STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235038	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Grand Rapids	2000 Leonard NE Grand Rapids, MI 49505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. This citation pertains to intake: MI00149223 Based on interview and record review, the facility failed to implement facility policy and procedure for reporting an incident of neglect (resident choking and subsequent death due to recieving wrong meal tray) to the State Agency in 1 of 1 resident (Resident #100) reviewed for neglect, resulting in the potential for continued violations going unreported or without thorough investigation. Findings include: Review of an admission Record revealed Resident #100 was a male with pertinent diagnoses which included paralysis on right dominant side, aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke), cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), dysphagia (damage to the brain responsible for production and comprehension of speech), need for assistance with personal care, intellectual disabilities, and cerebral infarction affecting right dominant side (blood flow to the brain is blocked, causing an area of tissue death in the brain . Review of Care Plan with 10/22/24, revealed the focus, .Resident has an ADL (Activities of daily living) self care performance deficit related to CVA (cerebral vascular accident), epilepsy, dysphagia (damage to the brain responsible for production and comprehension of speech), pulmonary vascular congestion, hemiplegia . with the intervention .EATING: 1 person assist. Uses divided plate, built up utensils, and clothing protector as resident allows . Review of Order dated 10/22/24, revealed, .NDD (National Dysphagia Diet) Level 1 diet, Pureed Texture, Honey/Moderately Thick Consistency (a liquid that pours slowly, similar to honey, where it is thick enough to not easily flow out of a cup but can still be sipped from a spoon), oral care before and after each meal. No straws. Upright in wheelchair in dining room for all meals. DOUBLE PORTIONS . Review of Level 1 Dysphagia Puree received on 1/6/25, revealed, .ALL FOODS PUREED smooth without lumps and seeds .Cream of Wheat needs to be lump free and oatmeal pureed .Cannot puree bacon or pepperoni unless stated otherwise .No pureed fruits with skim, pulp, or seeds .Sandwiches pureed as separate components .No sticky or chewy foods . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Summary of Daily Skilled Services dated 11/27/24, revealed, .Precautions: Fall risk, aphasia, PEG tube, low vision, NDD level 1 textures, honey-thick liquids, no straws .Pt (Patient) alert/awake in dining room. Pt cooperative with treatment session, in which recertification was completed. Pt continues on a NDD level 1 texture diet honey-thick liquids. Pt has been safely tolerating therapeutic trials of NDD level 2 textures, however, pt continues to require max cueing for implementation of safe swallowing strategies. Recommend continued education in strategies, including small bites/sips, alternate bites/sips, and eat slowly. No therapeutic trials of upgraded liquids have been trialed d/t (due to) no upgrade recommended until f/u VFSS. Pt implementing safe swallowing strategies with 75% accuracy given max verbal cues. Pt agreeable to continue to participate in skilled SLP services 3-4x/week for 30 days to continue to complete pharyngeal strengthening exercises and facilitate diet advancement as appropriate . Review of Incident Report dated 12/3/24, revealed, .Incident Description: Resident sitting in dining room on (Unit). New employee CENA delivered resident tray. Resident .diet/honey thick liquids, but was served a regular tray accidentally by CENA. Was noted to be choking .nurse .Immediate Action Taken: RN immediately attempted Heimlich x3, resident turning blue and no air exchange noted, placed on floor, Heimlich .CPR initiated, 9-1-1 called. AED attached -no shock needed. No food noted in mouth. EMS arrived and took over .(Local Hospital) via EMS who were continuing to work on resident .Other Info: New CENA in orientation provided wrong diet to resident. Preceptor was assisting another resident and was not aware of wrong tray .noted resident in choking position with hands at throat . Review of Nurse's Notes dated 12/3/24 at 8:51 PM, revealed, .Witnessed choking event occurred. Approximately 1730 dinner trays passed by CNA's. Resident sitting in dining area on (Unit) in wheelchair. At 1735 RN (Registered Nurse) who was passing meds on (Unit) was alerted by CNA (Certified Nursing Assistant) F that resident was choking as resident put hands over throat and signaled to help. After rapidly attending to resident, this RN attempted Heimlich multiple times while in wheelchair without success. Resident rapidly turned blue in lips and gasping without any air exchange. Unable to visualize any food in mouth. Resident then assisted to floor and positioned supine. Heimlich reattempted without any success. 911 called after establishing no pulse. CPR started by this RN and assisted by CNA. After approximately 3 rounds of CPR EMS arrived. LMA (laryngeal mask airway) and IO (Intraosseous- procedure that involves injecting fluids, medications, or blood products directly into the bone marrow. This done when intravenous access (IV) is not available or feasible, such as in cardiac arrest or decompensated shock) iv placed per EMS and AED applied. Resident eventually transported to (Local Hospital) with no spontaneous pulse . Review of the State Agency reporting program revealed the incident resulting in the death of Resident #100 was not reported to the State Agency. In an interview on 1/3/25 at 2:31 PM, Admininstrator A reported they were told not to report the incident by corporate and it was not our call and the hospital would report it. In an subsequent interview on 1/3/25 at 4:11 PM, Administrator A reported as a team they did not feel that it was a reportable incident.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake: MI00149223 Based on interview and record review, the facility failed to ensure 1 of 1 residents (Resident #100) reviewed for safety, received the correct food tray and assistance with eating on 12/3/24, resulting in an Immediate Jeopardy when Resident #100 choked on a piece of cauliflower and subsequently died. Findings include: The immediate jeopardy began on 12/03/24 and was identified on 01/03/25 due to the facility's failure to provide the correct diet tray and no assistance when eating resulting in Resident #100 choking on a piece of cauliflower and subsequent death. On 01/06/25 at 12:00 PM, the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review that the Immediate jeopardy was removed on 1/6/25 but noncompliance remains at the scope of isolated and severity of actual harm due to not all staff had received the education and sustained compliance has not been verified by the State Agency. Dysphagia refers to difficulty swallowing. The causes and complications of dysphagia vary. Complications include aspiration pneumonia, dehydration, decreased nutritional status, and weight loss. [NAME], [NAME] A. ; [NAME], [NAME]: Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 64741-64743). Elsevier Health Sciences. Kindle Edition. Resident #100: Review of an admission Record revealed Resident #100 was a male with pertinent diagnoses which included paralysis on right dominant side, aphasia (loss of the ability to understand or express speech caused by brain damage, like with a stroke), cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), dysphagia (damage to the brain responsible for production and comprehension of speech), need for assistance with personal care, intellectual disabilities, and cerebral infarction affecting right dominant side (blood flow to the brain is blocked, causing an area of tissue death in the brain . Review of Care Plan with 10/22/24, revealed the focus, .Resident has an ADL (Activities of daily living) self-care performance deficit related to CVA (cerebral vascular accident), epilepsy, dysphagia (damage to the brain responsible for production and comprehension of speech), pulmonary vascular congestion, hemiplegia . with the intervention .EATING: 1 person assist. Uses divided plate, built up utensils, and clothing protector as resident allows . (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Order dated 10/22/24, revealed, .NDD (National Dysphagia Diet) Level 1 diet, Pureed Texture, Honey/Moderately Thick Consistency (a liquid that pours slowly, similar to honey, where it is thick enough to not easily flow out of a cup but can still be sipped from a spoon), oral care before and after each meal. No straws. Upright in wheelchair in dining room for all meals. DOUBLE PORTIONS . Review of Level 1 Dysphagia Puree received on 1/6/25, revealed, .ALL FOODS PUREED smooth without lumps and seeds .Cream of Wheat needs to be lump free, and oatmeal pureed .Cannot puree bacon or pepperoni unless stated otherwise .No pureed fruits with skim, pulp, or seeds .Sandwiches pureed as separate components .No sticky or chewy foods . Review of Summary of Daily Skilled Services dated 11/27/24, revealed, .Precautions: Fall risk, aphasia, PEG tube, low vision, NDD level 1 textures, honey-thick liquids, no straws .Pt (Patient) alert/awake in dining room. Pt cooperative with treatment session, in which recertification was completed. Pt continues on a NDD level 1 texture diet honey-thick liquids. Pt has been safely tolerating therapeutic trials of NDD level 2 textures, however, pt continues to require max cueing for implementation of safe swallowing strategies. Recommend continued education in strategies, including small bites/sips, alternate bites/sips, and eat slowly. No therapeutic trials of upgraded liquids have been trialed d/t (due to) no upgrade recommended until f/u VFSS. Pt implementing safe swallowing strategies with 75% accuracy given max verbal cues. Pt agreeable to continue to participate in skilled SLP (Speech Language Pathologist) services 3-4x/week for 30 days to continue to complete pharyngeal strengthening exercises and facilitate diet advancement as appropriate . Review of Incident Report dated 12/3/24, revealed, .Incident Description: Resident sitting in dining room on (Unit). New employee CENA delivered resident tray. Resident .diet/honey thick liquids but was served a regular tray accidentally by CENA. Was noted to be choking .nurse .Immediate Action Taken: RN immediately attempted Heimlich x3, resident turning blue and no air exchange noted, placed on floor, Heimlich .CPR initiated, 9-1-1 called. AED attached -no shock needed. No food noted in mouth. EMS arrived and took over .(Local Hospital) via EMS who were continuing to work on resident .Other Info: New CENA in orientation provided wrong diet to resident. Preceptor was assisting another resident and was not aware of wrong tray .noted resident in choking position with hands at throat . Review of Nurse's Notes dated 12/3/24 at 8:51 PM, revealed, .Witnessed choking event occurred. Approximately 1730 dinner trays passed by CNA's. Resident sitting in dining area on (Unit) in wheelchair. At 1735 RN (Registered Nurse) who was passing meds on (Unit) was alerted by CNA (Certified Nursing Assistant) F that resident was choking as resident put hands over throat and signaled to help. After rapidly attending to resident, this RN attempted Heimlich multiple times while in wheelchair without success. Resident rapidly turned blue in lips and gasping without any air exchange. Unable to visualize any food in mouth. Resident then assisted to floor and positioned supine. Heimlich reattempted without any success. 911 called after establishing no pulse. CPR started by this RN and assisted by CNA. After approximately 3 rounds of CPR EMS arrived. LMA (laryngeal mask airway) and IO (Intraosseous- procedure that involves injecting fluids, medications, or blood products directly into the bone marrow. This done when intravenous access (IV) is not available or feasible, such as in cardiac arrest or decompensated shock) iv placed per EMS and AED applied. Resident eventually transported to (Local Hospital) with no spontaneous pulse . (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of IDT-Interdisciplinary Progress Note dated 12/5/2024 at 2:38 PM, revealed, .IDT (Interdisciplinary Team), including RDC met to review choking incident. Resident on puree diet received the wrong tray of a regular diet that belonged to his roommate. (CNA G), CNA orientee, had mistakenly given (Resident #100) the dinner tray that should have gone to his roommate. (CNA F) was supervising the dining room when she noted that (Resident #100) had placed his hands at his throat indicating he was choking. She called for the nurse who immediately attended to the resident and performed the Heimlich maneuver with no results and called 911 and began CPR. Paramedics arrived and took over; he was then transported to (Local hospital) where he was later deceased . In an interview on 1/3/25 at 12:27, Registered Nurse (RN) E reported she was on a different hallway administering medications. RN E reported the facility only had two nurses on shift and when that happened, the unit Resident #100 was on was split between the nurses. RN E reported the incident occurred at dinner time and there was not a nurse down on that unit at that time. CNA F was the only CNA on the unit, and she had a trainee with her, CNA G who was employed by the facility but was orienting. CNA F yelled to me loudly (Resident #100) was choking, sprinted down there and he was sitting at the table in the dining room area. Resident #100 was seated in his wheelchair, he was trying to breath, he was gasping and totally occluded. He was starting to turn blue. RN E reported CNA F had been in that area, he raised his hand and grabbed his throat, she quickly yelled to me. RN E reported she tried Heimlich on him, he was a bigger guy, tall and heavier set guy. RN E reported she tried multiple times, and nothing was happening. He slumped over, RN E reported he was not ambulatory person, and he was in his wheelchair, she was behind him trying the Heimlich maneuver doing the best she could. RN E reported he had lost consciousness not sure how long it had been by the time she called me to come down to assist Resident #100. RN E reported she had to get him to the floor. CNA F and her got him to the floor and tried abdominal thrusts on him, looked in his airway and there was nothing there. RN E reported they had him on the floor in the middle of the dining room and she couldn't feel a pulse, she called 911 and then started cardiopulmonary resuscitation (CPR). RN E reported CNA H came down from another unit and grabbed the crash cart. RN E had called 911 and they told the staff to start CPR, and she was doing 30/2, 911 told her to stay on the phone and someone would be there right away, and then Fires rescue arrived, not sure how many rounds of CPR she had performed on Resident #100. RN E reported when Fire Rescue got there, they began running the code and soon after EMS arrived. CNA F had been assisting the other residents out of the dining room and back to their rooms. RN E reported the responders tried putting an oral airway in him but were unsuccessful and they ended up intubating him. RN E reported the AED reported a shock was not advised, and the code was ran for a good 30-40 minutes. RN E reported the incident happened at like 5:35 PM and the responders took him sometime after 6:00 PM. RN E reported it wasn't until she took a look at his tray, she realized the CNA had delivered the wrong tray to Resident #100. RN E reported there were chunks of cauliflower and penne pasta roasted on the tray. RN E reported had decompensated in the ICU (Intensive Care Unit) that night and had died. RN E' reported she was informed by the hospital it was the cauliflower caught in his throat. RN E reported CNA G didn't know the residents well and she fell apart when she realized she had given Resident #100 the wrong diet tray. Review of Risk Management Statement dated 12/6/24, revealed, CNA G wrote .Began passing trays, I delivered a tray to (Resident #100) that belonged to his roommate by mistake. (Resident #100) was seated at the table in the dining room. I then went to another unit to assist another resident with their meal. I returned to (Unit) to see the staff providing CPR to (Resident #100) . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/3/25 at 1:06 PM, CNA G reported she was training on (Unit) when it was dinner time, reported we were passing the trays out. CNA G reported she was told to pass out trays for Resident #100 and his roommate. CNA G reported she dropped the trays off and was to go to another hall and feed another resident. When CNA G came out of the room, she saw EMS giving him (Resident #100) CPR. CNA G reported she had only worked at the facility for approximately two weeks prior to this incident and she was still in training. CNA G reported she didn't' know who the residents were on that unit as she had only worked over there one other time. CNA G reported the staff were to check the meal ticket and she had mixed them up. CNA G reported she was supposed to check the kiosk if she did not know who the resident was and/or to verify the resident's diet order was correct, but she didn't have access to the charting system but if had access she could have checked the charting system. CNA G reported they were working short staffed and CNA F had other things to do and she told me here the tray go ahead and pass it. She had pointed the trays out to me and told me they went to the residents in Resident #100's room. CNA G reported she did not verify who she gave the meal tray too was correct as she had to go assist another resident with eating. CNA G stated, she felt, .Terrible for his family because of my mistake . Review of Risk Management Statement dated 12/6/24, revealed, .I, (CNA F), CNA was supervising the dining room when I saw and heard the resident placed his hand to his chest and give the sign that he was choking. I went right over to him, asked him if he was ok, he shook his head no, I immediately called out for the nurse, (RN E) ran to the resident and began the Heimlich maneuver. That was unsuccessful. 911 was called and we laid the resident to the floor and began CPR until paramedics arrived and they took over . This writer attempted to contact CNA F on 1/3/25 at 2:35 PM and 1/6/25 at 10:39 AM and was unable to reach her prior to the end of survey. Review of Risk Management Statement dated 12/6/24, revealed, .I, (CNA H), was in another room assisting a resident to eat their meal. I exited the room and walked to dining room area to see (RN E), RN and (CNA F), CNA performing the Heimlich maneuver on resident (Resident #100). I then went for emergency cart/AED and brought to the nurse. Paramedics then arrived as (RN E) and (CNA F) were performing CPR . In an interview on 1/3/25 at 12:16 PM, Family Member (FM) K reported they were in the building frequently and stated, .You don't know how many times the wrong trays are given to the wrong people, see it quite a bit . In an interview on 1/6/25 at 2:31 PM, CNA J reported Resident #100 was one person assist, and he needed to be watched when he ate as he ate too fast, he had built up silverware and he was getting better, but he was still on a pureed diet. In an interview on 1/6/25 at 4:17 PM, Director of Nursing (DON) C reported there were two residents who needed assistance on 12/3/24 and Resident #100 would have been one of them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/3/24 at 2:07 PM, Director of Rehabilitation, Speech Language Pathologist (SLP) I reported Resident #100 admitted to the facility in August 24, he was originally NPO (nothing by mouth) with a peg tube. SLP I reported she saw him from August to October and he had a swallow study done on 10/18/24 and was upgraded to a Level I Pureed diet, thick liquids via cup only no straws. SLP I reported she had done some trials with Resident #100 with a Level II diet, mechanical soft and pretty mushy. SLP I reported she had only given him a little bite and she never felt comfortable upgrading his diet to Level II because he ate super, super fast and she wanted to do another swallow study before any upgrades. SLP I reported for the trails she used a very small piece of oatmeal cream pie cookie, didn't do a ton of trials as he ate too fast. SLP I reported she was working with Resident #100 4 days a week when he had dies. SLP I reported he was a new stroke still and that was part of what brought him here in August 24. SLP I reported on 11/27/24 note it was written, Resident #100 was safely tolerating of level textures, max cueing safe swallowing not recommended to upgrade. SLP I reported she saw Resident #100 for aphasia as well. Review of ED to Hosp-Admission note dated 12/3/24 at 7:37 PM, revealed, .HISTORY OF PRESENT ILLNESS: 75 yo M (male) who presents via EMS from (Long Term Care Facility) after he went down. Patient was eating dinner when he suddenly choked on his food. Patient was supposed to be eating a pureed diet but had solid food. He went down, lost pulses and CPR was started. EMS attempted to intubate however there was a food bolus passed the vocal cords they were unable to remove. I gel (airway device used to manage airway during resuscitation or anesthesia) was placed. They continued CPR and did get return of spontaneous circulation at 1 point. Estimated downtime of approximately 40-45 minutes. They did give 4 rounds of epinephrine .75 yo male with cardiac arrest due to acute airway obstruction after aspirating (inhalation of a foreign object into the lungs) on a piece of cauliflower. Downtime at least 40 minutes. Neurologic assessment unable to be obtained due to severe shock and hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). Chest imaging with evidence of severe aspiration pneumonitis. Bronchoscopy (procedure that allows the doctor to examine the inside of the lungs, trachea, and bronchi using a thin, lighted tube called a bronchoscope) done at bedside with pulmonary hemorrhage, presuming due to trauma from CPR done while aspirated food content was lodged in airway. Etiology (cause or manner for a disease or condition) of shock likely due to severe acute lung injury and impending ARDS (acute respiratory distress syndrome). Review of policy, .Resident Meal Service reviewed/revised on 01/01/2022, revealed, .Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance .2. Nursing personnel will ensure that residents ware served the correct food tray .3. Prior to service the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident. IF there is doubt, the nurse supervisor will check the written physician's order . Review of policy, Tray Identification reviewed/revised on 01/01/2022, revealed, .3. Nursing staff shall check each food tray for the correct diet before serving the residents . The immediate jeopardy that began on 12/3/24 was removed on 1/6/25 when the facility took the following actions to remove the immediacy: On December 3,2024, the facility identified that a resident was given a regular diet instead of his ordered puree honey thick liquid diet. The resident began choking and ultimately requiring CPR. The facility identified that the CENA in orientation did not have her preceptor with her and did not know how to identify residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On December 3, 2024, the Director of Nursing and/or designee began education of facility staff on providing accurate diet, not providing care without preceptor/Nurse in attendance until relieved from Orientation, and that preceptors will not leave or allow new employees to provide care until they are deemed competent to provide care without preceptor. Staff were also educated on utilizing the kiosk when needing to identify residents. NHA and DON were educated on 12/4/24 on orientation process and preceptor expectations as well as the policy for orientation. On 12/5/24 the facility implemented resident diet info binders to include diet terminology conversion, pictures of diets and allowable foods for texture, resident pictures who have altered diets. The facility implemented re-education on January 6, 2025, upon identification that staff were unable to verbalize use of resident diet info binders. The facility has 15 Licensed Nurses and 27 C.E.N.A.'s ·As of January 6, 2025, the facility had educated 6 of the 15 Licensed Nurses and 14 of the 27 C.E.N. A/s. ·Any staff not educated at the time would not be permitted to work a shift until education had been completed. ·The facility Medical Director was notified on January 6, 2025, at 1:55pm. ·The Director of Nursing and/or designee completed an audit on all residents with an altered diets to ensure orders are entered correctly and match the binders. This audit for accuracy was completed on January 6,2025 and no concerns notes. The QAPI committee has reviewed the Orientation policy, therapeutic diet orders and ADLs and has deemed them appropriate 1/6/25. The facility had an Ad hoc QAPI meeting including the Medical Director (via phone) on January 6,2025 and deemed this removal plan appropriate. The Administrator and Director of Nursing are responsible for continued compliance.