STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015371	A. Building B. Wing	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care & Rehab Inc	1101 Snows Mill Avenue Tuscaloosa, AL 35406

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility procedure review titled, Restorative Nursing Program, the facility failed to update Resident Identifier (RI) #48's care plan with recommendations from the speech therapy department. This deficient practice affected RI #48, one of 25 sampled residents whose care plans were reviewed. Findings Include: A review of a facility procedure titled, Restorative Nursing Program, written in November of 2016 and revised in November of 2017, revealed in part, Those residents on a restorative program will have a care plan developed to reflect the goal(s) of the restorative program. RI #48 was admitted to the facility on [DATE] and had diagnoses to include Dysphagia (difficulty swallowing). A review of RI #48's Care Plan, with a problem onset date of 09/27/18, indicated the resident was at risk for impaired nutrition and hydration related to issues including a history of cerebrovascular accident (CVA) and had a self-care deficit related to CVA with left-sided Hemiplegia (paralysis of half of the body). Interventions included Requires supervision with meals and Provide assistance with ADL's [activities of daily living]. The care plans regarding impaired nutrition and hydration and self-care deficit lacked updating since 09/27/18. The care plans also lacked interventions recommended in a functional maintenance plan (FMP) developed by the speech therapy department. A Speech Therapy Functional Maintenance Plan (FMP), with a run date of 01/11/21, indicated the patient presented with swallowing deficits, including pocketing, with recommendations to provide minimal verbal and visual cueing as needed to take one sip from a cup rim after one to two bites to improve oral clearance. Recommendations also included providing instruction and demonstration to use swish and swallow as needed at the end of meals to completely clear the oral cavity. An ST [Speech Therapy] - Therapist Progress & Discharge Summary, dated 01/15/21, indicated therapy staff designed and implemented an FMP with caregiver education provided. The summary identified that recommendations and education included providing verbal and visual cueing frequently to promote self-feeding during meals and providing verbal instruction to use one-to-one cyclic ingestion and/or swish-and-swallow technique to facilitate oropharyngeal clearance at meals to improve airway safety. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/22 at 10:55 a.m., EI #2, Director of Nursing (DON), stated that, when there were therapy recommendations, the nurses received communication from therapy and an order was entered. The DON stated supervisory nursing staff were responsible to ensure recommendations and/or orders were added to resident care plans. During an interview on 01/27/22 at 11:09 a.m., EI #11, Registered Nurse (RN) Supervisor, stated care plans should be updated within 24 hours after a new intervention was recommended. EI #11 noted that any information or intervention that needed to be communicated to staff should be included with the update. EI #11 stated that nursing staff were responsible for updating care plans. During an interview on 01/27/22 at 11:15 a.m., EI #1, Licensed Nursing Home Administrator (LNHA), stated that care plans should be reviewed quarterly. The LNHA stated resident care plans should be updated as needed with changes, and that nursing staff were responsible for updating the care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of a facility policy titled, Activities of Daily Living (ADLs) the facility failed to provide Resident Identifier (RI) #48 and RI #62 with necessary and appropriate care and services with eating. This deficient practice affected RI #48 and RI #62, two of three residents reviewed for assistance with ADLs. Findings Include: A review of the Activities of Daily Living (ADLs) policy, written in January of 2018 and last reviewed in January of 2020, which was provided by EI #2, revealed, . C. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1.) RI #62 was admitted to the facility on [DATE] with diagnoses that included Dysphagia, Schizophrenia, Anxiety Disorder, Major Depressive Disorder, Adult Failure To Thrive, Severe Protein Calorie Malnutrition, and Type 2 Diabetes Mellitus. RI #62's Annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 12/03/21, revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated RI #62 had severe cognitive impairment. Further review of the MDS revealed RI #62 required total assistance with meals and received 51% or more daily calories from a feeding tube. A review of RI #62's Care Plan, dated 12/31/20, revealed the resident had an ADL self-care deficit related to issues including weakness and cognitive impairment and was dependent on staff for eating. The plan also identified that RI #62 was at risk for an alteration in respiratory status related to dysphasia. Interventions included providing assistance with ADLs. RI #62's Care Plan, dated 12/31/20, revealed the resident was at risk for impaired nutrition/hydration related to requiring assistance with eating, dysphagia, and use of a therapeutic diet. Interventions directed staff, in part, to observe RI #62 for nausea, vomiting, and shortness of breath and to provide speech therapy services as ordered. Review of a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) document, dated 06/11/21, revealed that recommendations for RI #62 included providing small portions of pureed food with honey thick liquids per spoon presentation at a slow rate with cyclic ingestion. A review of RI #62's Speech Therapy Functional Maintenance Plan (FMP), dated 06/16/21, indicated RI #62 benefited from the use of strict safe swallow precautions and feeding strategies of feeding in ½ teaspoon quantities for both liquids and purees. RI #62 was not to be allowed to drink from a cup or straw. Per the plan, staff were to alternate bites and sips utilizing a slow rate and ensure RI #62's mouth was clear of all food and fluids following intake. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A meal observation was conducted on 01/25/22 at 12:37 p.m. RI #62 was observed receiving assistance from EI #6, a Certified Nursing Assistant (CNA). The resident received thickened liquids per the speech therapy recommendation. RI #62 was observed to cough and gag after each bite of food. The serving size of the pureed food was observed to be a heaping serving filling the entire standard spoon. EI #6 was observed to hold a cup of tea to the lips of RI #62, though staff were to offer thickened liquids to the resident via spoon. The resident was observed to take a drink and start coughing. EI #6 was observed to give RI #62 two to three servings of pureed food and then hold the cup of fluid to the mouth of RI #62 to take a drink. EI #6 was observed to wipe the excess food coming out of the mouth of RI #62 with the edge of the spoon and place it in RI #62's mouth while RI #62 was actively coughing. EI #6 was observed to hold the cup of fluid to the mouth of RI #62 while RI #62 was actively coughing and encouraged RI #62 to take a drink, causing RI #62 to gag and continue to cough. An interview was conducted with EI #6 on 01/25/22 at 1:10 p.m. EI #6 stated that feeding responsibilities were rotated among all assigned CNAs. EI #6 stated there was no specific training for feeding RI #62, but noted instructions were posted on the wall above the bed, which EI #6 thought directed staff to use a spoon when feeding RI #62. An observation on 01/25/22 at 1:10 p.m. of the posted signage was made with EI #6. The posted signage contained the message, Please only feed [RI #62] ½ teaspoon quantities for both drinks and food. No cups or straws please. A nursing Departmental Note, dated 01/25/22 at 1:56 p.m., revealed staff reported RI #62 was coughing with lunch. EI #6 reported that she gave the resident a rest period after coughing episodes then resumed. The nursing note contradicted the observation made by the surveyor. An interview was conducted with EI #5, a CNA, on 01/26/22 at 10:07 a.m. EI #5 stated that, when assigned to a resident that needed assistance, staff were supposed to look at the posted instructions at the head of the bed. EI #5 stated that RI #62 got small bites of food, which was just a small amount at the end of the spoon. Per EI #5, if RI #62 coughed, they waited a few minutes and tried again, but if the coughing continued then the nurse was informed immediately. EI #5 stated that signs of gagging, facial expressions, and excessive coughing were signs to stop the feeding and notify the nurse. EI #5 stated that fluids were served from the cup they arrived in, and after peeling the lid off, the cup was held to the mouth of RI #62 from which to take small sips. An interview was conducted with EI #11, a Registered Nurse (RN) Supervisor, on 01/26/22 at 10:40 a.m. EI #11 stated that RI #62 received pleasure feedings because the family wanted RI #62 to eat, and RI #62 wanted to eat as well. EI #11 stated that EI #3, a Speech Language Pathologist (SLP), had informed them that coughing during the meal was beneficial to help keep the passage clear. However, if the cough was continuous or wet, the feeding should be stopped, and nursing needed to be informed. EI #11 stated that if the resident was coughing, nothing else should be put in the mouth, and the resident needed to rest and then be asked to continue. EI #11 stated that the main goal was to make sure RI #62 was safe during the meal. EI #11 stated that EI #6 had reported the continuous coughing of RI #62 the previous day after EI #6 had completed feeding RI #62. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the lunch meal on 01/26/22 at 12:21 p.m. revealed EI #11 was feeding RI #62. EI #11 was using a standard spoon and feeding a small amount of puree at the tip of the spoon, allowing RI #62 to swallow between each bite of food. The same method was used to deliver the fluids during the meal and fluids and pureed food were alternated during the meal. There was no coughing noted during the meal. RI #62 was noted to clear their throat without coughing during the meal. An interview was conducted on 01/26/22 at 2:30 p.m. with EI #3. EI #3 stated they received a referral from nursing for RI #62 related to difficulty with the meals. EI #3 stated that the FEES report recommended small bites of solids and fluids served from a spoon for both pureed food and fluids. EI #3 stated that the posted signage was correct, and that no cups or straws should be used during the meal because there was no control of the portion consumed. EI #3 stated that coughing was beneficial and could help clear the throat. However, EI #3 noted that RI #62 should be monitored for signs and symptoms of aspiration. An interview was conducted with EI #14, a Registered Dietitian (RD), on 01/26/22 at 2:50 p.m. EI #14 stated RI #62 had swallowing problems and required total assistance with meals and depended on the staff to provide this care. An interview with EI #1, the Administrator, was conducted on 01/27/22 at 9:20 a.m. EI #1 stated it was their expectation that staff followed the diet orders for every resident and reported any problems to the nursing staff, who would then follow up with either an RD or SLP. An interview was conducted with EI #2 on 01/27/22 at 10:30 a.m. EI #2 stated that staff were to follow physician and SLP therapy orders, and staff were expected to report any problems or concerns to nursing staff, who would then follow up with an SLP, RD, or physician. 2.) The facility admitted RI #48 on 09/27/18 and RI #48 had a diagnosis of Dysphagia (difficulty swallowing). RI #48's Physician Orders for the month of January 2022 directed staff to change diet to regular, dysphagia advanced with thin liquids, with an order and start date of 12/22/20. A review of RI #48's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 11/13/20, indicated a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The MDS also indicated RI #48 ate independently with set-up help. A review of RI #48's Care Plan, with a problem onset date of 09/27/18, indicated the resident was at risk for impaired nutrition and hydration related to issues including a history of cerebrovascular accident (CVA) and had a self-care deficit related to CVA with left-sided Hemiplegia (paralysis of half of the body). Interventions included Requires supervision with meals and Provide assistance with ADL's. A nursing Departmental Note, documented as written on 12/20/21 at 10:41 p.m. by Employee Identifier (EI) #15, Licensed Practical Nurse (LPN), indicated RI #48 was noted to be holding food in their mouth upon giving the resident their 4:00 p.m. medications. Per the note, RI #48 swallowed the remaining food when drinking fluids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Speech Therapy Functional Maintenance Plan (FMP), with a run date of 01/11/21, indicated the patient presented with swallowing deficits, including pocketing, with recommendations to provide minimal verbal and visual cueing as needed to take one sip from a cup rim after one to two bites to improve oral clearance. Recommendations also included providing instruction and demonstration to use swish and swallow as needed at the end of meals to completely clear the oral cavity. A ST [Speech Therapy] - Therapist Progress & Discharge Summary, dated 01/15/21, indicated therapy staff designed and implemented a functional maintenance program with caregiver education provided. The summary identified recommendations including providing verbal and visual cueing frequently to promote self-feeding during meals and providing verbal instruction to use one-to-one cyclic ingestion and/or swish-and-swallow technique to facilitate oropharyngeal clearance at meals to improve airway safety. A review of RI #48's Completed Care Tasks, which showed ADL task documentation, revealed the resident ate independently with no setup or physical help from staff on 01/20/22 and ate independently after setup help on 01/21/22, 01/22/22, 01/23/22, 01/24/22 at 8:39 p.m., 01/25/22, and 01/26/22. Extensive one-person physical assistance was documented as required for RI #48 while eating on 01/24/22 at 11:48 a.m. A nursing Departmental Note, documented as written on 01/26/22 at 3:40 p.m. by EI #11, a Registered Nurse (RN) Supervisor, revealed that RI #48 was pocketing food at lunch and staff on the following shift were made aware to observe the resident during meals. A nursing Departmental Note, documented as written on 01/26/22 at 3:31 p.m. by EI #10 , LPN, revealed RI #48 had a large amount of food in their mouth and EI #10 had RI #48 take several sips of water before the resident was able to clear their mouth completely. On 01/25/22 at 12:28 p.m., observation revealed RI #48 had a lunch tray on an overbed table. While speaking with the resident, the surveyor identified that RI #48 had food in their mouth that they had not swallowed. On 01/25/22 at 1:13 p.m., RI #48 was observed in their room. The lunch tray had been removed. While speaking with the resident, the surveyor identified that RI #48 had food in their mouth that they had not swallowed. On 01/26/22 at 2:42 p.m., RI #48 was observed in their room. The lunch tray had been removed. While speaking with the resident, the surveyor identified that RI #48 had food in their mouth that they had not swallowed. During an interview on 01/26/22 at 2:49 p.m., EI #4, a Certified Nursing Assistant (CNA), said that RI #48 required set up and encouragement during meals. EI #4 said some people assisted RI #48 to finish eating and that RI #48 did fine swallowing their food, but would sometimes pocket food. EI #4 said that when RI #48 pocketed food, the resident needed to be encouraged to chew it up and wash it down. During a concurrent observation and interview on 01/26/22 at 2:54 p.m., EI #10 stated RI #48 required setup, supervision, and cueing when eating. EI #10 observed RI #48 with pocketed food in their mouth. EI #10 assisted RI #48 with clearing their mouth with cueing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/26/22 at 3:04 p.m., EI #11 stated RI #48 would be assigned a CNA for assistance during meals, noting CNAs were currently supposed to provide supervision during meals. During an interview on 01/27/22 at 10:11 a.m., EI #10 stated that if residents required assistance following discharge from therapy, an FMP would be developed for restorative therapy. Per EI #10, if there were recommendations to be carried out on the floor, an order would be placed, which would be communicated to CNAs from therapy staff. During an interview on 01/27/22 at 10:55 a.m., EI #2, the Director of Nursing (DON), stated that when there were therapy recommendations, the nurses received communication and an order was entered. The DON stated the nursing staff were responsible to ensure orders were carried out. During an interview on 01/27/22 at 11:04 a.m., EI #3, Speech Language Pathologist (SLP), stated that if residents were appropriate for an FMP, one was put in place. EI #3 stated the nursing staff monitored staff to ensure the FMP was carried out. EI #3 clarified she had not worked with RI #48 and was not personally involved in the development of RI #48's FMP based on her hire date. EI #3 stated that, once staff were trained to implement an FMP, SLP staff did not conduct routine monitoring of facility staff's implementation of the FMP. During an interview on 01/27/22 at 11:15 a.m., EI #1, the Licensed Nursing Home Administrator (LNHA), stated that upon discharge from therapy, when an FMP was written, the CNAs were trained on carrying it out.