACTED]. He said he did not remember if he cut the crust off. He said if the ticket said to cut the crust, then he cut it. He said he would only chop sandwiches upon request. He said the next day he found out that a resident passed from choking on a sandwich because the supervisor in charge of the servers along with the Executive Chef got cooks and servers in a huddle to let them know that whoever made the sandwiches last night caused the resident to choke on the sandwich. He said he defended himself because he said there were no instructions on the meal ticket that called for the sandwich to be mechanically chopped. He said an in-service training occurred next day. He said the facility's kitchen has a color-coded system now to identify mechanical chop, puree and ground. He said because before they would just go by whatever the healthcare staff told them to do. He said the pantry did not have any system like the hot food area had. He said they had a list of the residents with their diets. In an interview on [DATE] at 2:27 pm with Dietary Wait Staff, she said she had worked at the facility for two years. She said she put everyone's menu on serving line and for CR #1, staff ordered a turkey and cheese sandwich with the ends cut off. She said staff would order turkey and cheese sandwich a lot because that's what CR #1 liked. She said if they gave him his mechanical chop he would not eat it. She said he would just leave it there. She said the dishes got picked up about 6 pm. She said dinner usually started about 5:15 pm. She said around 5:45 pm they would bring CR #1's tray back to the kitchen and staff would say he didn't eat anything. She said on [DATE], the day the resident passed, the CNA forgot to tell the kitchen that the turkey and cheese sandwich order was for CR #1 (who was on mechanical chop). She said she delivered the sandwich to resident's room. She said she came back to work the next day and other staff that didn't work the evening before were saying CR #1 choked on a sandwich. She said her supervisor had a meeting with the kitchen staff to tell them if someone was on mechanical chop and they were going to order sandwiches, they had to be mechanically chopped. She said her supervisor developed a color-coded system to identify mechanical chop, puree and ground moving forward. Telephone interview on [DATE] at 12:31 pm with Physician, she said the facility notified her of CR #1's incident after he passed. She said they told her he choked on a sandwich. She said they told her they did everything they could for the resident while respecting his DNR status. She said she was told it happened so fast so there were no other interventions that they could have done while respecting his wishes. Observation on [DATE] at 1:00 pm revealed CR #1's past room had 1 outlet behind his end table located to the left as you entered the room. It had two plugs. There was another outlet behind the bed. It had two plugs. The bed was plugged into one plug. In an interview on [DATE] at 2:23 pm with DON, she said if a resident had signs of an obstructed airway or had a need for suctioning, the staff was expected to do the following: first, staff needed to make sure there was an order in place. She said if there was a suction machine in the room, there had to be an order. She said nurses would do a resident assessment and would suction as needed/accordingly. She said the facility did not have any residents with continuous suctioning orders. She said any resident with orders for suctioning should have the suctioning machine available for immediate use. She said when nurses conducted their rounds and assessed their resident's, O2 saturations were checked, they should be checking that all other emergency equipment was ready to go. She said if residents were on oxygen, they paid closer attention for the need to suction. She said O2 saturations gave nurses an idea of resident's condition. She said if O2 saturation dropped, the nurses would look into why. She said, the CNA's did vital signs at every shift. She said CNA's reported any change of condition to nurses. She said the nurses were responsible to ensure that machines or equipment used for respiratory care were properly working, maintained, and cleaned with a disinfectant. She said if the resident had a 24-hour CNA they too were responsible to ensure machines or equipment used for suctioning was plugged in, working and ready to go. She said CNA's sometimes used the electrical outlets for their personal use i.e. plug in cell phones. She said she had to constantly check on them to ensure they were not doing it. She said sometimes, they unplugged resident's equipment to charge their cell phones. She said the charge nurses were responsible to ensuring supervision of residents. She said the charge nurses gave direction to CNA's. She said, in my own opinion, I believed the resident had already passed at the time the CNA called for help. She said she could not explain the inconsistencies with the narratives provided by the RN and CNA because they were conflicting. She said the event occurred toward the end of the week and she did not find out what kind of sandwich until Monday. She said it was reported that the resident ate sandwiches every night. She said the resident could have had a sandwich just not turkey and cheese. She said the CNA gave the resident whatever he wanted. She said the CNA never told her she cut the sandwich up for the resident. Record review of the facility's policy titled Dysphagia Diets dated 2013 read in part . Procedure: 4. Nursing staff will notify the food service manager of needed consistency changes using the dietary order form. 7. Care will be taken to serve the foods and fluids as ordered on the consistency-altered diet or fluids. Note: Do not allow food consistency changes without a physician's orders [REDACTED]. Record review of facility's policy titled: Emergency Procedure for Choking revised ,[DATE] read in part . Policy Statement: Trained staff will assist the resident who is choking by attempting to expel the foreign body form the airway. Conscious Resident - Standing or Sitting. 1. Ask the resident if he or she is choking. Remember, a choking victim cannot speak or breathe and needs your help immediately. 2. Ask the resident to call or speak if at all possible to determine if his or her airway is obstructed. 3. If able to cough, instruct and encourage the resident to continue coughing to dislodge or expel any foreign object. 4. Call for help but stay with the resident. 5. Quickly assure the resident that you are going to stay and assist him or her. 6. If the resident cannot cough, only then should abdominal trust be performed as follows; a. Stand behind the resident. b. Wrap your arms around the resident's waist. c. Make a fist with one hand. d. Place the thumb side of your fist against the resident's upper mid-abdomen, below the rib cage and above the navel. e. Grass your clenched fist with your other hand. f. Press your fist into the resident's upper abdomen with a quick upward thrust. g. Do not squeeze the rib cage. Contain the force of the trust to your hands. h. Repeat the thrusts until the foreign body is expelled or the resident loses consciousness. Unconscious Resident - Lying Down 1. ease the resident as gently as possible to the floor. 2. Call for help if assistance is not already present but do not leave the resident unattended. 3. Position the resident on his or her back with the arms at his or her site. 4. Perform abdominal thrust as follows; a. Facing the resident, kneel down and straddle the resident's upper thighs with your body. b. Place the heel of one hand on the resident's upper mid-abdomen, below the rib cage and above the navel and with fingers pointed towards the resident's chest. c. Place the other hand directly over the positioned hand. d. Bring your shoulders forward over your hands. e. Use your body weight to press your hands into the resident's upper abdomen with a quick upper thrust. 5. Performed the finger sweep maneuver to check for a foreign body as follows; E. Keep the resident's face up . Record review of the Texas Board of Nursing, website at bon.texas.gov, Rules and Regulations relating to Nurse Education, Licensure, and Practice dated as published [DATE] read in part, . 217.11. Standards of Nursing Practice. The Texas Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for Vocational Nurses, Registered Nurses, and Registered Nurses with advanced practice authorization. The standards of practice establish a minimum acceptable level of nursing practice in any setting for each level of nursing licensure or advanced practice authorization. Failure to meet these standards may result in action against the nurse ' s license even if no actual patient injury resulted. (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall: (A) Know and conform to the Texas Nursing Practice Act and the board ' s rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse ' s current area of nursing practice; (B) Implement measures to promote a safe environment for clients and others; (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same; (D) Accurately and completely report and document: (i) the client ' s status including signs and symptoms; (ii) nursing care rendered; (iii) physician, dentist or podiatrist orders; (iv) administration of medications and treatments; (v) client response(s); and (vi) contacts with other health care team members concerning significant events regarding client ' s status; .(L) Provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served; (M)Institute appropriate nursing interventions that might be required to stabilize a client ' s condition and/or prevent complications; .(Q) Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care; .

F 0695

Level of harm - Actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, for 1 of 5 residents reviewed for suctioning care. (CR #1) reviewed for respiratory care. -The facility failed to ensure CR #1's suctioning machine was set up and plugged in causing a delay in successfully managing the airway for CR #1 during a choking emergency. This failure could affect all residents requiring respiratory services at risk of life-threatening [MEDICAL CONDITION] and could result in a delay in treatment, injury, hospitalization , and death. Findings include: Record review of CR #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 04 out of 15 indicating severe cognitive impairment. He required two-person assistance with bed mobility, transfer, dressing and toile use. He required one-person assistance with locomotion on unit, eating and personal hygiene. He was coded as always incontinent for urinary and bowel. He was coded as having shortness of breath. Section K: Swallowing/Nutritional Status was coded as C. Coughing or choking during meals or when swallowing medications. Record review of CR #1's care plan initiated on [DATE] and revised on [DATE] revealed the following: -Focus: CR #1 admitted to hospice with dx of Alzheimer's with comorbidities of [MEDICAL CONDITION] and dysphagia. Goal: Will maintain CR #1's quality of life through integrated care provided by Hospice and nursing staff. Interventions: Family/ Hospice/ IDT to coordinate plan of care and reach common goals for CR #1; Monitor for any changes in condition and notify hospice; No labs, Diagnostic testing or hospitalization ; Provide comfort care; and Refer to chart for hospice plan of care. -Focus: Resident has an ADL self-care performance deficit r/t Activity Intolerance, Alzheimer's Date initiated: [DATE] Goal: Reduce the risk of a decline in current participation. Date initiated [DATE] Intervention: Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Requires total assistance with 2 staff members for his showers Date Initiated: [DATE]. Bed mobility: Resident requires moderate assistance by 1 staff to turn and reposition in bed frequently and as necessary. Date Initiated: [DATE]. Dressing: Resident is totally dependent on 1 staff for dressing. Date Initiated: [DATE]. EATING: Resident is able to feed self with 1:1 supervision to monitor pace/rate. Diet is regular-mechanical soft consistency with thin liquids. Date Initiated: [DATE]. Personal Hygiene/Oral Care: Resident requires moderate assistance of 1 staff member for his hygiene. Date Initiated: [DATE]. Transfer: Resident requires 2-person assist with Hoyer lift transfers. Date initiated: [DATE]. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of CR #1's DNR, Do Not Resuscitate, Order revealed it was dated [DATE]. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician orders [REDACTED].@ 2lpm via nc as needed for spo2 < 92% as needed. Record review of CR #1's physician orders [REDACTED]. Record review of CR #1's physician order [REDACTED].#1's progress notes written by RN on [DATE] read in part, 6 pm, sitter reported that the resident had been coughing during meals since this morning, resident has a communication deficit due to dementia, continues on aspiration precaution, HOB was kept on 90% (sic) during eating, VSS, no fever, temp 96.7 F, safety was maintained, call bell within reach, bed in low position, all needs attended. . Record review of CR #1's progress notes written by LVN A on [DATE] read, Resident was [MEDICAL CONDITION] a 114 pulse, rechecked the pulse and it was 58. His O2 saturation was 90% on room air, prn duo-nebulizer treatment was given. His oxygen increased to 97% on room air. Continued monitoring. No pain, a-febrile, skin warm to touch, no sob, no signs/symptoms of COVID. Record review of CR #1's progress note written by LVN D on [DATE] read in part, .Suction patient PRN DX congestion as needed. PRN Administration was: Effective. No coughing at this time. Will continue to monitor . Record review of CR #1's progress note written by RN on [DATE] read in part, Resident remains alert and responsive to all stimuli, not in distress, not able to make needs known, noted coughing this shift during meds administration, aspiration precaution maintained, HOB was kept elevated, dependent to all ADL's., incontinent care provided, noted staring at the ceiling, smiling, VSS, no SOB noted, afebrile, temperature 96.5 f, incontinent care provided, will continue to monitor. . Record review of CR #1's Orders-Administration note dated [DATE] written by LVN D revealed the following: Suction patient PRN DX congestion as needed. Resident coughing, unable to clear throat, suctioned at this time. Tolerated well. Oxygen saturation 95% to room air. HOB up 90-degrees. Record review of CR #1's progress note written by LVN D on [DATE] read in part, RN with Hospice here to evaluate resident. States 'resident may be transitioning.' Resident stable at this time, no productive cough at this time b/p ,[DATE], respirations 20, temperature 97.6, oxygen saturation 92% with oxygen at 2L/min via NC. New order obtained, [MEDICATION NAME] Tablet 0.125 mg give 1 tab SL for increased secretions. (Staff Name) will be back to evaluate in 2 days and if any further decline he will coordinate with the family for a visit. . Record review of CR #1's Health Status note written by RN on [DATE] read in part, .625 pm, called by the sitter to check on the resident because he's unable to respond verbally and choking on the sandwich that he's eating. In the room resident was on his bed on upright 90-degree position, unresponsive, not breathing and cyanotic, he was placed immediately on side lying position and was suctioned and was able to take out some of the liquified food that was stuck on his throat, O2 on @ ,[DATE] LPM via NC. Resident was trying to cough out but unable to do so, BP ,[DATE] HR 126 respiratory 0, still cyanotic (blue due to lack of oxygen), suctioning continued until vital signs was unappreciated, unresponsive, no breathing, no heart sound, pupil- dilated and the time was noted 642 pm. Hospice Care was made aware, RP and MD. Record review of CR #1's progress notes for [DATE] revealed no documentation of RN or other staff making notification of change in condition to Hospice or Attending Physician during the change of condition for CR #1. In an interview on [DATE] at 4:15 pm with RN, he said he worked at the facility for almost 3 years. He said he was familiar with CR #1. He said the resident passed (died). He said CR #1 had been at the facility since he had been working at the facility, so he knew him very well. He said on [DATE] he was charting for medications and the CNA for CR #1 was yelling and was calling his name to respond. He said he went over to CR #1's room and he saw the resident with both hands on his neck. He said he assumed he was choking. He said he asked the CNA if he was eating something. He said the CNA said the resident was eating a sandwich. He said he opened CR #1's mouth to assess and he saw a thick mucus. He said he did a finger sweep to clear his mouth and he retrieved some sticky mucous substance from his mouth and throat. He said it did not look like liquified bread. He said, It just looked thick like mucus. He said, I didn't see the sandwich. He said he lowered the bed to put the resident in a supine (lying flat face up) position. He said he gave the resident abdominal thrusts and nothing was coming out. He said he just used his judgement and told CNA to place the resident immediately on his side to drain the mucus. He said some secretions drained when he placed the resident on his side. He said he used the suction machine by the resident side table. He said he started to suction his mouth. He said there was some secretions post suctioning. He said the resident tried to gasp for air but, he was unable to continue to breathe on his own. He said he told the CNA to get CR #1's vitals while he was suctioning. He said at that point, the resident's blood pressure was low. He said he could not recall exactly how low. He said his heart was elevated. He said the resident was turning blue due to lack of oxygen. He said he continued suctioning because the resident was DNR, so he was unable to give him artificial ventilation. He said he kept suctioning because he knew they could not call 911 or use CPR because of the resident's DNR status. He said he wished he could have but, he knew that he needed to respect the resident's choice. He said it was past dinner time around 6:20 pm. He said the resident most likely got the sandwich from the kitchen but, he was not sure because he did not see it. He said the resident was on a restrictive diet. He said the resident's diet called for mechanical soft. He said the CNA knew the resident was on a mechanical diet. He said the CNA stayed to assist with post mortem care. He said he was the one that notified the family. He said he notified hospice, MD and the DON. He said he did not call the physician during the choking episode. In an interview on [DATE] at 4:38 pm with CNA, she said she worked for the department where sitters were assigned. She said she was a certified CNA. She said she went inside the restroom and when she came out, CR #1 was choking. She said the resident had mucus and foam coming out of his mouth. She said she hollered for the RN. She said he arrived and told her to turn the resident on his side, so he could use the suction machine. She said the RN tried to use the suction machine but, it was not plugged in. She said the RN was sitting on the side trying to get the suction machine to work, but it was not working because it was unplugged so she had to tell him that it was not plugged. She said she tried to plug it in. She said she did her best to help the RN get the suction machine going but she did not know how to use the facility's equipment. She said she spent time trying to plug the suction machine and the tubing. She said after she got the suction machine plugged in, the RN tried to suction CR #1's mouth but, it was too late, the resident had already passed. She said the RN pronounced him dead. She said she fed CR #1 a sandwich that she ordered from the facility's kitchen. She said she cut it up into bite size pieces for the resident. She said she fed him the sandwich about 5:10 pm on that day. She said the incident occurred about 5:45 pm because the resident passed around 6:45 pm. She said she worked with CR #1 for 2 years. She said she worked almost every day. She said the facility was saying that he choked on the sandwich but, he choked on mucous. She said he would have episodes where the resident would have increased amount of mucus coming out of his mouth and the nursing staff would suction it out. She said it happened frequently. She said the resident used to spit it out on the floor and she always gave him tissue. She said she did not know why the facility was saying the resident choked on a sandwich because she had already fed him and gave him water behind the sandwich and he was doing fine. She said she was suspended because the facility told her they had to investigate the matter. In an interview on [DATE] at 5:13 pm with DON, she said the CNA's role was to know equipment. She said it was the nurse's responsibility to ensure the equipment, like the suctioning machines, were in good repair and plugged in, so they were ready to go. She said she was not aware the suctioning machine was not plugged in. In a follow up interview on [DATE] at 5:20 pm with RN, he said the suction machine was not plugged in because there were only two outlets; one had the nebulizer plugged in and the other had the oxygen concentrator plugged in. He said he forgot to tell this Surveyor he used oxygen on the resident because it was right there next to his bedside. He said he was the one that unplugged the oxygen, so he could plug the suction machine. He could not recall if the CNA helped him plug in the suctioning machine because it happened so quickly. In an interview on [DATE] at 12:19 pm with Executive Chef, he said he had worked for the facility for 1 year and 3 months. He said he was not at the facility at the time the sandwich was ordered. He said the next day he spoke with the Dietician. He said she told him what had happened with the sandwich. She said a resident choked the night before, (CR #1). He said the sandwich was not ordered as mechanical chop. 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She said the resident was on hospice and he had been exhibiting a decline in respiratory functioning. She said he was having episodes where he had mucus buildup in his throat that had to be constantly suctioned. He said the RN was experienced with working with CR #1 so most of the time, the RN did not have to use the suction machine. In an interview on [DATE] at 1:10 pm with the Administrator, he said he questioned if the suction machine not being plugged in was the cause of death. He said he never got a clear answer. In a telephone interview on [DATE] at 1:42 pm with Hospice RN, he said CR #1 was one of his patients. He said he had not seen the death certificate because it was a duty of the funeral home. He said what happened in the hospice process was that there were two physician medical opinions and both certified a patient as hospice appropriate. He said they reviewed the case and selected the [DIAGNOSES REDACTED]. He said CR #1 was at end of life [MEDICAL CONDITION] with [MEDICAL CONDITION]. He said CR #1 was on PRN oxygen. He said he

also had severe dysphagia (difficulty swallowing). He said prior to hospice and while on hospice CR #1 was exhibiting several episodes of severe dysphagia and choking but, it was usually handled appropriately with hospice interventions. He said his interventions were suctioning and PRN oxygen. He said CR #1 was also receiving scheduled [MEDICATION NAME]. He said what probably happened was that he had a choking episode and that was to be expected. He said the resident was declining already. He said, it was super sad. He said he did not believe that the delay in using the suction machine was the cause of death because the resident was already declining, and it was expected. In an interview on [DATE] at 9:38 am with LVN C, she said she worked 7 am to 3 pm. She said she had worked at the facility for 3 weeks. She said she was not familiar with CR #1. She said she was aware that he passed. She said the nurses were talking about it and that was how she became aware. She said the only thing she knew was that he had a sandwich and he choked on the sandwich. She said her understanding of DNR orders were to not resuscitate. She said DNR meant no life saving measures. She said she would probably use abdominal thrusts and back blows if she needed. She said she would not use CPR on a resident with DNR orders. She said her understanding of full code was CPR, oxygen and anything else that could preserve the resident's life. She said if a resident had a DNR on his medical record and he was choking, her approach would be to try to clear his airway to get the obstruction out. She said she would use oxygen. She said she would suction if oxygen did not work. She said if the resident had a history of [REDACTED]. She said she needed a physician's orders [REDACTED]. She said she would call 911 only if instructed by the physician. In a follow-up interview on [DATE] at 9:53 am with CNA, she said CR #1 finished eating the sandwich about 5:30 pm or 5:45 pm or close to 6:00 pm because he ate slow. She said CR #1 ate the whole sandwich. She said the sandwich did not have any ends on it. She said it was a turkey sandwich with cheese. In an interview on [DATE] at 9:57 am with ADON, she said her understanding of DNR was not to perform any CPR, cardiac pacing and AED. She said nursing staff was not prohibited from performing, [MEDICATION NAME], any type of suctioning or any other comfort measures. She said her understanding of full code was to use any kind of life sustaining measures, i.e. AED, CPR, airway management, call 911 and continue CPR until emergency paramedics arrived at the facility. She said her approach to CR #1's situation would be to observe if there was something physically lodged. Perform the [MEDICATION NAME], if unsuccessful, turn him on his side, and then try suctioning. She said since CR #1 was a DNR, her next step would be to call hospice. She said she was uncertain what to do when a resident was DNR and on hospice, so she would call hospice to get further instructions. She said if the resident had a history of [REDACTED]. She said physician orders [REDACTED]. She said, most times, the suctioning orders are PRN. She said she was told CR #1 had aspirated. She said she assumed it was related to the mucus episodes CR #1 kept experiencing. She said she went into the chart to read what the RN had documented. She said the RN's story and the CNA's were inconsistent and not adding up. She said she had not been involved in the facility's investigation. She said if the sandwich did not have the edges, the bread gets kind of liquified. She said if CR #1 finished the sandwich around 6 pm, she did not believe the sandwich could still be lodged in CR #1's throat. She said if CR #1 had [MEDICAL CONDITION] reflux there was a possibility that the sandwich could come back up. She said CR #1 had already had a lot of episodes where he would decline, become lethargic, loss of appetite, confusion, and mucus build up in his mouth and perk right up the next day. In an interview on [DATE] at 10:42 am with Prep Cook, he said he had been with the facility about one year. He said the staff from the healthcare side come to the kitchen to ask for sandwiches. He said they gave them specifics for how they wanted the sandwich made, i.e, bread with no crust or with no condiments or choking hazards. He said he made the sandwich for CR #1. He could not recall what type of meat. He said it could have been turkey. He said some staff were very specific when placing orders and some just placed the ticket on the service counter. He said on the day when CR #1 passed a staff person from healthcare approached him with an order for [REDACTED]. He said he did not remember if he cut the crust off. He said if the ticket said to cut the crust, then he cut it. He said he would only chop sandwiches upon request. He said the next day he found out that a resident passed from choking on a sandwich because the supervisor in charge of the servers along with the Executive Chef got cooks and servers in a huddle to let them know that whoever made the sandwiches last night caused the resident to choke on the sandwich. He said he defended himself because he said there were no instructions on the meal ticket that called for the sandwich to be mechanically chopped. He said an in-service training occurred next day. He said the facility's kitchen has a color-coded system now to identify mechanical chop, puree and ground. He said because before they would just go by whatever the healthcare staff told them to do. He said the pantry did not have any system like the hot food area had. He said they had a list of the residents with their diets. In an interview on [DATE] at 2:27 pm with Dietary Wait Staff, she said she had worked at the facility for two years. She said she put everyone's menu on serving line and for CR #1, staff ordered a turkey and cheese sandwich with the ends cut off. She said staff would order turkey and cheese sandwich a lot because that's what CR #1 liked. She said if they gave him his mechanical chop he would not eat it. She said he would just leave it there. She said the dishes got picked up about 6 pm. She said dinner usually started about 5:15 pm. She said around 5:45 pm they would bring CR #1's tray back to the kitchen and staff would say he didn't eat anything. She said on [DATE], the day the resident passed, the CNA forgot to tell the kitchen that the turkey and cheese sandwich order was for CR #1 (who was on mechanical chop). She said she delivered the sandwich to resident's room. She said she came back to work the next day and other staff that didn't work the evening before were saying CR #1 choked on a sandwich. She said her supervisor had a meeting with the kitchen staff to tell them if someone was on mechanical chop and they were going to order sandwiches, they had to be mechanically chopped. She said her supervisor developed a color-coded system to identify mechanical chop, puree and ground moving forward. Telephone interview on [DATE] at 12:31 pm with Physician, she said the facility notified her of CR #1's incident after he passed. She said they told her he choked on a sandwich. She said they told her they did everything they could for the resident while respecting his DNR status. She said she was told it happened so fast so there were no other interventions that they could have done while respecting his wishes. Observation on [DATE] at 1:00 pm revealed CR #1's past room had 1 outlet behind his end table located to the left as you entered the room. It had two plugs. There was another outlet behind the bed. It had two plugs. The bed was plugged into one plug. In an interview on [DATE] at 2:23 pm with DON, she said if a resident had signs of an obstructed airway or had a need for suctioning, the staff was expected to do the following: first, staff needed to make sure there was an order in place. She said if there was a suction machine in the room, there had to be an order. She said nurses would do a resident assessment and would suction as needed/accordingly. She said the facility did not have any residents with continuous suctioning orders. She said any resident with orders for suctioning should have the suctioning machine available for immediate use. She said when nurses conducted their rounds and assessed their resident's, O2 saturations were checked, they should be checking that all other emergency equipment was ready to go. She said if residents were on oxygen, they paid closer attention for the need to suction. She said O2 saturations gave nurses an idea of resident's condition. She said if O2 saturation dropped, the nurses would look into why. She said, the CNA's did vital signs at every shift. She said CNA's reported any change of condition to nurses. She said the nurses were responsible to ensure that machines or equipment used for respiratory care were properly working, maintained, and cleaned with a disinfectant. She said if the resident had a 24-hour CNA they too were responsible to ensure machines or equipment used for suctioning was plugged in, working and ready to go. She said CNA's sometimes used the electrical outlets for their personal use i.e. plug in cell phones. She said she had to constantly check on them to ensure they were not doing it. She said sometimes, they unplugged resident's equipment to charge their cell phones. She said the charge nurses were responsible to ensuring supervision of residents. She said the charge nurses gave direction to CNA's. She said, in my own opinion, I believed the resident had already passed at the time the CNA called for help. She said she could not explain the inconsistencies with the narratives provided by the RN and CNA because they were conflicting. She said the event occurred toward the end of the week and she did not find out what kind of sandwich until Monday. She said it was reported that the resident ate sandwiches every night. She said the resident could have had a sandwich just not turkey and cheese. She said the CNA gave the resident whatever he wanted. She said the CNA never told her she cut the sandwich up for the resident. Record review of the facility's policy titled: PAS Policy Manual revised on [DATE] read in part . Personal Assistance Services: Routine ongoing care or services required by an individual in a residence or independent living environment that enable the individual to engage in the activities of daily living or to perform the physical functions required for independent living, including respite services. The term includes: Personal care - The provisions of one or more of the following services required by an individual in a residence or independent living environment: Bathing, Dressing, Grooming, Feeding, Exercising, Toileting, Positioning, Assisting with self-administered medications, Routine hair and skin care; and Transfer of ambulation. Health-related services performed under circumstances that are defined as not constituting the practice of professional nursing by the Board of Nurse Examiners through a memorandum of understanding with the department in accordance with the delegation's rules adopted by the Board of Nurse Examiners . Record review of the facility's statement of acknowledgement between IHA Staff and IHA Management not dated read in part . I understand that the ADL's tasks include the following (but not limited to): transfer/repositioning, assist with feeding, bathing, dressing/grooming, oral care, toileting and record/reporting percentages of input and output or meals and taking vital signs. In understand that my assistance may be needed, and I am NOT eliminated from participating in the assistance for the resident. Tasks outside of ADL's may be required and should be supported as appropriately . Record review of the facility's job description for charge nurse dated [DATE] read in part . Job specific responsibilities: A. Delivery of Resident Care. 8. Assembles and utilizes resident care equipment and ancillary supplies . Record review of publication, titled: Emergency suction equipment: barriers to use and effective interventions located at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 00/, published on [DATE] read in part . Emergency suction is a fundamental item of equipment which should be readily available for use to all healthcare professionals in the hospital setting. Use of emergency suction can be vital in an emergency, for example when dealing with vomit or secretions. It is natural to assume that emergency suction would be maintained in a state of readiness and that the equipment would be, by its nature, intuitive to use. In studies, individuals however had personal experiences where they were let down by the inability of ward staff to effectively use emergency suction, either due to deficiencies in equipment readiness or operator inability . Record review of publication, titled: Journal of Medical Services located at https://www.jems.com/[DATE]/overview-of-prehospital-airway-suctioning/, dated [DATE] read in part . SUCTION EQUIPMENT: Prehospital suction units fall into two categories: portable and vehicle mounted. Both types depend on essentially the same components: catheters and tubing, collection canister and ability to create a vacuum, typically with a positive displacement pump and power source. Each of these components are integral in creating suction and thus must be checked each shift and after every use, to be considered response-ready. Each component, if not properly cared for, can become the weak link that renders your suction unit useless during the exact moment your patient needs it most. Required suction unit checks should be clearly spelled out in department policies and procedures. Documentation they've been checked is your best defense if a unit fails to operate. At a minimum, a quick 10-second system check can be conducted by following these simple steps: unplug the suction unit from the onboard charging system, pinch the distal end of the large bore suction tubing, turn the unit on while listening for the distinct sound of the motor being put under a load. This quick check provides the following: 1. The tubing is connected properly, and the integrity of the tubing hasn't been compromised by a significant crack or break; 2. The canister and lid are maintaining an airtight seal; 3. The motor is functioning properly (see your manufacturer specifications for the vacuum pressure your device should be able to achieve); and 4. The batteries are charged and connected correctly. It's important to note that this quick shift check doesn't replace the manufacturer's suggested bench tests and maintenance schedule. In addition, providers should check to ensure responding apparatus have manufacturer-sealed spare tubing and suction catheters in the event replacements are needed on scene. Lastly, agencies should be prepared with appropriate equipment and training to rapidly suction a variety of very different airways .

F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were maintained in accordance with accepted professional standards and practices as complete and accurate for 1 of 5 residents (CR #1) reviewed for resident records. -The facility failed to ensure LVN D documented CR #1's nebulizer treatment on the MAR indicated [REDACTED]. Findings include: Record review of CR #1's face sheet revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of CR #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 04 out of 15 indicating severe cognitive impairment. He required two-person assistance with bed mobility, transfer, dressing and toile use. He required one-person assistance with locomotion on unit, eating and personal hygiene. He was coded as always incontinent for urinary and bowel. He was coded as having shortness of breath. Section K: Swallowing/Nutritional Status was coded as C. Coughing or choking during meals or when swallowing medications. Record review of CR #1's care plan initiated on 3/4/19 and revised on 9/9/20 revealed the following: Focus: CR #1 admitted to hospice with dx of Alzheimer's with comorbidities of [MEDICAL CONDITION] and dysphagia. Goal: Will maintain CR #1's quality of life through integrated care provided by Hospice and nursing staff. Interventions: Family/ Hospice/ IDT to coordinate plan of care and reach common goals for CR #1; Monitor for any changes in condition and notify hospice; No labs, Diagnostic testing or hospitalization ; Provide comfort care; and Refer to chart for hospice plan of care. Record review of CR #1's current Physician orders [REDACTED]. Record review of CR #1's progress notes by LVN D dated 6/1/20 read in part, .Suction patient PRN DX congestion as needed. PRN Administration was: Effective. No coughing at this time. Will continue to monitor. . Record review of CR #1's MAR indicated [REDACTED]. In an interview on 9/24/20 at 2:23 pm with DON, she said the nurses were responsible for accurate documentation being transcribed to the MAR. She said the nurses were also responsible for ensuring that progress notes reconciled with the MAR. She said blanks on the MAR meant it did not occur. She said the nurse forgot to go back to document CR #1's nebulizer treatment on the MAR. She said it was important to be accurate on the MAR indicated [REDACTED]. She said the risk to residents was medication errors that would jeopardize the health of the residents. She said herself, the DON, and the ADON were responsible for audits of the MARs. Record review of the facility's policy titled, Charting and Documentation revised July 2017 read in part . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1. Documentation in the medical record may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676423	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HALLMARK	**4718 HALLMARK DR HOUSTON, TX 77056**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) be electronic, manual or a combination. 7. Documentation of procedures and treatments will include care-specific details, including: g. The signature and title of the individual documenting .