STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265534	A. BUILDING _____ B. WING _____	C 12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE CENTER	4401 NORTH HANLEY ROAD SAINT LOUIS, MO 63134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure they followed their abuse and neglect policy by failing to conduct a thorough investigation into one resident (Resident #8) who was found to have unknown pills in his/her possession and allegedly drank a solution of magnesium citrate (a salt that contains magnesium and citrate ions which is commonly used as a laxative to treat occasional constipation). The sample was eight. The census was 110. Review of the facility's policy, "When to Notify Management", dated 8/2/24, showed the following: -Purpose: The purpose of this policy is to ensure that the facility management and Regional	F 610		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tina L Hill | TITLE: LNHA | (X6) DATE: 12/30/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Director are notified for concerns related to the protective oversight of residents and facility operations.

Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed the following:
-Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames.
-Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation:
-The Administrator or designee will:
-a. Administrator/Designee will complete an Administrative Investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency, or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment;
-b. The Administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the Administrative staff, all statements attached from residents and staff involved and any training or education that the Administration feels needs to be provided to staff or residents to ensure education has been provided to prevent future similar situations;

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c. The Administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the Plan of Care was updated to reflect the change in medical or behavioral status.

Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 10/31/24, showed the following:
-No cognitive impairment;
-No moods or behaviors
-Independent with activities of daily living;
-Diagnoses of high blood pressure, seizure disorder, depression and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors).

Review of the resident's nurse's note, showed the following:
-11/6/24 at 9:40 P.M., the resident is a current readmission on Wednesday 11/6/24. He/She was sent back to hospital on Wednesday 11/6/24 at or around 9:10 P.M. The nurse was passing medication when staff said that resident was on the ground in smoking area after drinking a bottle of "medicine". Upon assessment resident was lying on right side with foam coming from his/her mouth. No biting of tongue was noted, pupil size was unable to be determined, pulse at 100 beats per minute and he/she was not responding to verbal or painful stimuli though conscious. The resident's semi jerky movements lasted from two to five minutes plus and including the time from

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my being told that he/she was on the ground and reaching him/her to be assessed. After possible seizure activity abated and or ceased, the resident was lifted into a chair to wheelchair and laid in his/her bed. Emergency Medical Services was called and report was given. Upon their arrival resident was alert but incoherent with continued intermediate jerky body movements. He/She sat up in bed when the Emergency Medical Technician (EMT) officer attempted asking him/her questions regarding what happened. The resident's cognitive thought process was not associative. He/She said that he/she drank the bottle of solution and took the "pills" that the doctor at the hospital had given him/her. The resident said that the doctor at the hospital told him/her to drink the solution in the bottle and take pills. All appropriate parties were notified;
-11/7/24 at 9:22 A.M., addendum note. The liquid the resident consumed was a 296 milliliter (ml) bottle of magnesium citrate and was unable to determine the name and type of the various pills he/she consumed. It was reported that the bottle was full at the time of consumption.

Review of the resident's medical records, showed no documentation of an investigation regarding the pills or the bottle of magnesium citrate.

During an interview on 12/6/24 at 9:48 A.M., the resident said he/she came back from the hospital with pills to take and a solution to drink. The resident said he/she did not know the name of the pills or the solution. The resident gave the pills to the charge nurse and kept the solution. The resident told the charge nurse he/she was going to go and drink the solution. The resident said the charge nurse did not stop him/her from drinking

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the solution.

During an interview on 12/6/24 at 1:57 P.M., Certified Nurse Aide (CNA) A, said the resident was outside smoking, when he/she starting shaking. The resident was lowered to the ground and a code blue (medical emergency) was called. The charge nurse and other staff came to assist the resident. The resident was placed into a wheelchair and taken to his/her room. Another CNA (unknown name) starting searching through the resident's suitcase and found an empty bottle and a small bag of pills. The charge nurse took the pills and empty bottle. CNA A said he/she did not see the resident take any pills or drink any solution.

During an interview on 12/10/24 at 7:48 A.M., Registered Nurse (RN) B said he/she asked the resident where he/she got the pills and solution. The resident did not answer. RN B took the pills (unknown how many) and took a picture of the pills and solution to send the picture to management. RN B held onto the pills and solution bottle until the next morning 11/7/24, and gave them to the oncoming Resident Care Coordinator (RCC) D. RN B texted the picture of the pills and bottle to the Administrator and Director of Nursing (DON) on 11/6/24 at 10:02 P.M. according to his/her cellular phone history.

During an interview on 12/10/24 at 8:12 A.M., Licensed Practical Nurse (LPN) C said he/she admitted the resident to the facility on 11/6/24. When the resident was admitted, he/she did not have any pills or solution and the resident did not come back with any orders. LPN C did not ask the resident if he/she had any pills or bottle of solution. LPN C said it would not be normal for

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the resident to have any medication on him/her. The resident did not give him/her any pills and did not say anything about a bottle of solution.

During an interview on 12/12/24 at 10:52 A.M., RCC D said he/she recalled seeing the empty bottle of magnesium citrate on the morning of 11/7/24. The bottle was shown to him/her by RN B but was not given to him/her. RCC D said RN B should have reported this to the DON. RCC D did not think reporting the incident to the DON was necessary because he/she is not a supervisor over anyone.

During an interview on 12/12/24 at 7:52 A.M., the DON said did not see the text from RN B. The DON said had she seen the text, she would have started an investigation immediately. The DON said she was not aware RCC D was aware of the incident. The DON said she expected RCC D to report this immediately.

During an interview on 12/6/24 at 12:33 P.M., the Administrator and the Regional Nurse Consultant said they expected the incident to be investigated immediately.

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	00411	A. BUILDING: _____ B. WING _____	C 12/26/2024

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A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* See the deficiency cited at F610. *This higher classification merited due to the extent of the violation.	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	Heritage Care Center Of Berkeley, LLC
Street Address, City, Zip:	4401 N. Hanley Rd. Berkeley, MO 63134
Date of Survey:	12/26/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265534

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F-610	The facility will thoroughly investigate, report, and document all alleged violations of abuse, neglect, or mistreatment for resident #8 and all residents as required by state and federal regulations. 1. The Director of Nursing and Administrator will be re-educated on facility's policies and procedures by the Regional Director of Operations. 2. The DON and/or Designee will re-educate the nursing staff on all reportable situations, proper documentation, and appropriate communication of those incidents. 3. The DON and/or Designee will complete random audits monitoring all incident reports, nursing report sheets, and progress notes, 3 times per week for 8 weeks to ensure all incidents are being appropriately reported, investigated, documented, and communicated. 4. The DON and Administrator will sign off on every resident incident report in the EHR daily Monday through Friday and ensure that all reports are completed and reported appropriately. 5. The DON and/or Designee will conduct Nursing Meetings daily Monday through Friday, discussing all incidents from the previous day to ensure facility policy and procedure was followed and to ensure the incident as investigated appropriately. Every Nurses Meeting will be documented with attendance. 6. Residents, legal guardians, and/or family re-educated on proper searches of residents' belongings when re-entering the facility. 7. DON and/or Designee will re-educate facility staff on the Gatekeeper Policy regarding resident searches when residents re-enter the facility to ensure contraband is not brought into the facility.	1/13/2025

Lydia Bell 12/30/2024

	8. The DON and/or Designee re-educated all staff on When to Notify Management Policy. This process will be reviewed in the facilities QAPI process monthly and as needed.	
A8023	Refer to F-610	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

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{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This deficiency is uncorrected. For previous examples, please see the Statement of Deficiencies dated 12/26/24. Based on interview and record review, the facility failed to follow their abuse and neglect policy by failing to conduct a thorough investigation for one resident (Resident #7) who had an order for a mechanical soft diet and was served a regular diet. The resident choked and later expired in the hospital. The sample was 10. The census was 110. Review of the facility's policy, "When to Notify Management", dated 8/2/24, showed the following: -Purpose: The purpose of this policy is to ensure	{F 610}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa Shooter CPN, LNHA | TITLE | (X6) DATE: 2/13/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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that the facility management and Regional Director are notified for concerns related to the protective oversight of residents and facility operations.

Review of the facility's Abuse and Neglect Policy, dated 6/12/24, showed the following:
-Purpose: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames.
-Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation:
-The Administrator or designee will:
-a. Administrator/Designee will complete an Administrative Investigation to include personal statements from staff and residents involved in a situation that has any type of accusations of abuse either staff or resident abuse, any unexpected medical emergency, or when the administrative staff feel uncomfortable in any situation involving resident care or treatment or staff treatment;
-b. The Administrative investigation will consist of any pertinent information describing the situation being investigated, the names of all staff and residents involved, the root cause of the incident, the recommendations from the investigation including the facts that prove or disprove the alleged situation occurred, the plan of correction or action by the Administrative staff, all statements attached from residents and staff involved and any training or education that the Administration feels needs to be provided to staff or residents to ensure education has been

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provided to prevent future similar situations;

c. The Administrative investigation will also include a review of the resident's record to ensure that the documentation reveals that the legal guardian and/or responsible party was notified (if applicable), the physician was made aware, the resident was fully assessed, interventions and physician's orders were followed, the resident was re-evaluated, and the Plan of Care was updated to reflect the change in medical or behavioral status.

Review of Resident #7's physician's order sheet (POS) dated 9/23/24, showed an order for a regular mechanical soft diet with thin liquids.

Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/16/24, showed the following:
-Brief Interview for Mental Status score of 13 indicates moderately impaired.
-Required supervision (touch/assistance) with eating.
-No signs of swallowing disorder.
-No nutritional approaches.
-Not on a mechanically altered diet.

Review of the resident's care plan dated 10/9/24, and updated on 1/24/25 (the resident expired on 1/17/25) showed:
-Problem: At risk for aspiration related to mechanically altered diet and resident swallows chewing tobacco;
-Desired outcome: Resident will have no choking episodes when eating;
-Interventions included:
-All staff to be informed of the resident's special dietary and safety needs;

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-Alternate small bites and sips. Use a teaspoon for eating, do not use a straw;
-Diet to be followed (No documentation on type of diet);
-Instruct the resident to eat in an upright position, to eat slowly and to chew each bite thoroughly.

Review of the dietary spreadsheet, dated 2024, showed a ham and cheese sandwich for mechanical soft diet was ground ham and cheese.

Review of the resident's progress note dated 1/13/25, showed:
-Resident in dining room eating lunch;
-Certified Nursing Assistant (CNA) and Director of Nursing (DON) observed resident choking, staff intervened and provided Heimlich maneuver (a first-aid procedure for dislodging an obstruction from a person's windpipe (throat) in which a sudden strong pressure is applied on the abdomen, between the navel and the rib cage) and mouth sweeps;
-The resident was without a pulse;
-Cardiopulmonary resuscitation (CPR, an emergency treatment that's done when someone's breathing or heartbeat has stopped.);
-Police and Emergency Medical Services (EMS) arrived and took over;
-At 12:40 P.M., resident transported to hospital.

Review of the investigation provided by the facility and dated 1/13/25, showed:
-Three handwritten statements:
-A statement from the DON, showing he/she was walking through the dining room. The DON and a CNA observed the resident was choking. Both attempted the Heimlich Maneuver. Resident non-responsive. CPR started and 911 called. No

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additional information;
-A statement from the CNA who said he/she witnessed the resident choking, He/She and another employee did CPR for the resident until 911 arrived. No additional information provided;
-A written statement from Dietary Staff (DS) S which said he/she was serving on the line. He/She served the resident a mechanical soft plate. The resident said he/she did not want it. Twenty minutes later Certified Medication Technician (CMT) B came and asked for two sandwiches. He/she did not say who the sandwiches were for. Fifteen minutes later he/she saw the resident on the floor;
-There were no other statements from nursing staff, dietary staff, support staff, the speech therapist or resident witnesses.
-No summary of events or what, if any corrective actions were put in place.

Review of the facility's incident summary, dated 1/14/25 at 3:19 P.M., showed the Administrator provided the following information:
-On 1/13/25, resident was in the dining room eating lunch. CNA and DON observed the resident choking;
-Resident went without a pulse;
-Police and EMS called;
-EMS arrived and took over CPR;
-Resident transported to the hospital.

Review of the resident's hospital record dated 1/17/25, showed:
-1/13/25, patient presents with pulseless electrical activity (PEA, a condition where a person is unresponsive and has no pulse, but there is some electrical activity in the heart) arrest;
-Acute respiratory failure, and aspiration pneumonia with shock;

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-Onset of symptoms was abrupt. The patient has dysphagia. He/She was eating a sandwich at his/her nursing home when he/she began choking, aspirated, and went into PEA arrest and was in asystole when EMS arrived;
-The patient received CPR, intubated (tube put down throat for artificial breathing), and central line placed (a catheter placed into a vein for medication administration);
-1/17/25, Remains comatose. Patient extubated (breathing tube removed) at 3:17 P.M. Patient died at 3:33 P.M.

During an interview on 1/29/25, at 7:20 A.M., DS A said on 1/13/25, the resident was served a mechanical soft lunch. The resident refused the meal. A short time later Certified Medication Technician (CMT) B came to the kitchen window and asked for two sandwiches. CMT B did not say he/she needed mechanical soft sandwiches. Dietary staff gave CMT B two ham and cheese sandwiches with some cheese puffs. The sandwiches were not mechanical soft.

During an interview on 1/29/25 at 7:18 A.M., CMT B said on 1/13/25, the resident refused his/her meal tray and asked for sandwiches. CMT B got the sandwiches from dietary. The sandwiches were mechanical soft.

During an interview on 1/29/25 at 7:27 A.M., the DON said he/she was walking past the resident in the dining room and noticed the resident was choking. He/She called a code blue (medical emergency) and attempted the Heimlich Maneuver. At that time the resident became unresponsive. Staff lowered the resident to the floor and CPR was initiated. He/She swept the resident's mouth but only got chewed up cheese

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puffs. He/She noted the resident's dietary card showed he/she was on a mechanical soft diet. EMS arrived and took over CPR. The resident was transported to the hospital. The resident expired on 1/17/25.

During interviews on 1/29/25 at 9:50 A.M., and 11:21 A.M., the Dietary Manager (DM) said he/she was not in the facility when the incident occurred. He/She knew the resident refused his/her meal tray. Staff came and asked for two sandwiches but did not say who the sandwiches were for and/or if they needed mechanical soft sandwiches. DS A called the DM and said the resident was given two regular diet sandwiches, choked and had to have CPR. When the DM returned to the facility and interviewed the dietary staff, they confirmed the resident was provided two regular textured ham and cheese sandwiches. He/She told the Administrator what the dietary staff said, but no one asked him/her to write a statement about it.

During an interview on 1/29/25 at 9:54 A.M. Licensed Practical Nurse (LPN) C said he/she worked the day the resident choked on a sandwich. he/she did not participate in the code blue but did see what looked like bread when the DON performed the mouth sweep.

During an interview on 1/29/25 at 10:07 A.M., DS D said he/she worked on the day the resident choked. nursing staff asked for two sandwiches. They did not say who the sandwiches were for or what diet consistency was needed. Dietary staff gave the nursing staff two regular ham and cheese sandwiches. The ham had not been ground up.

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During an interview on 1/29/25 at 10:10 A.M., DS A said on 1/13/25, DS E made sandwiches in advance of the meal as substitutes if residents did not want the chicken. All the sandwiches were regular consistency. No mechanical soft sandwiches were made. CMT B asked for two sandwiches. He/She did not say who the sandwiches were for and/or what consistency the sandwiches should be. Dietary staff did not ask who the sandwiches were for and/or if they should be mechanical soft.

During an interview on 1/29/25 at 11:32 A.M., DS E said he/she made the sandwiches on 1/13/25, but did not give the sandwiches to CMT B. He/She did not know who gave the sandwiches to the CMT but he/she had not prepared any mechanical soft sandwiches. If the nursing staff gave the resident sandwiches that DS E made, the sandwiches were regular consistency.

During an interview on 1/29/25, at 11:07 A.M., the Speech Therapist said he/she worked with the resident for intelligibility of speech (articulation) and communication cognitive skills. He/She was supposed to be monitored in the assisted dining area during meals. The resident refused to sit in the assisted dining area and would eat on the ledge of the counter between the main dining room and the assisted dining area. The dietary staff did not always grind up the deli meat. He/She worked the day the resident choked but was in the assisted dining area and had his/her back to the resident.

During an interview on 1/29/25 at 12:19 P.M., the Chief Medical Officer from EMS said he/she responded to the facility on 1/13/25, for a chief complaint of resident in cardiac arrest. He/She

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{F 610}	Continued From page 8 suctioned the resident's mouth and pulled out multiple large pieces of thinly sliced deli meat. During an interview on 1/29/25 at 12:52 P.M., CNA F said he/she did see EMS pull sliced ham out of the resident's mouth. During an interview on 1/30/24, at 9:08 A.M., the DON and Administrator said they were not aware the resident was served two regular consistency sandwiches. If a resident requests an alternate food, they would expect the nursing staff to tell the dietary staff who the resident is and what their diet order is. The DON said after EMS left she noticed the resident's dietary card which showed he/she was on a mechanical soft diet. She did not see a meal tray or left over food. Staff had already removed the resident's plate, so she didn't know the resident had been served regular consistency sandwiches. She assumed the resident had be provided a mechanical soft diet. In hindsight, a complete and thorough investigation had not been completed by the facility. MO00248025 MO00248163	{F 610}		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure staff served a resident, who required supervision, the correct diet ordered by the physician. (Resident #7). The resident had a diet order, dated 9/13/24, for mechanical soft texture (food is altered to be soft and easy to chew) foods. During lunch, on 1/13/25, staff served the resident a regular textured ham sandwich. The resident began to choke. Staff intervened and were unsuccessful with completely clearing the resident's airway. Staff performed life saving measures until emergency medical staff arrived; who eventually were able to dislodge several pieces of regular textured thinly sliced meat. The resident was hospitalized and expired on 1/17/25. The sample was 10. The census was 110.

The Administrator was notified on 1/30/25 at 12:23 P.M. of an Immediate Jeopardy (IJ) which began on 1/13/25. The IJ was removed on 1/30/25, as confirmed by surveyor onsite verification.

Review of the facility's Explanation of Diets dated, 2024 showed:
-Mechanical Soft: This consistency modified diet is for individuals with limited or difficulty in chewing regular textured food;
-The diet consists of food of nearly regular textures but eliminated very hard, sticky, crunchy or hard to chew foods;
-Foods should be moist and fork tender;
-Meat is ground or chopped into "bite-sized" pieces (1/2 inch or smaller).

Review of the facility's Diets Policy dated 1/29/25,

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showed:
-The facility will provide each resident with a regular or therapeutic diet as ordered by the physician; the consistency of the diet shall also be ordered;
-A therapeutic diet is defined as any deviation from the regular diet;
-Diets available in the facility included regular mechanical soft diet.
-Regular mechanical soft diet consists of soft fruits, vegetables and ground meat.

Review of Resident #7's physician's progress note dated 12/12/24, showed:
Noted: Provincial dyskinesia (ODK, a movement disorder that causes involuntary, repetitive, and sometimes painful movements of the face, mouth, and can directly cause swallowing problems (dysphagia) because the involuntary movements affecting the face and mouth muscles can interfere with the coordinated movements needed for chewing and swallowing food, leading to difficulties transferring food to the throat and potential choking hazards).

Review of the mechanical soft lunch menu for 1/13/25, showed:
-Ground chicken with onions;
-Stuffing with gravy;
-Soft vegetable medley;
-Apple streusel cake.

Review of the facility's dietary spread sheet, dated 2024, showed a ham and cheese sandwich for mechanical soft diet should be made with ground ham and cheese. It was on the menu as an alternate food selection.

Review of Resident #7's care plan dated 10/9/24,

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and updated on 1/24/25 (the resident expired on 1/17/25) showed:
-Problem: At risk for aspiration related to mechanically altered diet and resident swallows chewing tobacco;
-Desired outcome: Resident will have no choking episodes when eating;
-Interventions included:
-All staff to be informed of the resident's special dietary and safety needs;
-Alternate small bites and sips. Use a teaspoon for eating, do not use a straw;
-Diet to be followed (No documentation on type of diet);
-Instruct the resident to eat in an upright position, to eat slowly and to chew each bite thoroughly.

Review of the resident's progress note dated, 1/13/25, showed:
-Resident in dining room eating lunch;
-Certified Nursing Assistant (CNA) Q and Director of Nursing (DON) observed resident choking, staff intervened and provided Heimlich maneuver (a first-aid procedure for dislodging an obstruction from a person's windpipe (throat) in which a sudden strong pressure is applied on the abdomen, between the navel and the rib cage) and mouth sweeps;
-The resident was without a pulse;
-Cardiopulmonary resuscitation (CPR, an emergency treatment that's done when someone's breathing or heartbeat has stopped.);
-Police and Emergency Medical Services (EMS) arrived and took over;
-At 12:40 P.M., resident transported to hospital.

Review of the EMS trip sheet, dated 1/13/25, showed:

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-Responded to facility for a cardiac arrest;
-Took over CPR;
-The resident was connected to a monitor and it displayed asystole (no heartbeat);
-EMS removed an obstruction in the resident's airway;
-Resident transported to hospital.

Review of the resident's hospital record dated 1/17/25, showed:
-Patient Active Problem List:
-Acute respiratory failure with hypoxia (inadequate supply of oxygen to the body's tissues);
-Aspiration pneumonia of both lower lobes;
-Anoxic brain injury (caused by a complete lack of oxygen to the brain);
-1/13/25, resident presents with pulseless electrical activity (PEA, a condition where a person is unresponsive and has no pulse, but there is some electrical activity in the heart) arrest;
-Acute respiratory failure, and aspiration pneumonia with shock;
-Onset of symptoms was abrupt. The resident has dysphagia. He/She was eating a sandwich at his/her nursing home when he/she began choking, aspirated, and went into PEA arrest and was in asystole when EMS arrived;
-The resident received CPR, intubated (tube put down throat for artificial breathing), and central line placed (a catheter placed into a vein for medication administration);
-1/17/25, remains comatose. Resident extubated (breathing tube removed) at 3:17 P.M. and died at 3:33 P.M.

During an interview on 1/29/25, at 7:20 A.M., Dietary Staff (DS) A said on 1/13/25, the resident

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was served a mechanical soft lunch. The resident refused the meal. A short time later Certified Medication Technician (CMT) B came to the kitchen window and asked for two sandwiches. CMT B did not say he/she needed mechanical soft sandwiches. Dietary staff gave CMT B two ham and cheese sandwiches with some cheese puffs. The sandwiches were not mechanical soft.

During an interview on 1/29/25 at 7:18 A.M., CMT B said on 1/13/25, the resident refused his/her meal tray and asked for sandwiches. CMT B got the sandwiches from dietary. The sandwiches were mechanical soft.

During an interview on 1/29/25 at 7:27 A.M., the DON said he/she was walking past the resident in the dining room and noticed the resident was choking. He/She called a Code Blue (medical emergency) and attempted the Heimlich Maneuver. At that time the resident became unresponsive. Staff lowered the resident to the floor and CPR was initiated. He/She swept the resident's mouth, but only got chewed up cheese puffs. He/She said the resident's dietary card showed he/she was on a mechanical soft diet. EMS arrived and took over CPR. The resident was transported to the hospital. The resident expired on 1/17/25.

During interviews on 1/29/25 at 9:50 A.M. and 11:21 A.M., the Dietary Manager (DM) said he/she was not in the facility when the incident occurred. He/She knew the resident refused his/her meal tray. Staff came and asked for two sandwiches, but did not say who the sandwiches were for and/or if they needed mechanical soft sandwiches. DS A called the DM and said the resident was given two regular diet sandwiches,

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choked and had to have CPR. When the DM returned to the facility and interviewed the dietary staff, they confirmed the resident was provided two regular textured ham and cheese sandwiches. He/She told the Administrator what the dietary staff said.

During an interview on 1/29/25 at 9:54 A.M., Licensed Practical Nurse (LPN) C said he/she worked the day the resident choked on a sandwich and he/she saw what looked like bread when the DON performed the mouth sweep.

During an interview on 1/29/25 at 10:07 A.M., DS D said he/she worked the day the resident choked. Nursing staff asked for two sandwiches. They did not say who the sandwiches were for or what diet consistency was needed. Dietary staff gave the nursing staff two regular ham and cheese sandwiches. The ham had not been ground up.

During an interview on 1/29/25 at 10:10 A.M., DS A said DS E made sandwiches in advance of the meal as substitutes if residents did not want the chicken. All the sandwiches were regular consistency. No mechanical soft sandwiches were made. CMT B asked for two sandwiches. He/She did not say who the sandwiches were for and/or what consistency the sandwiches should be. Dietary staff did not ask who the sandwiches were for and/or if they should be mechanical soft.

During an interview on 1/29/25, at 11:32 A.M., DS E said he/she made the sandwiches, but did not give the sandwiches to CMT B. He/She did not know who gave the sandwiches to the CMT, but he/she had not prepared any mechanical soft sandwiches. If the nursing staff gave the resident

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sandwiches that DS E made, the sandwiches were regular consistency.

During an interview on 1/29/25 at 11:39 A.M., the Registered Dietitian said if a resident was on a mechanical soft diet, all lunch meat should be ground up. Staff should never serve sliced meat to a resident with orders for a mechanical soft diet. He/She was aware the resident choked on a sandwich. He/She was told the resident was provided a regular sandwich with sliced ham. Nursing staff should have identified who they wanted the sandwich for and dietary staff should have asked what consistency sandwich was needed.

During an interview on 1/29/25, at 11:07 A.M., the Speech Therapist said he/she worked with the resident for intelligibility of speech (articulation) and communication cognitive skills. He/She did not work on swallowing problems with the resident. The resident had an order for a mechanical soft diet. He/She was admitted with the order for a mechanical soft diet. Speech Therapy screened the resident, but did not request Skilled Speech therapy for swallowing. The resident was at risk for aspiration. If a resident had an order for a mechanical soft diet, the deli meat on the sandwich should be ground up. The dietary staff did not always grind up the deli meat. He/She worked the day the resident choked, but was in the assisted dining area and had his/her back to the resident.

During an interview on 1/29/25 at 11:53 A.M., the Medical Director's Nurse Practitioner said he/she was notified by facility staff the resident aspirated on food while in the dining room and was sent to the hospital. Facility staff did not provide any

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details about what the resident aspirated on. The resident had dysphagia. Staff did not report the resident might have been provided the wrong diet consistency. The resident was on a mechanical soft diet. He/She should have been served a mechanical soft meal and should have been supervised at each meal. The facility should always follow physician's order when it came to the consistency of a resident's diet.

During an interview on 1/29/25 at 12:19 P.M., the Chief Medical Officer from EMS said he/she responded to the facility for a chief complaint of resident in cardiac arrest. He/She suctioned the resident's mouth and pulled out multiple large pieces of thinly sliced deli meat.

During an interview on 1/29/25 at 12:52 P.M., CNA F said he/she saw EMS pull sliced ham out of the resident's mouth.

During an interview on 1/30/24, at 9:08 A.M., the DON and Administrator both said they were not aware the resident was served two regular consistency sandwiches. If a resident requested an alternate food, they expected nursing staff to tell dietary staff who the resident was and what their diet order was. The DON said after EMS left, she noticed the resident's dietary card showed he/she was on a mechanical soft diet. She did not see a meal tray or left over food. Staff had already removed the resident's plate, so she didn't know the resident had been served regular consistency sandwiches. She assumed the resident had been provided a mechanical soft diet.

During an interview on 1/30/25 at 1:21 P.M., the Speech Therapist said each resident should be

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F 689	Continued From page 17 assessed for the amount of supervision required when they were eating and drinking. The level of supervision should be on the resident's care plan. Each resident was different and needed to be assessed individually for the amount of supervision required. Note: At the time of the survey, the violation was determined to be at the immediate jeopardy level "J". Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective actions to remove the "IJ" violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of the exit, the deficiency was lowered to the "D" level. This statement does not denote the facility has complied with state law (section 198.026.1 RSMO) requiring that prompt remedial action to be taken to address Class I violation(s). MO00248025 MO00248163	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE CENTER	4401 NORTH HANLEY ROAD SAINT LOUIS, MO 63134

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class I* See the deficiency cited at F689. *The higher classification merited due to the extent of the violation and the violation's effect on the resident(s). NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger class I level. Based on observation, interview and record review, completed during the onsite visit, it was determined the facility had implemented corrective action to address the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the class II level.	A4074		
{A8023}	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit	{A8023}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00411	A. BUILDING: _____ B. WING _____	R-C 02/03/2025

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{A8023}	Continued From page 1 mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: The deficiency is uncorrected. For previous examples, please see the Statement of Deficiencies dated 12/26/24. Class II* See the deficiency cited at F610. *The higher classification merited due to the impact when combined with other deficiencies.	{A8023}		

PLAN OF CORRECTION

Provider/Supplier Name:	Heritage Care Center
Street Address, City, Zip:	44001 North Hanley Road St. Louis, Mo 63134
Date of Survey:	2/3/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 610	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12C)(2)-(4)	
	1.) Resident #7 is no longer at the facility	
	2.) All residents have the potential to be affected by the deficient practice	
	3.) All Staff were in-serviced on the facilities Abuse and Neglect policy on 1/30/2025. • All staff were in-serviced on the facilities "When to Notify" policy on 1/30/2025. • The Director of Nursing will be in-serviced on ensuring statements are obtained from staff in all departments at the time of the incident, and statements shall also be obtained from residents who witnessed any incident, to be included in the thorough and complete investigation. • All staff will be in-serviced on the facility policy titled "Incidents and Accidents" and the facilities policy titled "Accidents and Supervision"	2/16/25
	4.) The Director of Nursing/Designee will review all incidents and investigations within 24 hours on the Incident call with the RDO, Clinical RN, Care plan Nurse, and Administrator which is held daily at 9am and 4pm to ensure thorough and complete investigation is completed. The DON/Designee will ensure the conclusion of all incidents is sent to the appropriate licensing authority within the required time from. All incidents will be discussed in the facilities monthly QAPI meeting.	2/16/25
	5.) Date Completed: 2/16/25	
	Cross Reference State Tag A8023	
F689	Free of Accident Hazards/Supervision Devices CFR(s): 483.255(d)(1)(2)	
	1.) Resident #7 is no longer at the facility	
	2.) All residents have the potential to be affected by this deficient practice.	

	3.) All staff will be in-serviced on the facility policy titled "Incidents and Accidents" and the facilities policy titled "Accidents and Supervision" by 2/15/25 • All Staff were in-serviced on the facilities Abuse and Neglect policy on 1/30/2025. All staff were in-serviced on the facilities "When to Notify" policy. • All residents diet orders were audited on 1/30/25 • All residents' care plans were audited to ensure the appropriate diet is reflected, according to the physician order on 1/30/25 • All tray cards were audited to ensure the appropriate diet is reflected, as ordered by the physician on 1/30/25 • All staff were educated on the required level of supervision required for residents who have an altered diet, and the required level of supervision was also added to the residents' care plan on 1/30/25 • The "supervision types are posted in the dining room for staff reference 1/30/25 • The altered diet list was updated to reflect the type, and consistency of food, consistency of liquids, and level of supervision required for those residents who require an altered diet on 1/30/25 • Diet order changes will be reviewed daily in standup. • Registered nurses and Licensed nurses were in-serviced on the requirement of being in the dining room during mealtimes, and all residents requiring an altered diet should eat in the assisted dining room on 1/30/25	2/16/25
	4.) The Director of Nursing and/or Designee will review all investigations Monday through Friday during standup to ensure they are through and complete with interventions in place to prevent any further incidents or accidents from occurring. All incidents will be reviewed monthly during QAPI meeting, to validate compliance.	
	5.) Date Completed: 2/16/2025	
	Cross Reference State Tag A4074	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.