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W 000	INITIAL COMMENTS An annual survey, completed on 9/20/22 to 9/27/22, resulted in the determination of Immediate Jeopardy (IJ) on 9/22/22 at 12:20 p.m. based on failure to consistently provide prescribed food textures. The facility developed a plan to remove the IJ which included training, and a plan to monitor diet textures and mealtime supervision. The IJ was removed on 9/27/22 at 10:40 a.m. The facility was found to be out of compliance with the Condition of Participation (COP) Dietetic Services. The condition-level deficiency was cited at W459 and standard-level deficiencies were cited at W474 and W485. The investigation of #105188-C was also conducted during the annual survey and resulted in no deficiencies cited. The revisit for the annual survey and investigation #99193-I (8/24/21) was also completed at the time of the annual survey. The revisit was NOT MET and was re-cited at W474.	W 000	POC 11/21/22	
W 459	DIETETIC SERVICES CFR(s): 483.480 The facility must ensure that specific dietetic services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain minimal compliance with the Condition of Participation (CoP) - Dietetic Services. Findings follow:	W 459	A plan has been developed and implemented to ensure client safety during dining times. Please reference plan of correction for tag W474 and W485. On going training and monitoring by members of the Regional Team Members occurs to ensure continued safety of clients when eating and drinking.	11/21/22

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

Shelli Kerns | Regional Director | 12.6.22

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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W 459	Continued From page 1 Cross-reference W474: Based on observation, interviews and record review the facility failed to ensure clients received appropriate food textures as prescribed. Cross-reference W485: Based on observation, interviews and record reviews the facility failed to ensure adequate trained staff to appropriately supervise and prompt clients as needed while eating. Lack of staff supervision also resulted in delayed mealtime. These findings resulted in the determination of Immediate Jeopardy (IJ) on 9/20/22 at 12:20 p.m. due to concerns for client safety related to the lack of appropriate food textures as prescribed for the clients. The facility developed and implemented a plan to train and monitor all relevant staff on diet texture and supervision levels for clients at all meals. The IJ was removed on 9/27/22 at 10:40 a.m.	W 459		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, interview and record review the facility failed to ensure staff consistently provided clients with the correct food texture and/or liquid consistency. This affected 3 of 3 sample clients (Client #1, Client #2 and Client #3) and two clients added to the sample (Client #4 and Client #5). Findings follow: 1. Observation on 9/20/22 at 3:20 p.m. revealed staff provided Client #1 with a snack and a drink.	W 474	Staff have been trained on how to properly prepare the person supported meals as outlined in each individual plan. Staff have been trained on the different consistencies of liquids; thin, nectar thick and honey think. The use of Simply Thick product to thicken liquids continues to be used. Staff have been trained on the various food preparation needs. Regular, cut up with appropriate bite size, ground meats with the addition of moisture, moist mechanical soft with the addition of moisture, and puree diets. On-going monitoring for compliance is done by members of the Regional Team.	11/21/22

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Staff poured three ounces of prepared thickened liquid from a larger tumbler into Client #1's small nosey cup. The Associate Manager (AM) noted Client #1 should receive honey-thick liquids. The drink appeared nectar-thick. Client #1 coughed off and on as he ate his snack and drank the liquid. At 3:34 p.m. the AM added approximately an additional three ounces to Client #1's small nosey cup from the larger glass. The surveyor used a spoon to check the consistency of the liquid. The liquid was barely nectar consistency, not honey-thick. The surveyor commented to the AM the liquid did not appear to be thick enough, but the AM failed to respond or add additional thickener.

Record review on 9/21/22 revealed Client #1's physician's order for a pureed diet with honey-thick liquid. Client #1's Occupational Therapy (OT) Assessment dated 3/24/22, indicated he demonstrated signs of aspiration when eating and drinking with coughing, nasal drainage, wet, gurgling voice tones throughout all meals.

According to Client #1's Annual Health Care Report dated 3/23/22, Client #1's diagnoses included Dysphagia and Personal History of Recurrent Pneumonia (frequent aspiration). The Health Care report noted Client #1 was hospitalized from 6/20/21 to 7/02/21 with pneumonia, likely due to aspiration. Discharge recommendations included continuing with a special diet and close monitoring. Client #1 was again hospitalized 9/05/21 to 9/07/21 with aspiration pneumonia. On 9/28/21, Client #1 was diagnosed with aspiration pneumonia, but not admitted to the hospital.

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Client #1's Dining Program, developed by the OT and the Qualified Intellectual Disability Professional (QIDP), updated 9/02/22, contained the following information:

a. Client #1 continues to demonstrate signs of aspiration when eating and drinking with coughing, nasal drainage, wet and gurgling voice sounds. He receives pureed food with honey thick liquids.

b. Staff should notify the Occupational Therapist (OT) by S-Com (internal email) of signs of aspiration, which included coughing or gagging during or following a drink or bite of food and making gurgling sounds or a "wet voice".

c. Client #1's liquid "MUST BE THICKENED TO THE CONSISTENCY OF HONEY AND NO THINNER. Nectar thick is NOT thick enough." Client #1 "should only have 3 ounce nosey-cups at his place at the table. No regular cups should be present at his place. This is done so that he gets no more then 2-3 ounces of fluid at a time."

d. Staff should prompt and encourage Client #1 to clear his mouth of all his food before he takes a drink.

When interviewed on 9/22/22 at 9:30 a.m. the OT indicated Client #1 was at high risk for aspiration and likely aspirated a small amount at every meal, but he was not a good candidate for a feeding tube. The OT confirmed Client #1's drinks should be a honey-thick consistency. Staff should give Client #1 two to three ounces of thickened liquid at a time in his small nosey cups. The OT reported staff should notify her if Client #1 coughed during mealtime, especially if the cough

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sounded wet or gurgling. Staff failed to notify the OT of Client #1 coughing during meals.

2. Observation on 9/21/22 at 8:45 a.m. revealed a staff person cut up Client #2's sausage patty into approximately dime to nickel sized pieces. At approximately 8:54 a.m., a different staff person supervised Client #2 while he ate the sausage patty. Staff failed to ensure Client #2 received the prescribed food texture.

Observations at the day program on 9/21/22 during lunch revealed Client #2 received Nilla Wafer cookies broken into pieces. The dry cookie pieces were not provided with a moistening agent.

Record review on 9/21/22 revealed Client #2's physician's order for a moist mechanical soft diet with ground meat. Client #2's Dietary Assessment noted, for safety purposes, he received a soft, moist mechanical diet with ground meat. Client #2's Eating Program, last updated 5/12/22, described his mechanical soft diet of moist texture soft enough to mash with a fork. Client #2 's meats should be ground and have moisture added to all breads, cookies and cakes.

When interviewed on 9/22/22 at 9:30 a.m. the OT confirmed Client #2's diet order for moist mechanical soft food. She verified a sausage patty should be ground and dry foods should be moistened. The OT noted Client #2 was at risk for choking.

3. Observations on 9/20/22 at 6:21 p.m. revealed Client #3 drank an eight-ounce cup of

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nectar-thick juice, utilizing a lid and straw without assistance. At 7:01 p.m., Client #3 drank a second eight-ounce cup of nectar-thick liquid, utilizing a lid and straw, without assistance.

Observations on 9/21/22 at 8:48 a.m. revealed Client #3 drank an eight-ounce cup of nectar-thick juice, with a lid and straw, without assistance. Staff failed to provide Client #3 a second eight-ounce cup of liquid.

Record review on 9/22/22 revealed Client #3's Eating Guidelines dated 8/20/22, indicated staff should spoon feed the second eight-ounce cup of liquids in honey-consistency to Client #2.

When interviewed on 9/22/22 at 9:51 a.m., the Occupational Therapist confirmed staff should have spoon-fed Client #3 a second eight-ounce cup of honey consistency liquid.

4. Observations on 9/20/22 during dinner revealed staff served Client #4's hamburger with ground meat. Staff failed to moisten or add condiments to the hamburger.

Observation at breakfast on 9/21/22 at 8:45 a.m. revealed staff served Client #4's sausage patty cut into dime to nickel sized pieces. Staff failed to moisten the meat. Client #4 coughed off and on as she ate her breakfast.

Record review on 9/21/22 revealed Client #4's annual OT evaluation dated 11/18/21, indicated she needed a modified diet with ground meat. An appropriate liquid or condiment should be added to her meat to give it moisture. According to the OT evaluation, Client #4 had a weak vertical chew with difficulty breaking down solid foods and

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difficulty moving the bolus (chewed food) in her mouth. Client #4's annual Dietary Evaluation, dated 11/16/21, indicated Client #4's meat should be ground.

Client #4's Eating Guideline procedure dated 12/28/21, indicated her meat should be ground, with an added appropriate condiment or liquid for extra moisture for safe swallowing. The Eating Guideline also provided a list of signs of aspiration, which included coughing or gagging during or following drinks or bites. Staff should report any signs of aspiration to the OT.

When interviewed on 9/22/22 at 9:30 a.m. the OT confirmed Client #4's meat should have been ground and moistened. She explained Client #4's limited ability to chew. Client #4 was at risk for choking and aspiration. The OT also acknowledged Client #4's eating procedure directed staff to contact her if Client #4 was coughing during mealtime. Staff failed to contact her regarding Client #4's coughing.

5. Observations on 9/20/22 during breakfast revealed Living Skills Advisor (LSA) B added thickener to Client #5's drinks. The surveyor's check of the consistency revealed nectar consistency liquid. Observations during lunch revealed Client #5 received nectar thick liquids. LSA C fed Client #5 and gave him drinks between 12:13 p.m. and 12:47 p.m. Client #5 coughed repeatedly between 12:24 p.m. and 12:38 p.m.

Record review on 9/22/22 revealed Client #5's Eating Guidelines dated 12/28/21, indicated Client #5 should receive honey consistency liquids. A review of Client #5's Nutritional Report

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W 474	Continued From page 7 dated 6/14/22, indicated Client #5 should receive honey/malt consistency liquids because of his diagnosis of oral Dysphagia with poor oral motor control, weak mastication, and a delayed swallow with increased risk of choking and aspiration. When interviewed on 9/22/22 at 9:58 a.m., the Occupational Therapist (OT) confirmed the staff should have thickened Client #5's liquids to honey consistency. The OT indicated Client #5 is at high risk for aspiration.	W 474		
W 485	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure adequate staff presence during mealtime resulting in inconsistent supervision and delayed mealtime. This affected 2 of 3 sample clients (Client #1 and Client #3) and 5 clients added to the sample (Client #4, Client #6, Client #7, Client #8 and Client #9). Findings follow: 1. Observations during dinner on 9/20/22 from 6:47 p.m. to 6:55 p.m. revealed Client #1 ate his meal without staff supervision. Living Skills Advisor (LSA) A prepared and served food in the kitchen while six clients remained in the dining room without staff present. At 6:55 p.m. LSA A called for staff assistance.At 6:55 p.m. a staff person prompted Client #1 to take a drink, and moved his nosey cups within his reach. Client #1 took two very large bites of pureed meat at 7:09 p.m., which staff did not see. Client #1 ate his dinner with intermittent staff supervision. He	W 485	A plan has been developed to ensure that person supported are properly supervised during dining times. The people supported eat in groups of 3-4 individuals at varying times. Staff are to be in the dining room at all times to provide supervision of the people supported who are eating. The AM staff use a chart in the kitchen to document when someone has eaten and how much each person has consumed and drank to ensure that all people supported receive the meal. The PM shift eats with their assigned group at the appropriate times. When eating snack, staff will monitor the individuals in their group to ensure proper supervision is given during that time. Ongoing monitoring and coaching will be completed by members of the Regional Team.	11/21/22

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produced wet and congested sounding coughs at times throughout the meal.

Observation during breakfast on 9/21/22 revealed Client #1 took a very large first bite and then rapidly ate three or four more bites, with no staff supervision. After Client #1 ate several bites, a staff person brought him his thickened drinks and began to supervise him. Client #1 continued to intermittently eat very large bites of his pureed food. At 8:30 a.m. Client #1 produced wet and gurgling sounding coughs. Client #1 received inconsistent supervision as he continued to eat breakfast from approximately 8:30 a.m. to 8:45 a.m. Client #1 continued to cough off and on as he ate.

Observation during lunch at the day program on 9/21/22 at approximately 12:15 p.m. revealed staff poured about three ounces of thickened liquid into Client #1's two small nosey cups. Staff set two larger tumblers with approximately five to six ounces of thickened liquid on the table. At 12:26 p.m. Client #1 finished drinking the liquid in his small nosey cups. At 12:29 p.m. Client #1 picked up one of the larger glasses of liquid and drank the entire contents. The only staff person in the area saw Client #1 drink from the large glass as he fed another client. The staff failed to move the second large glass out of Client #1's reach. Client #1 picked up the second glass of liquid and quickly drank the entire contents. At 12:36 p.m. Client #1 produced wet and phlegmy coughs.

Record review on 9/21/22 revealed Client #1's Comprehensive Functional Assessment (CFA) dated 3/24/22, indicated he needed prompts and assistance to eat at an appropriate rate, take appropriate size bites, chew and swallow food

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before taking another bite and to drink liquids at an appropriate pace. Client #1's Dietary Assessment dated 3/22/22, noted he needed constant staff supervision with verbal and gestures to slow down and clear mouth before taking another bite or drink. Client #1's Occupational Therapy Assessment dated 3/24/22, indicated he demonstrated signs of aspiration when eating and drinking with coughing, nasal drainage, wet, gurgling voice tones throughout all meals. He should have constant supervision and verbal and gestural prompting to assist him with slowing his rate of consumption, taking small bites and with clearing his mouth before taking another bite or before taking a drink.

According to Client #1's Annual Health Care Report dated 3/23/22, Client #1's diagnoses included Dysphagia and Personal History of Recurrent Pneumonia (frequent aspiration). The Health Care report noted Client #1 was hospitalized from 6/20/21 to 7/02/21 with pneumonia, likely due to aspiration. Discharge recommendations included continuing with a special diet and close monitoring. Client #1 was again hospitalized 9/05/21 to 9/07/21 with aspiration pneumonia. On 9/28/21, Client #1 was diagnosed with aspiration pneumonia, but not admitted to the hospital.

Client #1's Dining Program, developed by the OT and the Qualified Intellectual Disability Professional (QIDP), updated 9/02/22, contained the following information:

a. Client #1 continues to demonstrate signs of aspiration when eating and drinking with coughing, nasal drainage, wet and gurgling voice

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sounds. He receives pureed food with honey thick liquids.

b. Staff should notify the Occupational Therapist (OT) by S-Com (internal email) of signs of aspiration, which included coughing or gagging during or following a drink or bite of food and making gurgling sounds or a "wet voice".

c. Client #1's liquid "MUST BE THICKENED TO THE CONSISTENCY OF HONEY AND NO THINNER. Nectarthick is NOT thick enough." Client #1 "should only have 3 ounce nosey-cups at his place at the table. No regular cups should be present at his place. This is done so that he gets no more then 2-3 ounces of fluid at a time."

d. Staff should prompt and encourage Client #1 to clear his mouth of all his food before he takes a drink.

When interviewed on 9/22/22 at 9:30 a.m. the OT confirmed staff should notify her if Client #1 coughed during mealtime, especially if the cough sounded wet or gurgling. Staff failed to notify the OT of Client #1 coughing during meals. She indicated Client #1 was at high risk for aspiration and likely aspirated a small amount at every meal, but he was not a good candidate for a feeding tube. The OT said staff should supervise Client #1 as he ate, in order to prompt him as needed. Client #1 needed to clear his mouth before taking his next bite. Taking extremely large bites of food would be a concern. A staff person didn't necessarily need to be next to Client #1 as he ate, but should at least be in the dining room to supervise Client #1. The OT confirmed Client #1's drinks should be a honey-thick consistency and not nectar thick. Staff should give Client #1

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2-3 ounces of thickened liquid at a time in his small nosey cups. The OT said the larger glasses of liquid should be placed out of reach of Client #1.

2. Observations at dinner on 9/20/22 revealed staff brought Client #3 her drinks and returned to the kitchen to continue dinner preparations. At 6:25 p.m. Client #3 coughed following a drink. Staff failed to respond. At 6:44 p.m. staff brought a plate of food to Client #3 in the dining room and returned to the kitchen. At 7:00 p.m. staff brought Client #3 a second drink. Staff failed to supervise Client #3 as she fed herself between 6:56 p.m. and 7:15 p.m.

Observations at breakfast on 9/21/22 revealed staff served Client #3 her breakfast and drinks. Between 8:28 a.m. and 9:30 a.m. staff failed to supervise Client #3 as she fed herself. She intermittently took large spoons of food. At 9:16 a.m., staff failed to respond when Client #3 coughed. Client #3 intermittently ate food off her clothing protector throughout the meal without consistent staff redirection. When asked whether Client #3 would get more drinks, staff indicated she received an additional liquid with her morning medications.

Record review on 9/22/22 revealed Client #3's Eating Guidelines dated 8/30/22, indicated staff should intermittently ask Client #3 to raise her arms over her head and sing to assist with clearing her lungs. The guidelines also instruct staff to spoon feed Client #3 her second cup of liquid.

A review of Client #3's Occupational Therapy

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	16G011	A. BUILDING _____ B. WING _____	C 09/27/2022

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CHRISTIAN OPPORTUNITY CENTER	1554 BROADWAY ST PELLA, IA 50219

(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
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Evaluation dated 12/2/21, indicated Client #3 required supervision and prompting throughout the meal to eat and drink safely and appropriately.

A review of Client #3's Nutrition Report dated 11/30/21, indicated Client #3 required staff supervision and reminders to take small bites, clear her mouth and drink to clear her throat throughout the meal.

When interviewed on 9/22/22 at 9:46 a.m., the Occupational Therapist (OT) confirmed staff should have supervised Client #3 throughout meals and contacted her when she coughed. In addition, Client #3 should have received two eight-ounce cups of liquids; one with nectar-thick liquid she would drink with a straw and the second with honey-thick liquid staff should spoon-feed her.

3. Observations on 9/20/22 at 6:39 p.m. revealed staff left Client #4's drinks on the kitchen pass-through window counter. Client #4 ate without drinks available. Client #4 coughed off and on as she ate her meal. At 7:00 p.m. staff gave Client #4 her drinks. Staff failed to remain in the dining room throughout dinner as six clients ate.

Record review on 9/21/22 revealed Client #4's Eating Guideline procedure dated 12/28/21, indicated staff should prompt Client #4 to take a drink after every two to three bites.

When interviewed on 9/22/22 at 9:30 a.m. the OT indicated Client #4 should take a drink after two to three bites of food. The cups of liquid should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G011	A. BUILDING _____ B. WING _____	C 09/27/2022

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W 485	Continued From page 13 be in her reach as she ate. 4. Observations on the morning of 9/21/22 revealed breakfast lasted from approximately 8:20 a.m. to 10:40 a.m. Clients were up and ready to eat, but staff were busy with other clients. At approximately 10:00 a.m. Work Skills Supervisor (WSS) A asked other staff which clients had not ate breakfast. A staff responded Client #6 and Client #7 had not been offered breakfast yet. WSS A began to prepare their breakfast. Client #8 sat at a dining room table from 9:40 a.m. to 9:56 a.m., but didn't receive any food. He left the dining room to go sit in the living room. At 10:06 a.m. WSS B asked Client #8 if he had a good breakfast. Client #8 was non-verbal. The surveyors informed WSS B that Client #8 had not received breakfast yet. WSS B looked surprised and said she saw Client #8 at the dining room table. WSS B then asked WSS A to also prepare breakfast for Client #8. Staff served Client #7 his breakfast at 10:11 a.m. and served Client #9 her breakfast at 10:16 a.m. Client #6 was also served breakfast around the same time. Client #8 was the last client to be served breakfast, at 10:24 a.m. The clients later had lunch at 12:00 p.m. When interviewed on 9/21/22 at 10:12 a.m. WSS A explained the staff did the best they could could in the morning to get everyone up, dressed, fed and pass morning medications but they needed more staff. Four staff were working with 12 clients on the morning of 9/21/22.	W 485		