Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 12, 2026

Administrator
MINNEWASKA COMMUNITY HEALTH SERVICES
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

RE: CCN: 245537
Cycle Start Date: September 22, 2026

Dear Administrator:

On October 13, 2026, we notified you a remedy was imposed. On November 5, 2026 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 30, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 28, 2026, be discontinued as of October 30, 2026 (42 CFR 488.417 (b)).

In our letter of October 13, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 28, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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November 12, 2026

Administrator
MINNEWASKA COMMUNITY HEALTH SERVICES
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

Re: Reinspection Results
Event ID: 3448AD-H2

Dear Administrator:

On November 5, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 22, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

October 13, 2026

Administrator
MINNEWASKA COMMUNITY HEALTH SERVICES
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

RE: CCN: 328542100

Cycle Start Date: September 22, 2026

Dear Administrator:

On September 22, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 22, 2026, the situation of immediate jeopardy to potential health and safety cited at F803 - Menus Meet Resident Nds/Prep in Adv/Followed was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 28, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 28, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 28, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, MINNEWASKA COMMUNITY HEALTH SERVICES will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of

compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated byMarch 22, 2027, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice.
A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver

along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

October 13, 2026

Administrator
MINNEWASKA COMMUNITY HEALTH SERVICES
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: 3448AD-H1

Dear Administrator:

The above facility survey was completed on September 22, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction

Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/ rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381

(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
F0000	INITIAL COMMENTS On 9/15/26, through 9/18/26, and 9/22/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed. H55374128C (3190421) with a deficiency issued at F803. As a result of the investigation, deficiencies were issued at F610, F802. The survey resulted in an Immediate Jeopardy (IJ) at F803 when the facility failed to ensure R1 was free from choking on 9/6/26, during a meal an ordered modified diet was not followed. The IJ began on 9/6/26, and the immediacy was removed on 9/22/26 at 3:15 p.m. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		10/14/2026
F0803 SS = K	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F0803	F0803, Menus Meet Resident Needs / Prepared in Advance / Followed 1. Corrective Action for Residents Affected and Other Residents Immediate dietary hold-and-verify process was initiated for all residents with modified diets, including R2-R5. The incorrect meal service process was stopped immediately. Nursing and dietary staff were instructed to verify all meals against the resident’s current diet order, IDDSI level, and liquid	10/23/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381

(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
F0803 SS = K	Continued from page 1 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: During observation, document review, and interview, the facility failed to ensure residents' ordered diets were followed for 5 of 5 residents (R1, R2, R3, R4, and R5) reviewed who had an order for a modified diet. This resulted in R1 choking during a meal then required staff intervention, emergency medical services (EMS) intervention and evaluation at the hospital where R1 later died. The immediate jeopardy began on 9/6/26, when the facility failed to ensure R1 was served an International Dysphagia Diet Standardization Initiative (IDDSI) (a global standard that provide common terminology and testing method for texture-modified foods and thicken liquids) level-6 soft and bit sized (foods are soft, tender and moist pieces no larger than 1.5 centimeters by 1.5 centimeters, designed for people who can chew but cannot safely bite off larger pieces) diet. R1 was served and ate lasagna roll ups, pasta salad with uncooked vegetables and garlic toast, foods contraindicated for her physician-ordered diet. R1 choked during the meal, staff performed the Heimlich maneuver and called emergency services (EMS). R1 died at the hospital. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/18/26 at 5:45 p.m. The immediacy was removed on 9/22/26, at 3:15 p.m. but noncompliance remained at the	F0803	Continued from page 1 consistency before tray delivery. The care plan and physician/SLP diet orders for each affected resident were reviewed and reconciled. All residents remaining in the facility who required modified textures or thickened liquids were assessed for immediate safety concerns, and their meal service was corrected before the next meals. 2. Systemic Changes The facility implemented a dietary order reconciliation process that entails all new or changed diet orders must be reconciled across the EMR, diet card, and care plan before the next meal service. A two-step tray verification process was established for all modified diets wherein dietary staff verify tray contents against the diet ticket. Diet cards must be updated immediately upon and reviewed each shift for residents on modified diets. IDDSI Education provided to Dietary Staff, Activities Staff and Nursing Staff. Residents requiring modified diets are to receive meals only after confirmation of correct texture, consistency, and approved substitutions. Residents who have the ability to make informed decisions will not be prohibited from exercising their rights solely because their food choice is inconsistent with a recommended or ordered diet. When a resident chooses to consume food inconsistent with the recommended diet, the Director of Nursing or designee will provide education regarding the purpose of the recommended diet, the potential risks associated with consuming foods outside the recommended diet, the potential benefits of following the recommended diet, and available alternatives. The resident's understanding and decision will be documented in the medical record. Risk v. Benefit documentation will be completed according to facility policy. The interdisciplinary team will be notified, and the resident's comprehensive care plan will be reviewed and revised to reflect the resident's preferences, informed choice, identified risks, and individualized interventions. Dietary communication tools, including diet cards, will be updated to ensure all appropriate staff have accurate information regarding both the resident's ordered diet and individualized plan. The IDT team will periodically reevaluate the resident and will reassess the plan when there is a significant change in condition, swallowing ability, cognition, diet order, or expressed preference. 3. Monitoring and Quality Assurance The Regional Food Services Director or designee will	10/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381

(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
F0803 SS = K	Continued from page 2 lower scope and severity level E (pattern, scope and severity level) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Vulnerable Adult Report dated 9/8/26 at 1:01 p.m., identified on 9/6/26 at 6:35 p.m., R1 was seen struggling to breathe in dining room. Nurse started Heimlich maneuver immediately, food was small and bite sized per care plan, police and emergency medical system (EMS) were contacted immediately. R1 was transported to emergency room (ER) and pronounced deceased at the hospital. Description of physical injury or pain: death by choking. Facility 5-day report dated 9/12/26 at 5:33 p.m., identified on 9/6/26, the facility licensed practical nurse (LPN)-A noticed R1 had trouble breathing, started the Heimlich maneuver, and directed the other LPN to call the police at 6:34 p.m. Police officer (PO) arrived at facility at 6:35 p.m., the ambulance arrived at 6:37 p.m., and transferred R1 to the hospital, who was pronounced dead at 6:50 p.m. It was confirmed with the cook on duty, at the time of the incident the meal served was correct for the R1's diet orders and the care plan was followed. No allegation was verified. The facility found R1's airway was obstructed during mealtimes, staff acted quickly to intervene, and the meal was appropriately served per her care plan. A routine random audit was implemented meals served were correct per the IDDSI framework to ensure they continued to follow diet orders correctly as they did with this incident. No systemic changes other than ongoing routine random International IDDSI audits. R1 R1's quarterly Minimum Data Set (MDS) dated 8/12/26, indicated R1 had moderately impaired cognition and no behaviors. She required set up or clean-up assistance with eating. R1's diagnoses included non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), and dysphagia. R1's diet was a mechanically altered diet and required change in texture of food or liquids (e.g., pureed food, thickened liquids) and received speech-language pathology services. R1's provider orders signed on 9/9/26, identified regular diet IDDSI level 6 – Soft and bite sized	F0803	Continued from page 2 perform daily audits of one meal per day of all modified diet trays for 30 days and then weekly for 60 days and reviewed by QAPI. Audit findings will include correct resident tray identification, correct texture level, correct liquid consistency, correct substitutions, and presence of current diet order documentation. Any variance will be corrected immediately, reported to leadership, and tracked for trend analysis. Findings will be reported to the Quality Assurance and Performance Improvement committee for review and action. 5. Training and Education All nursing, dietary, and activities staff will be educated prior to their next shift regarding identification of altered/modified diet orders, the responsibility to provide residents with food consistent with the ordered diet and individualized care plan, recognition of situations in which a resident is independently obtaining food outside of the recommended diet and updating nursing, communication with dietary and the interdisciplinary team & New hires will receive this education during orientation. 6. Completion Date: 10/23/26	10/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEWASKA COMMUNITY HEALTH SERVICES	**605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381**

(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
F0803 SS = K	Continued from page 3 texture, IDDSI level 2 liquids – mildly thick (nectar) consistency, no straws per therapy. Date initiated: 4/11/26. R1's care plan dated 11/12/25, identified: at risk for imbalanced nutrition related to gastro-esophageal reflux (GERD) (a chronic condition where stomach and acid frequently flows back into the tube connecting your mouth and stomach, irritating the lining), hypoosmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low sodium). Interventions included R1's diet will be provided as prescribed by provider. Staff were directed to encourage healthy choices and fluid intake without straws. R1's Speech Language Pathologist (SLP) evaluation and plan of treatment dated 6/17/26, identified diagnoses pneumonia and dysphagia. Plan of treatment included treatment of swallowing dysfunction and/or function for feeding and evaluation of oral and pharyngeal swallow function three to four times a week for eight weeks. R1 was unable to follow directions to complete a pharyngeal exercise (designated to strengthen the muscles involved in swallowing and improving the coordination and effectiveness of swallowing process). R1 required moderate to maximal cues to consume diet safely as she demonstrated rapid rate and pocketing of food. Mildly thickened liquids and soft and bit sized diet currently. Goals: increase R1's ability to consume least restrictive diet without signs and symptoms of aspiration and least amount of supervision needed. Initial assessment/current level of function and underlying impairments identified IDDIS drinks: mildly thick drinks. IDDSI foods: soft/bite sized food level 6. R1 required supervision at mealtime prior to onset and during the assessment 50 to 75% of the time. R1's progress notes dated 9/6/26, indicated: At 6:38 p.m., this nurse went to give resident her scheduled medications at the dining room table and noted that resident's dentures had fallen out and resident appeared to be choking. Heimlich maneuver immediately started, and ambulance called. Resident continued to struggle to breathe. All nursing staff assisted. Police here and assisting. Ambulance is currently here and transferred to local hospital. At 7:01 p.m., local hospital ER nurse called and reported R1 had passed. Director of nursing notified	F0803		10/23/2026

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F0803 SS = K	Continued from page 4 and R1's son and both daughters were called, no answer. Message left with both daughters to call facility as soon as possible. Police department incident report dated 9/6/26 at 6:32 p.m., indicated assigned at 6:34 p.m., arrived at 6:35 p.m., and last cleared at 7:05 p.m. Short description: dining room/person choking, cardiac pulmonary resuscitation (CPR) in progress, taken to local hospital, deceased. Assisted ambulance with medical and CPR in route to hospital. R1's EMS ambulance report incident date/time: 9/6/26 at 6:34 p.m. Call type: choking. Response mode: emergent (immediate response). Arrived on scene at 6:37 p.m. Narrative: we were dispatched to the local nursing home for a 96-year-old female choking. When arrived on scene police department (PD) was already on scene, with patient whose staff had moved to the outside entrance in a wheelchair. They were performing the Heimlich maneuver. Mental/neurological/status identified as unresponsive and left/right side weakness. We quickly exited the ambulance and grabbed the Life Vac (an anti-choking device designed to provide an airway clearance solution as a second line of treatment during choking emergencies). Multiple attempts were made to dislodge the blockage with no success of air movement. We moved the patient to the stretcher where she was placed in supine (lying flat on back with face and torso facing upward) secured and prepped to transport. Upon initial exam, patient was unresponsive, apneic (a temporary state when a person stops breathing or experience a complete cessation of airflow), still had no color in her face and lips, and brownish material was on her face and clothing. PD assisted in the back of the ambulance while enroute to the hospital. As we went enroute, a few more attempts were made with the Life Vac and were unsuccessful. A bag-valve-mask (BVM) (often called an Ambu bag or manual resuscitator, handheld medical device used to deliver positive pressure ventilation to patients not breathing or are breathing inadequately) was attempted to try and get some air movement also with no success. A king airway (a disposable supraglottic/above the vocal cords airway used in emergency to maintain an open airway to provide ventilation) was attempted with no success. Automated external defibrillator (AED) pads were placed and analyzed patient, a rhythm was present and AED stated no shock advised. Attempts with the King, BVM, and Life-Vac were continued without success until AED said to start cardiopulmonary resuscitation (CPR). Manual CPR was started and continued for a couple of minutes until arrival at	F0803		10/23/2026

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F0803 SS = K	Continued from page 5 hospital. Upon arrival patient care and report was transferred to the emergency room (ER) registered nurse (RN). R1's E-Care Emergency code blue flow sheet dated 9/6/26 at 6:46 p.m., identified at 6:47 p.m. [R1] arrived via EMS, provider at bedside. Compressions are not being performed. At 6:49 p.m., bedside nurse suctioned airway. At 6:50 p.m., bedside staff verified do not resuscitate (DNR) on file. Bedside staff provide checking for cardiac activity with ultrasound. Time of death 6:50 p.m. Emergency Department Note dated 9/6/26, identified patient presented via basic life support (BLS), EMS, with CPR in progress believed to be the result of complete airway obstruction (choking). EMS reported patient sitting at the dinner table when she suddenly started choking. Exactly what led staff and bystanders to believe she was choking is unclear. On their arrival patient was apneic and pulseless. No shock was advised on her AED. They did attempt to ventilate with BVM and were unable to achieve any chest rise or air entry. They did attempt to pass a King laryngeal tube (LT) (to secure an open airway) without success. CPR was initiated and transported to hospital. On arrival, the patient was unconscious, with no respiratory effort or pulse. Chart review finds the patient was admitted to the hospital one time, less than six weeks ago, her code status was ordered as DNR/DNI (do not resuscitate/do not intubate) but no advance directives were in her chart. Confirmation with skilled nursing facility (SNF) code status was DNR/DNI. Bedside echocardiogram showed most faint cardiac activity that is perceptible, but clearly not enough to be perfusing. Given that she is apneic with an airway occlusion and non-perfusing cardiac activity, there was no way to attempt resuscitation without further CPR and advanced airway management which would violate her advance directives. Even if cardiac activity could be restored the likelihood that she would avoid severe anoxic brain injury (severe medical emergency caused by a complete loss of oxygen to the brain, with brain cells beginning to die after about four minutes of deprivation) given her period of apnea had been at least 20 minutes is essentially zero. The provider believed the best possible outcome of resuscitation would be likely a permanent vegetative state. After brief discussion amongst staff in room, we all agree that resuscitation efforts would be discontinued. Time of death was pronounced at 6:50 p.m. on 9/6/26. R1's Death Certificate identified:	F0803		10/23/2026

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F0803 SS = K	Continued from page 6 Date and place of death 9/6/26 at 6:50 p.m. at nursing home/long term care. Cause of death: Immediate cause (final disease or condition resulting in death): Cardiac arrest. Condition that led to the immediate cause: Respiratory arrest. Underlying cause (disease or injury that initiated events resulting in death): Upper airway obstruction. Facility menu for 9/6/26, evening meal: Lasagna roll up, toss salad/dressing, garlic toast, peaches, and milk. Mealtime supper/dinner 6:00 p.m. A list of ingredients for Summer Pasta Salad undated, provided by dietary director, included pasta, mayonnaise, lemon juice, sugar, carrots, cucumbers, onions, green and red peppers. A picture of the salad was also provided and identified colored (green, orange, and ivory) spiral noodles and slivered carrots with a creamy sauce over the top. Nursing assistant (NA) task list documentation for 9/6/26, at 9:04 p.m. percentage of R1's meal eaten was 0 to 25%. A handwritten and signed statement dated 9/9/26, identified cook (C)-A, was the cook on duty 9/6/26 from 11:00 a.m. through 7:30 p.m. "I cooked lasagna roll-ups, garlic bread and a salad. I prepared everything to [R1's] specific diet as it should have been." An undated handwritten statement signed by NA-A identified "I cleared [R1's] plate on Sunday, 9/6/26 (meal or time of day was not identified) and the bread was not eaten at all." A handwritten and signed statement dated 9/6/26 at 6:38 p.m., identified NA-G was in dining room assisting with feeding supper and saw a staff nurse running and called 911. "[R1] was choking on meat. The Heimlich maneuver was done by two different people, but only a small piece of meat came out. [R1] was moved to another hallway, police officer (PO) arrived, then paramedics, [R1] was placed on gurney and left in ambulance."	F0803		10/23/2026

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F0803 SS = K	Continued from page 7 A handwritten and unsigned statement dated 9/6/26 at 7:00 p.m., indicated unidentified staff, “went to [R1’s] dining room table, upper dentures had fallen out, and [writer] placed them back in. It was noticed [R1] was having difficulties breathing and color started to turn bluish. Heimlich maneuver was immediately started. Staff called 9-1-1. [R1] was removed from dining room, police arrived, [writer] told staff to get [R1] to front doors. This nurse came back to dining room and started charting.” A typed statement dated 9/6/26, identified at 7:01 p.m., “Administrator received a call from DON (director of nursing). He was informed [R1] had an airway obstruction during dinner, police and ambulance called and [R1] passed away at local hospital. At 7:08 p.m., administrator called facility and spoke with LPN who detailed what had happened. At 6:34 p.m., LPN noted [R1’s] dentures had fallen out, went over and helped, noticed she was having a hard time breathing, started Heimlich maneuver and directed staff LPN to call ambulance at 6:34 p.m., NA took over Heimlich maneuver. At 6:35 p.m. police arrived, moved [R1] to front door. At 6:37 p.m., ambulance arrived, transferred to gurney and left in ambulance with EMS. LPN verified the prepared meal of lasagna was small and bite sized.” R2 R2’s comprehensive MDS dated 7/4/26, identified R2 had intact cognition without behaviors. R2 was independent with eating. R2’s diagnoses included GERD. Mechanically altered diet was not identified on the MDS. R2’s provider order signed on 8/20/26, identified: Regular diet. IDDSI Level 5 – Minced and moist texture (soft, moist foods with small lumps no larger than 4 millimeters that require minimal chewing and can be mashed with the tongue. Foods must hold their shape and be scoopable). Regular/Thin consistency, bit sized pieces, extra gravy, double protein. Order start date 8/5/26. R2’s care plan dated 8/6/26, identified: Activities of daily living (ADLs) self-care performance deficit related to ataxia (a neurological condition: poor muscle control that leads to uncoordinated movements, affecting balance, speech and motor skills), stroke, legal blindness, and weakness. Date initiated: 6/7/23. Revised: 6/15/25. Staff were directed to provide milkshakes or liquid food supplements when [R2] refused or had difficulty	F0803		10/23/2026

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F0803 SS = K	Continued from page 8 with solid food. Provide nutritious food that can be taken from a cup or mug where appropriate. [R2] was able to eat independently after set-up. Date initiated: 6/7/23. Dietary: had the potential for nutritional problems including weight loss related to GERD. Date initiated: 4/26/23. Dated revised: 10/9/23. Staff were directed to serve diet as ordered. Monitor intake and record every meal. Date initiated: 4/26/23. Date revised: 9/16/26. Registered dietician (RD) to evaluate and make diet change recommendations. Date initiated: 4/26/23. R2's Kardex dated 9/18/26, identified Special instructions: pills whole. monitor/record/report loss of appetite, refusal to eat, and weight loss. Eating/Nutrition: independently after set-up. Provide milkshakes or liquid food supplements when R2 refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or mug where appropriate R2's Diet Card identified diet: minced/moist, level 5 IDDSI, liquid level thin, and no bread. R3 R3's comprehensive MDS dated 6/29/26, identified R3 had intact cognition without behaviors. R3 required set-up or clean-up assistance for meals. R3 's diagnoses included diabetes mellitus (DM), and multiple sclerosis (MS). R3 received a mechanically altered diet, required change in texture of food or liquids (e.g. pureed food, thickened liquids). R3's provider order signed on 8/6/26, identified: Regular diet. Mechanical soft texture, regular thin consistency. Extra gravy/sauce for all meats. Small bites/sips. Regular meat texture. Order start date 9/18/23. Speech Therapy Swallow. Order date: 7/10/26. R3's care plan dated 9/11/26, identified: Impaired ability to perform activities of daily living related to diagnoses MS, spastic quadriplegia (most severe form of spastic cerebral palsy, affecting all	F0803		10/23/2026

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F0803 SS = K	Continued from page 9 four limbs, the trunk and often the face), and diabetes mellitus (DM). Date initiated: 2/1/24. Date revised: 6/25/26. Eating set up assist. Revised 4/27/26. Dietary: had the potential for nutritional problems due to dysphagia, MS, and paraplegia. Date initiated: 6/15/23. Dated revised: 11/15/24. Staff were directed to provide adequate equipment for feeding as needed, provide and serve diet as ordered. Monitor intake and record every meal. Date initiated: 6/15/23. Registered dietician to evaluate and make diet change recommendations as needed (PRN). Date: initiated 6/15/23. R3's Kardex dated 9/18/26, identified Eating /Nutrition: eating set-up assist. R3's Speech Language Pathologist evaluation and plan of treatment dated 7/14/26, identified diagnoses multiple sclerosis, DM, and dysphagia. R3 was known to the speech therapy department, was seen during bouts of speech therapy to determine appropriate diet textures with history of dysphagia related to multiple sclerosis (MS). R3 was observed coughing during meal(s) on two separate occasions. Plan of treatment recommended one time a week daily. Recommended liquid and diet for R3 to swallow safely was thin liquid (no modifications) and soft and bit sized food. Assessment of swallowing identified R3 required supervision/assistance at mealtime due to swallow safety 0 to 25% of the time. R3's Diet Card identified diet: minced/moist IDDSI level 5, liquid thin, no bread, hi-low scoop plate. During observation on 9/18/26 at 6:34 p.m., R3 sat in her recliner, alone in her room, with a cloth protector across her chest with approximately ½ of bun sandwich with sliced meat and cheese resting on the cloth protector. There was a plastic container, unopened, of grape tomatoes resting on R3's right thigh. R3 stated she just couldn't eat the food they gave to her for supper, so she went over to the grocery store, in her electric wheelchair, and bought the sandwich and tomatoes. R3 stated she had already eaten ½ of the sandwich and was not aware she was not supposed to eat bread. R3 verified there was sliced cold sandwich meat and a piece of cheese in between the bun. R3 stated she ate bread with all her meals (diet order: minced and moist IDDSI level 5, regular thing fluids, extra gravy/sauce for all meats. Small bites/sips, regular meat textures, no bread).	F0803		10/23/2026

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F0803 SS = K	Continued from page 10 R4 R4's quarterly MDS dated 7/13/26, indicated R4 had moderately impaired cognition and poor decision making. R4 was independent with eating. R4's diagnoses included non-Alzheimer's Dementia, traumatic brain injury, no mechanical diet was identified. R4 received speech-language pathology and audiology services. R4's hospital discharge orders dated 6/26/26, identified diet: bite size and soft and ensure plus or high protein. R4's provider order signed on 9/10/26, identified: Regular diet. IDDSI Level 6 – soft and bite sized texture. Regular/thin consistency, soft diet, ground meats, thin liquids. Order start date: 6/26/26. Speech therapy to evaluate and treat swallow. Order date: 6/17/26. R4's Speech Language Pathologist evaluation plan of treatment dated 6/29/26, identified diagnoses dementia, sequelae (the long-term or lasting medical conditions and physical or cognitive deficits that remain after a person has an ischemic stroke) of cerebral infarction (stroke), and cognitive communication deficit. Treatment was recommended for cognitive skills development such as speech, language, voice, communication, and/or auditory processing two to three times a week for 12 weeks. There was no mention about diet and swallowing difficulties. R4's care plan dated 7/9/26, identified: Activities of daily living self-care deficit related to traumatic subdural hemorrhage, stroke, mild protein-calorie malnutrition, dysphagia, and weakness. Date initiated 10/6/23. Date revised: 11/14/23. [R4] was independent with eating after setup. Revised date: 7/21/25. R4's Kardex dated 9/18/26, identified Special instructions: medications, crush in pudding. Diet: eating/nutrition – independent after set-up.	F0803		10/23/2026

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F0803 SS = K	Continued from page 11 R4's Diet Card identified diet: soft/bite sized texture, regular thin liquids, level 6 IDDSI food level, no bread, and hi-low scoop plate. R5 R5's quarterly MDS dated 6/22/26, indicated R5 had severely impaired cognition. R5 required set-up or clean-up assistance for eating. R5's diagnoses included non-Alzheimer's Dementia, anxiety, and respiratory failure. R5 required a mechanically altered diet and change in texture of food or liquids (e.g., pureed food, thickened liquids). Received speech-language pathology and audiology services. R5's Hospital Discharge Summary dated 5/14/26, identified discharge diagnosis: aspiration pneumonia of right lower lobe, unspecified aspiration pneumonia type. [R5] has had chronic intermittent aspiration pneumonia. Speech therapy consulted with [R5] for bedside evaluation. Diet changed after speech evaluation: mildly thicken liquids were recommended to prevent recurrent aspiration. R5's provider signed orders on 9/10/26, identified: Regular diet IDDSI Level 6 – soft and bite sized texture. IDDSI level 2 liquids– mildly thick (nectar) consistency. No straws, double protein with meals. Order start date: 8/5/26. R5's Speech Language Pathologist evaluation plan of treatment dated 6/3/26, identified diagnoses pneumonia due to inhalation of food and vomit and dysphagia. Assessment identified laryngeal (larynx (voice box)/pharyngeal (pharynx- the muscular throat region) performance impaired. Recommended liquid and diet for the patient to swallow safely: soft and bite-sized and mildly thick liquids. R5 required supervision/assistance at mealtime due swallow safety 50 to 75% of the time. The treatment plan recommended for swallowing dysfunction and/or oral function for feeding two to three times a week for eight weeks. R5's care plan dated 8/28/26, identified: ADL self-care performance deficit related to chronic obstructive pulmonary disease (COPD), cognitive/communication deficit, dementia, anxiety, and stroke. Revised on: 9/5/25. Staff were directed to provide set-up and assist of one for eating. Revised on 6/28/26.	F0803		10/23/2026

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F0803 SS = K	Continued from page 12 At risk for imbalanced nutrition. Dated initiated: 8/28/25. Date revised: 2/2/26. Staff were directed to provide diet as prescribed by provider, encourage fluids. Monitor weight routinely and PRN. Date initiated: 8/28/25. Family frequently brought in straws to [R5] despite staff education provided to family. Date initiated: 3/4/26. R5's Kardex dated 9/18/26, special instructions: medications whole in applesauce, mildly thick (nectar) consistency. Eating/Nutrition built up angled utensils. Eating: set-up assist of one. Encourage healthy choices. R5's Diet Card identified diet: Soft bite-sized, liquid level mildly thick, no bread, no straws. Level 6 IDDSI food level. During interview on 9/17/26 on11:53 p.m., R5 stated he was on a soft and bite sized diet and had to have his liquids thickened. R5 stated he received whole pieces of meat for meals and had to ask staff to cut it up for him. R5 stated he received raw vegetables many times, "I ate them and it went ok." R5 stated he received toast with the crust on it most mornings for breakfast and it was occasionally cut up into smaller pieces. R5 stated he had received lettuce about one week ago and one other time (unable to remember how long ago), "I choked on it a little bit, but it did go down ok. It just made me cough." Facility dietary Anytime Menu dated 1/31/25, identified alternative food list: Peanut Butter and Jelly Sandwich Cold Cereal Fruit Cup Pudding Cup/Jello Cup Chicken Broth/Beef Broth Celery and Carrot sticks with ranch Cheese Sandwich (grilled or cold) *available until	F0803		10/23/2026

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F0803 SS = K	Continued from page 13 6:00 p.m. Lettuce Salad *available until 6:00 p.m. Chicken noodle soup *available until 6:00 p.m. Vegetable Beef Noodle Soup *available until 6:00 p.m. Tomato Soup *available until 6:00 p.m. The Anytime Menu did not indicate which diet(s) the alternative food(s) would be appropriate for. Facility menu for 9/15/26, dinner/lunch (12:00 p.m.) indicated: Lemon garlic pork loin Pasta alfredo Broccoli Garlic toast Blueberry dessert Milk. Mealtime During observation on 9/15/26 at 12:05 p.m., dishing food from the serving table onto plates was completed by dietary aide (DA)-A with plates of food delivered by DA-B. DA-A stated the pureed meals would be served first. The regional food service director (FSD) stood off to the side with a clip board observing the meal service and did not intervene when meal cards were not used and/or referenced by DA-A and DA-B. At 12:14 p.m., DA-A cut up pork loin into bite-sized pieces and placed them on a plate with meat juice poured over the top, noodles, broccoli, and a slice of garlic toast with crust for R2 (diet order: minced/moist, bite sized pieces extra gravy, IDDSI level 5, and double protein). The same items were dished up for R3 (diet order: minced/moist, extra gravy/sauce for all meats, small bites/sips, IDDSI level 5, and regular meat textures),	F0803		10/23/2026

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F0803 SS = K	Continued from page 14 and R4 (diet order: soft bite sized texture, IDDSI level 6, regular/thin consistency). During interview on 9/15/26 at 2:13 p.m., DA-B stated dietary staff were expected to use the diet cards when they prepared and served the meals to the residents to ensure the correct diet and restrictions were provided to each resident. DA-B stated there were some residents who had a hard time chewing and required special foods and/or textures, “We do not want any resident choking or getting hurt because they were served the wrong diet.” DA-B stated before lunch was served today, “The [DS] reminded me the diet cards should be implemented and used with every meal served so that every meal is double checked to make sure all residents received the right foods.” DA-B stated she did not use the diet cards today when she served lunch to the residents because she usually went off memory and was confident all residents received the right meal. DA-B stated she understood if a resident received the wrong diet and/or food consistency, “The resident may not swallow properly and could choke. I should have used the diet cards.” DA-B stated, “Today after we served lunch, was the first time it was brought to my attention to use diet cards.” No education was provided to DA-B since the incident with R1 on 9/6/26, regarding preventing choking or providing the correct diet and food consistency. During interview on 9/15/26 at 3:09 p.m., DA-A stated dietary staff were expected to use the dietary cards when serving meals. DA-A stated she did not use the dietary cards today and relied on her memory. “I should have used the cards because if I gave the wrong foods to a resident, especially pureed or minced and moist meat, they could choke and I would get into trouble. I had too much going on today, I got distracted. I tried to get back on track, had to focus on what I was giving the residents when food was dished up. My memory is good and I had to stay focused and pay attention to what I was doing.” DA-A stated on 9/6/26, C-A dished up R1’s meal and DA-A served R1 the plate of food. DA-A stated R1 was served lasagna, garlic bread, peaches and was unsure if R1 got lettuce or another salad. R1’s diet was small soft bite/sized diet with thicken liquids. DA-A stated when she started to clean up the dining room, she noticed the nurse doing the Heimlich maneuver on R1. DA-A was unsure how much R1 had eaten. DA-A stated the garlic bread was soft and not cut up. Usually, when a diet order indicated small pieces, “We cut it up but R1’s was not.” DA-A stated she was unsure if R1 ate the garlic bread or had taken bites of it.	F0803		10/23/2026

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F0803 SS = K	Continued from page 15 DA-A stated she was not interviewed after R1's incident on 9/6/26. During interview on 9/15/26 at 3:57 p.m. the dietary supervisor (DS) stated all dietary staff were expected to use the diet cards when meals were served to make sure the diet order had not changed, avoid allergies, ensure residents received foods they enjoyed, and safely consumed nutrients. DS stated mildly thick (nectar) liquids and soft diet /small bites usually prescribed for those residents that had swallowing/dental/chewing issues. DS stated dietary staff had direct access to the electronic medical records on the computer to ensure they were able to serve meals to the residents safely. DS stated R1 should have been discouraged from having garlic bread. Dietary staff were not allowed to make changes to a resident's diet. Changes to diets had to be pre-approved by therapy first. DS stated the IDDSI framework discouraged bread from being given and all diet orders should be followed. DS stated giving R1 garlic toast would have increased her risk for choking and did not follow R1's diet order. DS stated she was not interviewed regarding R1's choking incident. DS talked to DA-A and DA-B prior to lunch being served today and reminded them to use the dietary cards. DS stated dietary cards should be double checked when serving a meal to make sure each resident received their ordered diet, their ordered food and drink consistency and to prevent choking. During interview on 9/15/26 at 5:30 p.m., LPN-A stated on 9/6/26 she walked over to R1's table, leaned over and noticed R1 was struggling to breathe. LPN-A stated she immediately did the Heimlich maneuver and instructed LPN-B to call 9-1-1. R1 was still alert but unable to talk. LPN-A removed R1 from the dining room and a police officer arrived. The police officer assessed R1 for a carotid pulse (found in the neck). No pulse or verbal response was noted so R1 was brought to the front of the building. LPN-A stated one of the NA's said they saw a small piece of lasagna came out of R1's mouth and remembered R1 had just set the fork down. LPN-A did not recall what food was on R1's plate. LPN-A stated she called the hospital to let them know R1 was coming. EMS showed up and left with R1. The hospital called and asked if R1 had a DNR, that is when the hospital informed LPN-A, R1 had passed away. Facility menu for 9/16/26, breakfast (8:00 a.m.) included:	F0803		10/23/2026

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F0803 SS = K	Continued from page 16 Choice of juice Cereal Scrambled egg with ham Toast Margarine/jelly Milk During observation on 9/16/26 at 8:40 a.m., the breakfast meal had already been served in the dining room. R4 had already left the dining room. NA-C verified R4's breakfast plate remained on the table with 15 small, bite sized pieces of toast, a small pile of scrambled eggs and approximately ½ a bowl of cream of wheat. At 8:43 a.m., R3 sat at the dining room table. R3 had just finished eating her breakfast and left the dining room. On her plate there were nine pieces of bite sized toast. At 8:53 a.m., R5 sat at a dining room table drinking his coffee. His breakfast plate had a small pile of scrambled eggs and pieces of meat, cream of wheat on edges of bowl, and two bite sized pieces of toast (diet order: soft bite-sized, IDDSI level 6, mildly thick (nectar) IDDSI level 2, no straws). During interview on 9/16/26 at 12:53 p.m., LPN-B stated on 9/6/26, during supper, LPN-A was trying to get her attention in the dining room. R1 was not breathing well, her face and lips were turning blue, she was still able to make eye contact but no verbal response and Heimlich maneuver was being done by LPN-A. LPN-B called 9-1-1, informed them there was a resident in the dining room choking, and the Heimlich maneuver was attempted without success. LPN-B waited by the front door, within one minute PO arrived and shortly after that EMS arrived. R1 was brought up to the front door in her wheelchair, and LPN-B assisted EMS with a transfer to the gurney. LPN-B did not remember looking at R1's plate on the table. LPN-B submitted a written statement to the administrator but was not interviewed. LPN-B stated she did not receive education regarding diets, choking or meal service after the incident on 9/6/26. An interview and education would have been important to make sure staff provided food according to the ordered diet.	F0803		10/23/2026

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F0803 SS = K	Continued from page 17 During interview on 9/16/26 at 1:56 p.m., registered dietician (RD) stated she reviewed the resident diets monthly and looked at high risk weight loss, tube feedings, and dialysis. The dietary staff would be expected to provide the proper meal for each resident according to their ordered diet. Dietary staff had a system they should follow which included referencing the residents' names and diet order. RD stated it was important for dietary staff to make sure each resident received the ordered diet due to allergies, weight problems, chewing/swallowing concerns, and requirements for adequate portions. During interview on 9/16/26 at 3:00 p.m. C-A stated he did not use diet cards because he knew what each residents' ordered diet, and what foods they were to receive. If C-A had questions, he would check the paper documents with pictures of the tables with the resident name and type of diet listed on it or the diet cards. C-A stated, "Once we know the resident's diet, [dietary staff] do not have to use the diet cards. The diet cards are there for those staff that are not sure of which diet to serve each resident." C-A stated staff were expected to serve each resident the correct ordered diet to avoid a resident from receiving the wrong diet/food or consistency. If the proper diet was not served, it placed the residents at risk for choking. C-A stated, "If the dietary staff served the wrong diet to a resident, hopefully one of the nursing staff sitting at the table would catch it. If not, it would not be good." C-A stated he did not use the diet cards on 9/6/26, when he served R1 her supper. "I went off memory. I pretty much knew what [R1's] diet was and which foods to give her." C-A stated when he served R1's supper on 9/6/26, she received lasagna noodle roll up, with cheese and plain tomato sauce baked in the oven, and garlic bread that was minced and moist. "I chopped it up and added a little bit of water, so basically wet breadcrumbs. The crust was left on the garlic toast, I placed it in the blender and added water then put the contents on her plate to serve it to her. The garlic toast had some chunks in it and was okay for a soft diet. [R1] got pasta salad, it was not pureed. The food [R1] received was appropriate for her diet order." C-A was not aware of previous swallowing or choking concerns for R1 prior to this incident. C-A was not in the dining room when R1 choked. C-A stated he was told to follow the diet cards and ask any questions. C-A stated dietary education he received for orientation was provided while he worked and he was shown what to do. C-A stated he thought R1's ordered diet was mince and moist. C-A stated he had not received education regarding meals, how to use diet cards, or how to dish modified diets following the	F0803		10/23/2026

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F0803 SS = K	Continued from page 18 incident on 9/6/26 but was directed to follow diet cards. During interview on 9/16/26 at 3:55 p.m., speech language pathologist (SP) stated R1 was treated by SP between 6/17/26 and 7/10/26, for a total of 20 sessions. Then eight sessions between 7/17/26 through 8/17/26, upon return from the hospital. R1's diet as of 4/11/26 was regular diet IDDSI level 6 soft bite size texture, level 2 mildly thick/nectar consistency and had not changed. SP did not trial R1 with bread because she knew R1's chewing and swallowing abilities. R1 took bigger bites if food is not cut into bite size pieces, this placed R1 at risk for choking and aspiration. SP stated staff were expected to follow the diet orders and not make changes without consulting with SP or another speech language pathologist (SLP). SP stated for a minced moist diet you can place toast/bread in a blender; it should be less than 4-millimeter piece. If liquid was added it may have gone down better but would depend on how big of a scoop R1 put in her mouth. The right amount of liquid needs to be added or it could potentially stick in a resident's throat and increase the risk of choking. SP stated, "A full piece of garlic bread should not have been given to [R1], it was not appropriate for her diet. [R1] could have choked and aspirated on a piece of garlic bread with crust still on it. The pasta noodle salad had ingredients other than pasta, if any of those ingredients were bigger than soft, bite sized, it would not have been appropriate for [R1's] diet order. If the vegetables in the pasta salad were raw, they would have been too hard for [R1] to chew and placed [R1] at a higher risk for choking and aspiration." SP stated the only residents without a modified diet can have cut up toast. Residents on a soft and bite-sized diet cannot have toast or sandwiches. Toast increased the risk of choking and aspiration. SP stated during the summer months she had noticed dietary staff would not serve soft meat or served bigger than bit sized pieces of meat to a resident on a soft and bite-sized diet with minced/moist meat ordered. SP stated she also noticed residents with an order for thickened liquids received mildly thicken liquids instead of the actually thickness ordered. SP would add more thickener to the liquids when she noticed this. SP brought these concerns to the dietary staff, "I told them to get it figured out." Additionally, SP was working with DS so dietary staff would receive more education, especially when hired do they did not rely on the cook for modified diets, that was the goal.	F0803		10/23/2026

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F0803 SS = K	Continued from page 19 During interview on 9/16/26 at 5:23 p.m., FSD stated prior to 9/6/26, he brought concerns to the interdisciplinary team meeting (IDT) regarding the need to evaluate those residents on modified diets. FSD stated the pasta salad ingredients included noodles, raw carrots (shredded but thicker than a regular piece of cheese), diced green peppers and diced cucumbers dice. FSD stated this pasta salad would not have been appropriate for R1's diet order due to the raw vegetables and would have increased R1's risk for choking. FSD stated he would have strongly recommended R1 did not receive garlic toast because the toast was not soft enough for R1 to chew, it and placed R1 at risk for choking. "Dietary staff should have been aware that [R1's] diet did not include garlic toast and placed her at risk for choking." Garlic toast would need to be mechanically altered, placed in a food processor/blender with water until it blended smooth, the texture of pureed food. FSD stated regular toast was appropriate for level 7 IDDSI diets easy to chew and regular only. The minced and moist diet would be the same option as the garlic toast, blended to a pureed texture. Toast cut up into bite sized pieces for mince and moist diets would not be appropriate and placed those residents at risk for choking. FSD stated dietary staff were expected to use the dietary cards when they served meals, so they are able to review the diet order. When they hand off the plate of food to the other dietary staff the diet card should be handed off also for them to check for the correct diet. FSD stated it was important to ensure that the resident received the proper texture, liquid consistency, and any other modified diet information such as diabetic, low sodium, and allergies. FSD stated if the diet order was not followed the risks could include allergies, the wrong texture, increased risk for choking and lacking the proper nutritional needs. FSD stated on 9/15/26, during lunch meal service, he noticed the dietary staff did not use the dietary card and was concerned. FSD stated he did not intervene/say anything because the surveyor was watching and was unsure if he should intervene. Facility menu for 9/16/26, supper (6:00 p.m.) included: Egg roll casserole Buttered peas Breadstick	F0803		10/23/2026

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F0803 SS = K	Continued from page 20 Mandarin oranges Milk During observation on 9/16/26 at 6:00 p.m. to 7:00 p.m., Food was dished up by the C and served to the residents by DA-A. Diet cards were accessible and used by the C and DA-A. The C reviewed each resident's diet card prior to dishing up the meal, handed the plate of food and the diet card to DA-A, while stating the resident's name. The DA-A reviewed the diet card and the plate of food before delivering it to the residents. Each verified the appropriate foods were provided for each resident's ordered diet. FSD monitored food service for the supper meal. During a follow-up interview on 9/17/26 at 10:50 a.m., the FSD stated he started an education binder in August 2026, regarding information on minced and moist diet orders. As of this interview, four out of 12 dietary staff had completed the education. The dietary staff had until the end of September 2026 to complete the education. FSD stated there were diet orders that seemed conflicting and ultimately the SLP and provider determine the orders. The FSD gave the following example: R2 had a diet order for minced and moist texture, like ground meat with gravy, the other part of R2's order was bite-sized pieces. "Those two textures are at different levels and needed to be reviewed to help prevent confusion among the dietary staff." FSD stated the alterative dietary menu was an anytime menu intended for any resident. Dietary staff would be responsible for deciding if the resident's choice was appropriate for their ordered diet. FSD gave the following example: a peanut butter and jelly sandwich would not be appropriate for the moist and minced diet and would increase their risk for aspiration and choking. FSD stated, "We currently do not have an alternative diet menu for special diets." During interview on 9/17/26 at 1:25 p.m., R1's primary provider (MD) stated the dietician recommended R1's diet and he did not believe he was aware of her swallowing problems. Staff would be expected to follow the diet orders and if R1 had concerns such as dysphagia and swallowing certain textures, then not providing the right foods, would have been concerning and placed her at risk for aspiration and choking. MD stated on 9/6/26, the DON was not working, and he was notified the	F0803		10/23/2026

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F0803 SS = K	Continued from page 21 following day on 9/7/26 about R1's choking event. MD was aware staff attempted the Heimlich maneuver, R1 was taken to the hospital and passed away from the event. During interview on 9/18/26 at 4:56 p.m., the DON stated the IDT met every Monday through Friday. Prior to 9/6/26, there had not been any information or conversation regarding concerns or the need to evaluate those residents on special diets. DON stated she expected dietary staff to serve the correct diet ordered and use the diet cards. DON stated if the dietary staff did not provide each resident with the correct consistency of foods and fluids, they would have increased risk for aspiration or choking. "Our facility process for investigating an incident would be to review the written statements provided by staff and if questions, interview them." DON stated the administrator completed the investigation for the incident with R1. DON stated more questions should have been asked about the cook (C) serving the meal to R1. DON stated she was not aware R1 was served garlic toast and pasta salad with raw vegetables until the surveyor came to the facility. DON stated R1 was on a soft diet and neither of those two food items would have been appropriate. "It would be concerning for any resident to not have the right diet and would place them at risk for aspiration and choking." DON expected staff to ask the nurse if they were unsure if a diet did not seem appropriate for a resident and/or check the report sheets at the desk, where the diets are identified. During interview on 9/18/26 at 5:23 p.m., the administrator stated following the incident on 9/6/26, the cook, two LPNs, three NA's provided written statements. The DA-A did not provide a statement until the surveyor arrived and was made aware the DA-A served R1 an unmodified piece of garlic toast. The administrator stated he followed up with LPN-A on the phone on 9/6/26, before she wrote her statement and two out of the three NA's to see if anything had changed or if there was more to add to their statements. The administrator stated he was unaware the dietary aide delivered the plate of food to R1 and should have followed up with her prior to the surveyor arriving. Administrator stated he met with the C along with the FSD on 9/8/26, to verify R1's diet was followed. The administrator was unsure why C-A did not report the unmodified garlic toast was served to R1, when they met on 9/8/26. The administrator stated R1's care plan was not followed; she was not served the diet ordered. This placed R1 at an increased risk for aspiration and choking. "In retrospect, I feel comfortable with	F0803		10/23/2026

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F0803 SS = K	Continued from page 22 statements from [C-A] and [LPN-A] but I could have done more for the investigation, such as interviewing the dietary aide. It is hard when staff tell me one thing and then tell [the surveyor] something different. I need to be more persistent with my interview questions.” During interview and observation 9/18/26 at 6:45 p.m., the DS confirmed R3’s diet order and card indicated no bread. DS went to R3’s room and confirmed R3 had eaten almost 1/2 of her bun sandwich and the other 1/2 of the sandwich remained with R3 in the room. At 6:50 p.m., the DON confirmed the facility did not use risk versus benefits documents. Nurse consultant (NC), also in the office, stated she had reviewed all R3’s progress notes and she did not identify a risk versus benefits had been covered with R3 regarding not following the ordered diet. The DON stated R3 was of sound mind, “She can make her own decisions. I plan on going to her room to complete the risk versus benefits with her now.” During a follow up interview on 9/22/26 at 3:15 p.m., the administrator stated he was recently made aware by FSD, the dietary staff were lacking in competencies and documentation regarding education on resident diets, what to serve, and an understanding of the diet types. There was no documentation they could provide regarding dietary staff education, other than what was provided. There was not a specific policy regarding this requirement either that they could find when dietary policies were requested. Facility policy Serving a Meal, date implemented 8/2025, date reviewed 9/2026, identified it is the policy of this facility to serve meals that meet the nutritional needs of residents. Policy explanation and Compliance Guidelines: Diets should be served in accordance with the physician’s order. Residents should be encouraged to eat in the dining room, however, requests to remain in the room should be honored. Mealtime service requires two dietary employees. One will dish up the resident plate, checking the plate against the diet cards with current textures, modified diet, and allergies. The second dietary employee will check the plate with the diet card for current textures, modified diets, and allergies. If plate meets the dietary orders serve the plate to the resident. Cut up meats and assist the resident. Use thickened liquids as provided by dietary department. The IDDSI framework used an 8-level continuum covering both drinks and foods (retrieved from	F0803		10/23/2026

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(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
F0803 SS = K	Continued from page 23 www.iddsi.org on 9/22/26): Level 0 – Thin: Flows freely like water. Level 1 – Slightly Thick: Thicker than water; flows through a straw. Level 2 – Mildly Thick: Flows slower than a thin liquid; can be sipped from a cup or straw. Level 3 – Moderately Thick / Liquidized: Can be eaten with a spoon or drunk from a cup; flows off a spoon slowly. Level 4 – Extremely Thick / Pureed: Spoon-consumable; completely smooth with no lumps and requires no chewing. Level 5 – Minced and Moist: Small, soft lumps (under 4 mm for adults); requires minimal chewing. Level 6 – Soft and Bite-Sized: Tender, moist pieces (1.5 cm cubes for adults) that break down easily with fork pressure. Level 7 – Easy to Chew / Regular: Normal, everyday soft foods that break easily under fork pressure, excluding hard, crunchy, or stringy items IDDSI level 5 minced and moist diet (www.iddsi.org) identified soft and moist with no liquid leaking/dripping from the food, biting is not required minimal chewing, lumps of 4 mm in size, lumps can be mashed with tongue, food can be easily mashed with just a little pressure from the fork and should be able to scoop food onto a fork, with no liquid dripping and not crumbs falling from fork. No regular dry bread due to high choking risk. Cooked vegetables, finely mashed or use blender to finely chop into 4mm lump size pieces with any excess liquid drained. Food characteristics to avoid:: crunchy foods such as raw carrots, raw apples, popcorn, floppy food: lettuce, cucumbers, baby spinach leaves, hard or dry food: raw vegetables (e.g. carrot, cauliflower, broccoli), dry cakes, bread, and dry cereal, and large or hard lumps of food: casserole pieces larger than 4 mm x 4 mm x 15 mm (4mm was slightly less than 0.2 inches, about the thickness of two standard wooden matchsticks stacked together); fruit, vegetable, meat, pasta, or other food pieces larger than those measurements. IDDSI level 6 soft and bite sized for adults (www.iddsi.org) identified as soft, tender, and moist but no thin liquid leaking/dripping from food. Ability to bit off a piece of food or use a knife to cut food	F0803		10/23/2026

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F0803 SS = K	Continued from page 24 was not required. Ability to chew bite-sized pieces is safe enough to swallow was required. Bite-sized pieces no bigger than 1.5 centimeter (cm) x 1.5 cm (about the size of a thumbnail or the width of a standard fork prong) in size. Vegetables steamed or boiled with final cooked size no bigger than 1.5 cm x 1.5 cm, stir fry vegetables are too firm and are not suitable. No regular bread due to high choking risk. Food characteristics to avoid crunchy foods such as raw carrots, raw apples, popcorn, floppy food: lettuce, cucumbers, baby spinach leaves, hard or dry food: nuts, raw vegetables (e.g. carrot, cauliflower, broccoli), dry cakes, bread, and dry cereal, and large or hard lumps of food: casserole pieces larger than 1.5 cm x 1.5 cm fruit, vegetable, meat, pasta, or other food pieces larger than those measurements. Facility Abuse, Neglect, and Exploitation policy dated 7/28/26, identified the facility will develop and implement written policies and procedures to investigate any such allegations such as abuse, neglect, exploitation, and misappropriation of property, reporting procedures, and an immediate investigation would be warranted. Identification of staff responsible/involved and interviewing all involved persons, including the alleged victim (if possible), alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The investigation should have focused on determining if abuse, neglect, exploitation, and/or mistreatment has occurred and the extent and cause. A complete and thorough documentation of the investigation should have been provided. Taking all necessary actions as a result of the investigation which may include but not limited to defining how care provision will be changed and/or improved to protect resident receiving services, training staff on changes made and demonstration of staff competency after training was implemented and identify staff responsible for implementation of correction actions. The immediate jeopardy that began on 9/6/26, was removed on 9/22/26 at 3:15 p.m., when the facility took immediate corrective actions were taken which included: all residents with altered diets were reviewed; verification of dietary orders was completed; meal service was corrected to ensure residents received food consistent with ordered altered diets; any inappropriate meal trays or food items identified were removed and replaced with correct items; nursing and dietary staff were notified of the deficiency and instructed to stop serving altered diets from the memory alone; resident care plans and diet orders were reviewed and updated as	F0803		10/23/2026

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F0803 SS = K	Continued from page 25 needed; all dietary, nursing and tray-line staff received IDDSI diet education and training of safe altered diet service with competency checks by 9/18/26, or prior to next shift worked, upon hire, and annual refresher training; an audit was completed of all current residents with altered, modified-texture, therapeutic, or otherwise restricted diets and risk versus benefits completed for those residents who choose to not follow their ordered diet, and care plans for those residents were updated. Additionally, on 9/18/26, the facility immediately implemented a facility risk/benefit decision making process. All staff, nursing, dietary, and activities, will be educated prior to their next shift worked regarding this process. Daily monitoring audits were initiated and scheduled for 30 days, then weekly monitoring audits for the next 60 days.	F0803		10/23/2026
F0802 SS = E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide appropriate education, training and competencies to the dietary staff to safely and effectively carry out the functions of the food and nutrition services to ensure proper food consistencies were served to 5 of 5 residents (R1, R2, R3, R4, R5) with orders for modified diets. This had the potential to affect all 11 residents with orders for modified diets who received meals from	F0802	F0802 – Dietary Services / Sufficient Dietary Support Personnel 1. Corrective Action for Residents Affected and other Residents An immediate review of any residents on modified diets was completed by the Director of Nursing, and Regional Food Service Director. Diet orders, texture modifications, and thickened-liquid orders were verified against the physician order, care plan, and diet ticket. The physician and responsible party were notified for any resident who may have been affected by the incorrect diet service. The audit included residents receiving all IDDSI Diets except IDDSI 7 consistency and liquids IDDSI 0-3. Diet cards, tray tickets, and current diet orders were reconciled for all identified residents. Any discrepancies found were corrected immediately, and resident-specific retraining was provided to staff involved in tray preparation and delivery. Meal Service staff were directed to use only the diet card for meal tray service. 2. Systemic Changes The facility has implemented a therapeutic diet reference tool. This incudes an IDDSI diet reference guide that was immediately made available and new diet cards with resident names, diet orders, texture levels, liquid consistencies, and any food allergies or special instructions. A formal onboarding and annual competency program was created for all dietary staff assigned to modified diet service. The regional food services director completed the certified dietary manager course and will complete a third party IDDSI training prior to completing competencies for the food services supervisor, dietary cooks, and	10/30/2026

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F0802 SS = E	Continued from page 26 the facility kitchen. Findings include: R1 R1’s quarterly Minimum Data Set (MDS) dated 8/12/26, indicated R1 had moderately impaired cognition and no behaviors. She required set up or clean-up assistance with eating. R1’s diagnoses included non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), and dysphagia. R1’s diet was a mechanically altered diet and required change in texture of food or liquids (e.g., pureed food, thickened liquids) and received speech-language pathology services. R1’s provider orders signed on 9/9/26, identified regular diet IDDSI level 6 – Soft and bite sized texture, IDDSI level 2 liquids – mildly thick (nectar) consistency, no straws per therapy. Date initiated: 4/11/26. R2 R2’s comprehensive MDS dated 7/4/26, identified R2 had intact cognition without behaviors. R2 was independent with eating. R2’s diagnoses included GERD. Mechanically altered diet was not identified on the MDS. R2’s provider order signed on 8/20/26, identified: Regular diet. IDDSI Level 5 – Minced and moist texture (soft, moist foods with small lumps no larger than 4 millimeters that require minimal chewing and can be mashed with the tongue. Foods must hold their shape and be scoopable). Regular/Thin consistency, bit sized pieces, extra gravy, double protein. Order start date 8/5/26. R2’s Diet Card identified diet: minced/moist, level 5 IDDSI, liquid level thin, and no bread. R3 R3’s comprehensive MDS dated 6/29/26, identified R3 had intact cognition without behaviors. R3 required set-up or clean-up assistance for meals. R3 ’s diagnoses included diabetes mellitus (DM), and multiple sclerosis (MS). R3 received a mechanically altered diet, required change in texture of food or liquids (e.g. pureed food, thickened	F0802	Continued from page 26 dietary aides. These competencies include identification of diet textures, thickened liquids, menu substitutions, tray accuracy, and escalation of discrepancies. A second-check verification process was implemented for all modified diets before trays leave service station. Supervisory rounds are conducted to verify compliance with diet orders and tray accuracy. 3. Monitoring and Quality Assurance The Regional Food Services Director or designee will perform a daily tray audit for one meal per day for all modified diets for 30 days and then weekly for 60 days and review with QAPI for Compliance. 4. Training and Education The Regional Food Services Director & Dietary supervisor, facility cooks, and dietary aides will receive competency education on IDDSI framework and therapeutic/modified diets. 5. Completion date: 10/30/26	10/30/2026

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F0802 SS = E	Continued from page 27 liquids). R3's provider order signed on 8/6/26, identified: Regular diet. Mechanical soft texture, regular thin consistency. Extra gravy/sauce for all meats. Small bites/sips. Regular meat texture. Order start date 9/18/23. Speech Therapy Swallow. Order date: 7/10/26. R3's Diet Card identified diet: minced/moist IDDSI level 5, liquid thin, no bread, hi-low scoop plate. R4 R4's quarterly MDS dated 7/13/26, indicated R4 had moderately impaired cognition and poor decision making. R4 was independent with eating. R4's diagnoses included non-Alzheimer's Dementia, traumatic brain injury, no mechanical diet was identified. R4 received speech-language pathology and audiology services. R4's provider order signed on 9/10/26, identified: Regular diet. IDDSI Level 6 – soft and bite sized texture. Regular/thin consistency, soft diet, ground meats, thin liquids. Order start date: 6/26/26. Speech therapy to evaluate and treat swallow. Order date: 6/17/26. R4's Diet Card identified diet: soft/bite sized texture, regular thin liquids, level 6 IDDSI food level, no bread, and hi-low scoop plate. R5 R5's quarterly MDS dated 6/22/26, indicated R5 had severely impaired cognition. R5 required set-up or clean-up assistance for eating. R5's diagnoses included non-Alzheimer's Dementia, anxiety, and respiratory failure. R5 required a mechanically altered diet and change in texture of food or liquids (e.g., pureed food, thickened liquids). Received speech-language pathology and audiology services.	F0802		10/30/2026

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F0802 SS = E	Continued from page 28 R5's provider signed orders on 9/10/26, identified: Regular diet IDDSI Level 6 – soft and bite sized texture. IDDSI level 2 liquids– mildly thick (nectar) consistency. No straws, double protein with meals. Order start date: 8/5/26. R5's Diet Card identified diet: Soft bite-sized, liquid level mildly thick, no bread, no straws. Level 6 IDDSI food level. Facility menu for 9/15/26, dinner/lunch (12:00 p.m.) indicated: Lemon garlic pork loin Pasta alfredo Broccoli Garlic toast Blueberry dessert Milk. Mealtime During observation on 9/15/26 at 12:05 p.m., dishing food from the serving table onto plates was completed by dietary aide (DA)-A with plates of food delivered by DA-B. The regional food service director (FSD) stood off to the side with a clip board observing the meal service and did not intervene when meal cards were not used and/or referenced by DA-A and DA-B. At 12:14 p.m., DA-A cut pork loin into bite-sized pieces and placed them on a plate with meat juice poured over the top, noodles, broccoli, and a slice of garlic toast with crust for R2 (diet order: minced/moist, bite sized pieces extra gravy, IDDSI level 5, and double protein). The same items were dished up for R3 (diet order: minced/moist, extra gravy/sauce for all meats, small bites/sips, IDDSI level 5, and regular meat textures), and R4 (diet order: soft bite sized texture, IDDSI level 6, regular/thin consistency). During interview on 9/15/26 at 2:13 p.m., DA-B stated dietary staff were expected to use the diet cards when they prepared and served the meals to	F0802		10/30/2026

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F0802 SS = E	Continued from page 29 the residents to ensure the correct diet and restrictions were provided to each resident. DA-B stated there were some residents who had a hard time chewing and required special foods and/or textures, “We do not want any resident choking or getting hurt because they were served the wrong diet.” DA-B stated before lunch was served today, “The [DS] reminded me the diet cards should be implemented and used with every meal served so that every meal is double checked to make sure all residents received the right foods.” DA-B stated she did not use the diet cards today when she served lunch to the residents because she usually went off memory and was confident all residents received the right meal. DA-B stated she understood if a resident received the wrong diet and/or food consistency, “The resident may not swallow properly and could choke. I should have used the diet cards.” DA-B stated, “Today after we served lunch, was the first time it was brought to my attention to use diet cards.” During interview on 9/15/26 at 3:09 p.m., DA-A stated dietary staff were expected to use the dietary cards when serving meals. DA-A stated she did not use the dietary cards today and relied on her memory. “I should have used the cards because if I gave the wrong foods to a resident, especially pureed or minced and moist meat, they could choke and I would get into trouble. I had too much going on today, I got distracted. I tried to get back on track. I had to focus on what I was giving the residents when food was dished up. My memory is good and I had to stay focused and pay attention to what I was doing.” DA-A stated on 9/6/26, C-A dished up R1’s meal and DA-A served R1 the plate of food. DA-A stated R1 was served lasagna, garlic bread, peaches and was unsure if R1 got lettuce or another salad. R1’s diet was small soft bite/sized diet with thicken liquids. DA-A stated when she started to clean up the dining room, she noticed the nurse doing the Heimlich maneuver on R1. DA-A was unsure how much R1 had eaten. DA-A stated the garlic bread was soft and was not cut up. Usually, when a diet order indicated small pieces, “We cut it up but R1’s was not.” DA-A stated she was unsure if R1 ate the garlic bread or had taken bites of it. During interview on 9/15/26 at 3:57 p.m. the dietary supervisor (DS) stated all dietary staff were expected to use the diet cards when meals were served to make sure the diet order had not changed, avoid allergies, ensure residents received foods they enjoyed, and safely consumed nutrients. DS stated mildly thick (nectar) liquids and soft diet /small bites	F0802		10/30/2026

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F0802 SS = E	Continued from page 30 usually prescribed for those residents that had swallowing/dental/chewing issues. DS stated dietary staff had direct access to the electronic medical records on the computer to ensure they were able to serve meals to the residents safely. DS stated R1 should have been discouraged from having garlic bread. Dietary staff were not allowed to make changes to a resident's diet. Changes to diets had to be pre-approved by therapy first. DS stated the IDDSI framework discouraged bread from being given and all diet orders should be followed. DS stated giving R1 garlic toast would have increased her risk for choking and did not follow R1's diet order. DS stated she was not interviewed regarding R1's choking incident. DS talked to DA-A and DA-B prior to lunch being served today and reminded them to use the dietary cards. DS stated dietary cards should be double checked when serving a meal to make sure each resident received their ordered diet, their ordered food and drink consistency and to prevent choking. Facility menu for 9/16/26, breakfast (8:00 a.m.) included: Choice of juice Cereal Scrambled egg with ham Toast Margarine/jelly Milk During observation on 9/16/26 at 8:40 a.m., the breakfast meal had already been served in the dining room. R4 had already left the dining room. NA-C verified R4's breakfast plate remained on the table with 15 small, bite sized pieces of toast, a small pile of scrambled eggs and approximately ½ a bowl of cream of wheat. At 8:43 a.m., R3 sat at the dining room table. R3 had just finished eating her breakfast and left the dining room. On her plate there were nine pieces of bite sized toast. At 8:53 a.m., R5 sat at a dining room table drinking his coffee. His breakfast plate had a small pile of scrambled eggs and pieces of meat, cream of wheat on edges of bowl, and two bite sized pieces of toast (diet order:	F0802		10/30/2026

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F0802 SS = E	Continued from page 31 soft bite-sized, IDDSI level 6, mildly thick (nectar) IDDSI level 2, no straws). During interview on 9/16/26 at 1:56 p.m., registered dietician (RD) stated dietary staff had a system they should follow which included referencing the residents' names and diet order. RD stated it was important for dietary staff to make sure each resident received the ordered diet due to allergies, weight problems, chewing/swallowing concerns, and requirements for adequate portions. During interview on 9/16/26 at 3:00 p.m. C-A stated he did not use diet cards because he knew each residents' ordered diet, and what foods they were to receive. If C-A had questions, he would check the paper documents with pictures of the tables with the resident name and type of diet listed on it or the diet cards. C-A stated, "Once we know the resident's diet, [dietary staff] do not have to use the diet cards. The diet cards are there for those staff that are not sure of which diet to serve each resident." C-A stated staff were expected to serve each resident the correct ordered diet to avoid a resident from receiving the wrong diet/food or consistency. If the proper diet was not served, it placed the residents at risk for choking. C-A stated, "If the dietary staff served the wrong diet to a resident, hopefully one of the nursing staff sitting at the table would catch it. If not, it would not be good." C-A stated he did not use the diet cards on 9/6/26, when he served R1 her supper. "I went off memory. I pretty much knew what [R1's] diet was and which foods to give her." C-A stated when he served R1's supper on 9/6/26, she received lasagna noodle roll up, with cheese and plain tomato sauce baked in the oven, and garlic bread that was minced and moist. "I chopped it up and added a little bit of water, so basically wet breadcrumbs. The crust was left on the garlic toast, I placed it in the blender and added water then put the contents on her plate to serve it to her. The garlic toast had some chunks in it and was okay for a soft diet. [R1] got pasta salad, it was not pureed. The food [R1] received was appropriate for her diet order." C-A stated dietary education he received for orientation was provided while he worked and he was shown what to do. C-A stated he thought R1's ordered diet was mince and moist. C-A stated he had not received education regarding meals, how to use diet cards, or how to dish modified diets following the incident on 9/6/26 but was directed to follow diet cards. During interview on 9/16/26 at 3:55 p.m., speech language pathologist (SP) stated staff were expected	F0802		10/30/2026

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F0802 SS = E	Continued from page 32 to follow the diet orders and not make changes without consulting with SP or another speech language pathologist (SLP). SP stated, “A full piece of garlic bread should not have been given to [R1], it was not appropriate for her diet. [R1] could have choked and aspirated on a piece of garlic bread with crust still on it. The pasta noodle salad had ingredients other than pasta, if any of those ingredients were bigger than soft, bite sized, it would not have been appropriate for [R1’s] diet order. If the vegetables in the pasta salad were raw, they would have been too hard for [R1] to chew and placed [R1] at a higher risk for choking and aspiration.” SP stated only residents without a modified diet can have cut up toast. Residents on a soft and bite-sized diet cannot have toast or sandwiches. Toast increased the risk of choking and aspiration. SP stated during the summer months she had noticed dietary staff would not serve soft meat or served bigger than bite sized pieces of meat to a resident on a soft and bite-sized diet with minced/moist meat ordered. SP stated she also noticed residents with an order for thickened liquids received mildly thickened liquids instead of the actual thickness ordered. SP brought these concerns to the dietary staff, “I told them to get it figured out.” Additionally, SP was working with DS so dietary staff would receive more education, especially when hired so they did not rely on the cook for modified diets, that was the goal. During interview on 9/16/26 at 5:23 p.m., FSD stated prior to 9/6/26, he brought concerns to the interdisciplinary team meeting (IDT) regarding the need to evaluate those residents on modified diets. FSD stated the pasta salad ingredients included noodles, raw carrots (shredded but thicker than a regular piece of cheese), diced green peppers and diced cucumbers dice. FSD stated this pasta salad would not have been appropriate for R1’s diet order due to the raw vegetables and would have increased R1’s risk for choking. FSD stated he would have strongly recommended R1 did not receive garlic toast because the toast was not soft enough for R1 to chew, it and placed R1 at risk for choking. “Dietary staff should have been aware that [R1’s] diet did not include garlic toast and placed her at risk for choking.” Toast cut up into bite sized pieces for mince and moist diets would not be appropriate and placed those residents at risk for choking. During a follow-up interview on 9/17/26 at 10:50 a.m., the FSD stated he started an education binder in August 2026, regarding information on minced and moist diet orders. As of this interview, four out	F0802		10/30/2026

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MINNEWASKA COMMUNITY HEALTH SERVICES	605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381

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F0802 SS = E	Continued from page 33 of 12 dietary staff had completed the education. During interview on 9/18/26 at 4:56 p.m., the DON stated the IDT met every Monday through Friday. Prior to 9/6/26, there had not been any information or conversation regarding concerns or the need to evaluate those residents on special diets. The DON stated she expected dietary staff to serve the correct diet ordered and use the diet cards. “It would be concerning for any resident to not have the right diet and would place them at risk for aspiration and choking.” The DON expected staff to ask the nurse if they were unsure if a diet did not seem appropriate for a resident and/or check the report sheets at the desk, where the diets are identified. During a follow up interview on 9/22/26 at 3:15 p.m., the administrator stated he was recently made aware by FSD, the dietary staff were lacking in competencies and documentation regarding education on resident diets, what to serve, and an understanding of the diet types. There was no documentation they could provide regarding dietary staff education, other than what was provided. There was not a specific policy regarding this requirement either that they could find when dietary policies were requested. Facility Diet Type Report dated 9/15/26, identified 29 residents, room number, allergies, diet type, diet texture, fluid consistency, and additional directions. Summary of document included: IDDSI Level 7, regular texture and regular thin fluids, 11 residents IDDSI level 6, soft/bite sized, regular thin liquids, five residents, liquids varied from thin to mildly thick (nectar), and two with no straws IDDIS level 5 minced and moist, regular thin liquids, three residents IDDSI level 4, pureed texture and level 3 liquids, one with moderately thick (honey), and one with mildly thick (nectar), pureed and nectar/mildly thick fluids, one resident, pureed, one resident Nothing by mouth (NPO), one resident. Facility dietary education binder, undated, identified information from the International Dysphagia Diet Standards Initiative (IDDSI) web site www.iddsi.org. Located on the cover of the binder was information specific to IDDSI level 5 minced and moist diet. The last document located within the binder provided	F0802		10/30/2026

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F0802 SS = E	Continued from page 34 examples of level 5 minced and moist foods for adults. Facility Dietary Aide job description dated 2/2012, identified the dietary aide will: Assist the cook in preparation and service of meals. Must be able to relate work with geriatric residents and understand their special needs. May dish salads and desserts, prepare vegetables, and beverages and assist cook in meal production. Assist in tray assemble, tray/cart deliver, dining room service, and clean up. Follows written dietary policies and procedures. DA-A signed a Statement of Understanding/facility dietary aide job description on 11/7/14 and verified she had read the job description and understood the responsibilities and physical demands of the job. DA-A's signature indicated she agreed to perform the duties of the position described to the best of her abilities consistent with the values of the facility. Facility Cook Job description dated 3/2014, identified the cook will: Help prepare food for any of the meals served at the facility. Follow dietary regulations, any dietary restrictions, and review menus prior to preparation of food. Prepare food for the therapeutic diets per policy and food with standardized recipes and special diet orders. Prepare and serve substitutes to residents who refuse meat or request alternatives. Must be able to relate work with geriatric residents and understand their special needs. Attend and participate in workshops, seminars, in-service training programs, as directed. C-A signed a Statement of Understanding/facility cook job description on 5/14/26 and verified he had read the job description and understood the responsibilities and physical demands of the job. C-A's signature indicated he agreed to perform the duties of the position described to the best of her abilities consistent with the values of the facility.	F0802		10/30/2026

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F0802 SS = E	Continued from page 35 C-A's facility education transcript identified the general mandatory education (abuse, communication, culture, dementia, emergency preparedness, infection control, HIPPA, Medicaid/Medicare fraud and abuse, OSHA, survey preparedness, vulnerable adult) was completed from 5/14/26 through 5/18/26. No dietary orientation/education was identified or received when requested. Dietary Staff Standards and Expectations meeting was held on 5/29/26 and 5/30/26, identified three cooks and seven dietary aids attended. The documented indicated the following: The goal was to ensure we are all on the same page when it comes to providing safe, nutritious and high-quality meals for those we serve. Daily responsibilities: Performance Standards – preparing food and beverages needs to be accurate, appealing and timely. Mistakes in people's diets can have serious consequences (i.e. thicken liquids). Feedback and Accountability – constructive feedback and coaching will be provided always something to learn. We all make mistakes but learn and grow from them. Facility policy Serving a Meal date implemented 8/2025, date reviewed 9/2026, identified it is the policy of this facility to serve meals that meet the nutritional needs of residents. Policy explanation and Compliance Guidelines: Diets should be served in accordance with the physician's order. Residents should be encouraged to eat in the dining room, however, requests to remain in the room should be honored. Mealtime service requires two dietary employees. One will dish up the resident plate, checking the plate against the diet cards with current textures, modified diet, and allergies. The second dietary employee will check the plate with the diet card for current textures, modified diets, and allergies. If plate meets the dietary orders serve the plate to the resident. Cut up meats and assist the resident. Use thickened liquids as provided by dietary department.	F0802		10/30/2026
F0610 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	F0610	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of	10/23/2026

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F0610 SS = D	Continued from page 36 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 interviews and document review the facility failed to thoroughly investigate an allegation of choking for 1 of 1 resident (R1) reviewed who had an order for a modified diet. Findings include: Vulnerable Adult Report dated 9/8/26 at 1:01 p.m., identified on 9/6/26 at 6:35 p.m., R1 was seen struggling to breathe in dining room. Nurse started Heimlich maneuver immediately, food was small and bite sized per care plan, police and emergency medical system (EMS) were contacted immediately. R1 was transported to emergency room (ER) and pronounced deceased at the hospital. Description of physical injury or pain: death by choking. Facility 5-day report dated 9/12/26 at 5:33 p.m., identified the facility licensed practical nurse (LPN) noticed R1 had trouble breathing, started Heimlich maneuver, and directed the other LPN to call the police at 6:34 p.m. Police officer (PO) arrived at facility at 6:35 p.m. ambulance arrived at 6:37 p.m., and transferred R1 to the hospital, and pronounced dead at 6:50 p.m. It was confirmed with the cook on duty, at the time of the incident the meal served was correct for the R1's diet orders and the care plan was followed. No allegation was verified. The facility found R1's airway was obstructed during mealtimes, staff acted quickly to intervene, and the meal was appropriately served per her care plan. A routine random audit was implemented meals served were correct per the IDDSI framework to ensure they continued to follow diet orders correctly as they did	F0610	Continued from page 36 correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Corrective Action for Other Residents The facility completed a review of all residents with swallowing risk and modified diets. All residents on altered textures or thickened liquids were assessed for current diet appropriateness and care plan accuracy. Dining supervisors or designee performed immediate observations during meal service to ensure compliance with diet orders and safe feeding practices. Any resident identified as potentially at risk received prompt care plan revision, provider notification as needed, and enhanced monitoring. 2. Systemic Changes The facility implemented a standardized investigation checklist to ensure completion of staff interviews, resident interviews, when possible, witness statements, timeline reconstruction, chart review, care plan review, diet order verification, and documentation of findings and corrective actions. The facility reinforced timelines for internal escalation and external reporting in accordance with policy and applicable state and federal requirements. The facility strengthened meal-delivery verification to ensure residents receive only food consistent with their prescribed diet texture and liquid consistency. Staff are now required to double-check diet before meal service. All serious incidents now require a documented root cause analysis identifying what happened, why it happened, contributing factors, and what system changes are necessary. 3. Monitoring and Quality Assurance The Director of Nursing, or designee will review all potential VA reports. A weekly audit of incident investigations will be conducted for 30 days then monthly based on performance and reviewed with QAPI. Audit tools will verify timely initiation of investigation, completion of staff/resident interviews, audit of affected residents, Root Cause Analysis, notification/reporting compliance when applicable, and corrective action implementation, and/or education. 4. Training and Education DON, Administrator and IDT Team will receive retraining on the facility's investigation process. 5. Documentation	10/23/2026

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F0610 SS = D	Continued from page 37 with this incident. No systemic changes other than ongoing routine random International IDDSI audits. R1's quarterly Minimum Data Set (MDS) dated 8/12/26, indicated R1 had moderately impaired cognition and no behaviors. She required set up or clean-up assistance with eating. R1's diagnoses included non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), and dysphagia. R1's diet was a mechanically altered diet and required change in texture of food or liquids (e.g., pureed food, thickened liquids) and received speech-language pathology services. R1's provider orders signed on 9/9/26, identified regular diet IDDSI level 6 – Soft and bite sized texture, IDDSI level 2 liquids – mildly thick (nectar) consistency, no straws per therapy. Date initiated: 4/11/26. R1's care plan dated 11/12/25, identified: at risk for imbalanced nutrition related to gastro-esophageal reflux (GERD) (a chronic condition where stomach and acid frequently flows back into the tube connecting your mouth and stomach, irritating the lining), hypoosmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low sodium). Interventions included R1's diet will be provided as prescribed by provider. Staff were directed to encourage healthy choices and fluid intake without straws. R1's progress notes dated 9/6/26, indicated: At 6:38 p.m., this nurse went to give resident her scheduled medications at the dining room table and noted that resident's dentures had fallen out and resident appeared to be choking. Heimlich maneuver immediately started, and ambulance called. Resident continued to struggle to breathe. All nursing staff assisted. Police here and assisting. Ambulance is currently here and transferred to local hospital. At 7:01 p.m., local hospital ER nurse called and reported R1 had passed. Director of nursing notified and R1's son and both daughters were called, no answer. Message left with both daughters to call facility as soon as possible. Facility menu for 9/6/26, indicated evening meal (6:00 p.m.): Lasagna roll up, tossed salad/dressing,	F0610	Continued from page 37 The facility will maintain documentation demonstrating compliance, including incident reports, investigation checklists, staff interview forms, physician/dietitian notifications, care plan revisions, audit tools, retraining attendance records, competency validations, QAPI meeting minutes, and corrective action logs. All documentation will be maintained in accordance with facility policy and record retention requirements. 6. Completion date: 10/23/26	10/23/2026

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F0610 SS = D	Continued from page 38 garlic toast, peaches, and milk. A handwritten and signed statement dated 9/9/26, identified cook (C)-A, was the cook on duty 9/6/26 from 11:00 a.m. through 7:30 p.m. “I cooked lasagna roll-ups, garlic bread and a salad. I prepared everything to [R1’s] specific diet as it should have been.” An undated handwritten statement signed by NA-A identified “I cleared [R1’s] plate on Sunday, 9/6/26 (meal or time of day was not identified) and the bread was not eaten at all.” A handwritten and signed statement dated 9/6/26 at 6:38 p.m., identified NA-G was in dining room assisting with feeding supper and saw a staff nurse running and called 9-1-1. “[R1] was choking on meat. The Heimlich maneuver was done by two different people, but only a small piece of meat came out. [R1] was moved to another hallway, police officer (PO) arrived, then paramedics, [R1] was placed on gurney and left in ambulance.” A handwritten and unsigned statement dated 9/6/26 at 7:00 p.m., indicated unidentified staff, “went to [R1’s] dining room table, upper dentures had fallen out, and [writer] placed them back in. It was noticed [R1] was having difficulties breathing and color started to turn bluish. Heimlich maneuver was immediately started. Staff called 9-1-1. [R1] was removed from dining room, police arrived, [writer] told staff to get [R1] to front doors. This nurse came back to dining room and started charting.” A typed statement dated 9/6/26, identified at 7:01 p.m., administrator received a call from DON (director of nursing). He was informed [R1] had an airway obstruction during dinner, police and ambulance called and [R1] passed away at local hospital. At 7:08 p.m., administrator called facility and spoke with LPN who detailed what had happened. At 6:34 p.m., LPN noted [R1’s] dentures had fallen out, went over and helped, noticed she was having a hard time breathing, started Heimlich maneuver and directed staff LPN to call ambulance at 6:34 p.m., NA took over Heimlich maneuver. At 6:35 p.m. police arrived, moved [R1] to front door. At 6:37 p.m., ambulance arrived, transferred to gurney and left in ambulance with EMS. LPN verified the prepared meal of lasagna was small and bite sized.” During interview on 9/15/26 at 3:09 p.m., the dietary aid (DA)-A stated on 9/6/26, C-A dished up R1’s meal and DA-A served R1 the plate of food. DA-A	F0610		10/23/2026

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F0610 SS = D	Continued from page 39 stated R1 was served lasagna, garlic bread, peaches and was unsure if R1 got lettuce or another salad. R1's diet was small soft bite/sized with thicken liquids. DA-A stated when she started to clean up the dining room, she noticed the nurse doing the Heimlich maneuver on R1. DA-A was unsure how much R1 had eaten. DA-A stated the garlic bread was soft and not cut up. Usually, when a diet order indicated small pieces, "We cut it up but R1's was not." DA-A stated she was unsure if R1 ate the garlic bread or had taken bites of it. DA-A stated she was not interviewed after R1's incident on 9/6/26. During interview on 9/15/26 at 3:57 p.m. the dietary supervisor (DS) stated she was not interviewed regarding R1's choking incident on 9/6/26. During interview on 9/15/26 at 5:30 p.m., LPN-A stated they worked on 9/6/26 and was the first staff to respond to R1 when she was choking. Following the incident on 9/6/26 with R1, the administrator called and asked her to give a written statement. LPN-A stated she was not interviewed after she provided the written statement. During interview on 9/16/26 at 12:53 p.m., LPN-B stated they worked on 9/6/26, during supper and witnessed the incident with R1. LPN-B submitted a written statement to the administrator but was not interviewed. During interview on 9/16/26 at 3:00 p.m. C-A stated he was the cook working during the evening meal on 9/6/26. C-A stated he dished R1's plate. "I went off memory. I pretty much knew what [R1's] diet was and which foods to give her." C-A stated when he served R1's supper on 9/6/26, she received lasagna noodle roll up, with cheese and plain tomato sauce baked in the oven, and garlic bread that was minced and moist. "I chopped it up and added a little bit of water, so basically wet breadcrumbs. The crust was left on the garlic toast, I placed it in the blender and added water then put the contents on her plate to serve it to her. The garlic toast had some chunks in it and was okay for a soft diet. [R1] got pasta salad, it was not pureed. The food [R1] received was appropriate for her diet order." C-A stated he gave a written statement to the administrator, regarding the incident on 9/6/26 but was not interviewed. During interview on 9/18/26 at 4:56 p.m., the DON stated the administrator completed the investigation for the incident on 9/6/26 with R1. DON stated more questions should have been asked and more	F0610		10/23/2026

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F0610 SS = D	Continued from page 40 information received from C-A. DON stated she was not aware R1 was served garlic toast and pasta salad with raw vegetables until the surveyor came to the facility. During interview on 9/18/26 at 5:23 p.m., the administrator stated following the incident on 9/6/26, the cook, two LPNs, and three NA's provided written statements. The DA-A did not provide a statement until the surveyor arrived and the administrator was made aware the DA-A served R1 an unmodified piece of garlic toast. The administrator stated he followed up with the LPN-A on the phone on 9/6/26, before she wrote her statement. The administrator also spoke with two out of the three NA's to see if anything had changed or if there was more to add to their statements. The administrator stated he was unaware the dietary aide delivered the plate of food to R1 and should have followed up with her prior to the surveyor arriving. The administrator stated he met with the C-A along with the FSD on 9/8/26, to verify R1's diet was followed. The administrator was unsure why C-A did not report the unmodified garlic toast was served to R1, when they met on 9/8/26. "In retrospect, I feel comfortable with statements from [C-A] and [LPN-A] but I could have done more for the investigation, such as interviewing the dietary aide. It is hard when staff tell me one thing and then tell [the surveyor] something different. I need to be more persistent with my interview questions." Facility policy Serving a Meal date implemented 8/2025, date reviewed 9/2026, identified it is the policy of this facility to serve meals that meet the nutritional needs of residents. Policy explanation and Compliance Guidelines: Diets should be served in accordance with the physician's order. Residents should be encouraged to eat in the dining room, however, requests to remain in the room should be honored. Mealtime service requires two dietary employees. One will dish up the resident plate, checking the plate against the diet cards with current textures, modified diet, and allergies. The second dietary employee will check the plate with the diet card for current textures, modified diets, and allergies. If plate meets the dietary orders serve the plate to the resident. Cut up meats and assist the resident. Use thickened liquids as provided by dietary department. Facility Abuse, Neglect, and Exploitation policy dated 7/28/26, identified the facility will develop and implement written policies and procedures to investigate any such allegations such as abuse,	F0610		10/23/2026

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F0610 SS = D	Continued from page 41 neglect, exploitation, and misappropriation of property, reporting procedures, and an immediate investigation would be warranted. Identification of staff responsible/involved and interviewing all involved persons, including the alleged victim (if possible), alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The investigation should have focused on determining if abuse, neglect, exploitation, and/or mistreatment has occurred and the extent and cause. A complete and thorough documentation of the investigation should have been provided. Taking all necessary actions as a result of the investigation which may include but not limited to defining how care provision will be changed and/or improved to protect resident receiving services, training staff on changes made and demonstration of staff competency after training was implemented and identify staff responsible for implementation of correction actions.	F0610		10/23/2026

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(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/15/26, through 9/18/26, and 9/22/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed:	20000		10/14/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/22/2026**

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20000	Continued from page 1 H55374128C (3190421) with licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		10/14/2026
21050	Menus; Meal Planning CFR(s): MN Rule 4658.0625 Subp. 1 Subpart 1. Menu planning. All menus must be planned in advance, dated, and followed. Any changes in the meals actually served must be of equal nutritional value. The general menu for a seven-day period must be posted prior to the start of that seven-day period at a location readily accessible to residents, and any changes to the general menu must be noted on that posted menu.	21050	Corrected.	10/23/2026

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21050	Continued from page 2 All menus and any changes for the current and following seven-day periods must be posted in the dietary area. Records of menus and of foods purchased must be filed for six months. A variety of foods must be provided. A file of tested recipes adjusted to a yield appropriate for the size of the home must be maintained. This LICENSURE REQUIREMENT is NOT MET as evidenced by: During observation, document review, and interview, the facility failed to ensure residents' ordered diets were followed for 5 of 5 residents (R1, R2, R3, R4, and R5) reviewed who had an order for a modified diet. This resulted in R1 choking during a meal then required staff intervention, emergency medical services (EMS) intervention and evaluation at the hospital where R1 later died. The immediate jeopardy began on 9/6/26, when the facility failed to ensure R1 was served an International Dysphagia Diet Standardization Initiative (IDDSI) (a global standard that provide common terminology and testing method for texture-modified foods and thicken liquids) level-6 soft and bit sized (foods are soft, tender and moist pieces no larger than 1.5 centimeters by 1.5 centimeters, designed for people who can chew but cannot safely bite off larger pieces) diet. R1 was served and ate lasagna roll ups, pasta salad with uncooked vegetables and garlic toast, foods contraindicated for her physician-ordered diet. R1 choked during the meal, staff performed the Heimlich maneuver and called emergency services (EMS). R1 died at the hospital. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 9/18/26 at 5:45 p.m. The immediacy was removed on 9/22/26, at 3:15 p.m. but noncompliance remained at the lower scope and severity level E (pattern, scope and severity level) which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Vulnerable Adult Report dated 9/8/26 at 1:01 p.m., identified on 9/6/26 at 6:35 p.m., R1 was seen struggling to breathe in dining room. Nurse started Heimlich maneuver immediately, food was small and bite sized per care plan, police and emergency medical system (EMS) were contacted immediately. R1 was transported to emergency room (ER) and pronounced deceased at the hospital. Description of physical injury or pain: death by choking.	21050		10/23/2026

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21050	Continued from page 3 Facility 5-day report dated 9/12/26 at 5:33 p.m., identified on 9/6/26, the facility licensed practical nurse (LPN)-A noticed R1 had trouble breathing, started the Heimlich maneuver, and directed the other LPN to call the police at 6:34 p.m. Police officer (PO) arrived at facility at 6:35 p.m., the ambulance arrived at 6:37 p.m., and transferred R1 to the hospital, who was pronounced dead at 6:50 p.m. It was confirmed with the cook on duty, at the time of the incident the meal served was correct for the R1's diet orders and the care plan was followed. No allegation was verified. The facility found R1's airway was obstructed during mealtimes, staff acted quickly to intervene, and the meal was appropriately served per her care plan. A routine random audit was implemented meals served were correct per the IDDSI framework to ensure they continued to follow diet orders correctly as they did with this incident. No systemic changes other than ongoing routine random International IDDSI audits. R1 R1's quarterly Minimum Data Set (MDS) dated 8/12/26, indicated R1 had moderately impaired cognition and no behaviors. She required set up or clean-up assistance with eating. R1's diagnoses included non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases), and dysphagia. R1's diet was a mechanically altered diet and required change in texture of food or liquids (e.g., pureed food, thickened liquids) and received speech-language pathology services. R1's provider orders signed on 9/9/26, identified regular diet IDDSI level 6 – Soft and bite sized texture, IDDSI level 2 liquids – mildly thick (nectar) consistency, no straws per therapy. Date initiated: 4/11/26. R1's care plan dated 11/12/25, identified: at risk for imbalanced nutrition related to gastro-esophageal reflux (GERD) (a chronic condition where stomach and acid frequently flows back into the tube connecting your mouth and stomach, irritating the lining), hypoosmolality (a condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low sodium). Interventions included R1's diet will be provided as prescribed by provider. Staff were directed to encourage healthy choices and fluid intake without straws.	21050		10/23/2026

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21050	Continued from page 4 R1's Speech Language Pathologist (SLP) evaluation and plan of treatment dated 6/17/26, identified diagnoses pneumonia and dysphagia. Plan of treatment included treatment of swallowing dysfunction and/or function for feeding and evaluation of oral and pharyngeal swallow function three to four times a week for eight weeks. R1 was unable to follow directions to complete a pharyngeal exercise (designated to strengthen the muscles involved in swallowing and improving the coordination and effectiveness of swallowing process). R1 required moderate to maximal cues to consume diet safely as she demonstrated rapid rate and pocketing of food. Mildly thickened liquids and soft and bit sized diet currently. Goals: increase R1's ability to consume least restrictive diet without signs and symptoms of aspiration and least amount of supervision needed. Initial assessment/current level of function and underlying impairments identified IDDIS drinks: mildly thick drinks. IDDSI foods: soft/bite sized food level 6. R1 required supervision at mealtime prior to onset and during the assessment 50 to 75% of the time. R1's progress notes dated 9/6/26, indicated: At 6:38 p.m., this nurse went to give resident her scheduled medications at the dining room table and noted that resident's dentures had fallen out and resident appeared to be choking. Heimlich maneuver immediately started, and ambulance called. Resident continued to struggle to breathe. All nursing staff assisted. Police here and assisting. Ambulance is currently here and transferred to local hospital. At 7:01 p.m., local hospital ER nurse called and reported R1 had passed. Director of nursing notified and R1's son and both daughters were called, no answer. Message left with both daughters to call facility as soon as possible. Police department incident report dated 9/6/26 at 6:32 p.m., indicated assigned at 6:34 p.m., arrived at 6:35 p.m., and last cleared at 7:05 p.m. Short description: dining room/person choking, cardiac pulmonary resuscitation (CPR) in progress, taken to local hospital, deceased. Assisted ambulance with medical and CPR in route to hospital. R1's EMS ambulance report incident date/time: 9/6/26 at 6:34 p.m. Call type: choking. Response mode: emergent (immediate response). Arrived on scene at 6:37 p.m. Narrative: we were dispatched to	21050		10/23/2026

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21050	Continued from page 5 the local nursing home for a 96-year-old female choking. When arrived on scene police department (PD) was already on scene, with patient whose staff had moved to the outside entrance in a wheelchair. They were performing the Heimlich maneuver. Mental/neurological/status identified as unresponsive and left/right side weakness. We quickly exited the ambulance and grabbed the Life Vac (an anti-choking device designed to provide an airway clearance solution as a second line of treatment during choking emergencies). Multiple attempts were made to dislodge the blockage with no success of air movement. We moved the patient to the stretcher where she was placed in supine (lying flat on back with face and torso facing upward) secured and prepped to transport. Upon initial exam, patient was unresponsive, apneic (a temporary state when a person stops breathing or experience a complete cessation of airflow), still had no color in her face and lips, and brownish material was on her face and clothing. PD assisted in the back of the ambulance while enroute to the hospital. As we went enroute, a few more attempts were made with the Life Vac and were unsuccessful. A bag-valve-mask (BVM) (often called an Ambu bag or manual resuscitator, handheld medical device used to deliver positive pressure ventilation to patients not breathing or are breathing inadequately) was attempted to try and get some air movement also with no success. A king airway (a disposable supraglottic/above the vocal cords airway used in emergency to maintain an open airway to provide ventilation) was attempted with no success. Automated external defibrillator (AED) pads were placed and analyzed patient, a rhythm was present and AED stated no shock advised. Attempts with the King, BVM, and Life-Vac were continued without success until AED said to start cardiopulmonary resuscitation (CPR). Manual CPR was started and continued for a couple of minutes until arrival at hospital. Upon arrival patient care and report was transferred to the emergency room (ER) registered nurse (RN). R1’s E-Care Emergency code blue flow sheet dated 9/6/26 at 6:46 p.m., identified at 6:47 p.m. [R1] arrived via EMS, provider at bedside. Compressions are not being performed. At 6:49 p.m., bedside nurse suctioned airway. At 6:50 p.m., bedside staff verified do not resuscitate (DNR) on file. Bedside staff provide checking for cardiac activity with ultrasound. Time of death 6:50 p.m. Emergency Department Note dated 9/6/26, identified patient presented via basic life support (BLS), EMS,	21050		10/23/2026

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21050	Continued from page 6 with CPR in progress believed to be the result of complete airway obstruction (choking). EMS reported patient sitting at the dinner table when she suddenly started choking. Exactly what led staff and bystanders to believe she was choking is unclear. On their arrival patient was apneic and pulseless. No shock was advised on her AED. They did attempt to ventilate with BVM and were unable to achieve any chest rise or air entry. They did attempt to pass a King laryngeal tube (LT) (to secure an open airway) without success. CPR was initiated and transported to hospital. On arrival, the patient was unconscious, with no respiratory effort or pulse. Chart review finds the patient was admitted to the hospital one time, less than six weeks ago, her code status was ordered as DNR/DNI (do not resuscitate/do not intubate) but no advance directives were in her chart. Confirmation with skilled nursing facility (SNF) code status was DNR/DNI. Bedside echocardiogram showed most faint cardiac activity that is perceptible, but clearly not enough to be perfusing. Given that she is apneic with an airway occlusion and non-perfusing cardiac activity, there was no way to attempt resuscitation without further CPR and advanced airway management which would violate her advance directives. Even if cardiac activity could be restored the likelihood that she would avoid severe anoxic brain injury (severe medical emergency caused by a complete loss of oxygen to the brain, with brain cells beginning to die after about four minutes of deprivation) given her period of apnea had been at least 20 minutes is essentially zero. The provider believed the best possible outcome of resuscitation would be likely a permanent vegetative state. After brief discussion amongst staff in room, we all agree that resuscitation efforts would be discontinued. Time of death was pronounced at 6:50 p.m. on 9/6/26. R1's Death Certificate identified: Date and place of death 9/6/26 at 6:50 p.m. at nursing home/long term care. Cause of death: Immediate cause (final disease or condition resulting in death): Cardiac arrest. Condition that led to the immediate cause: Respiratory arrest. Underlying cause (disease or injury that initiated events resulting in death): Upper airway obstruction.	21050		10/23/2026

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21050	Continued from page 7 Facility menu for 9/6/26, evening meal: Lasagna roll up, toss salad/dressing, garlic toast, peaches, and milk. Mealtime supper/dinner 6:00 p.m. A list of ingredients for Summer Pasta Salad undated, provided by dietary director, included pasta, mayonnaise, lemon juice, sugar, carrots, cucumbers, onions, green and red peppers. A picture of the salad was also provided and identified colored (green, orange, and ivory) spiral noodles and slivered carrots with a creamy sauce over the top. Nursing assistant (NA) task list documentation for 9/6/26, at 9:04 p.m. percentage of R1's meal eaten was 0 to 25%. A handwritten and signed statement dated 9/9/26, identified cook (C)-A, was the cook on duty 9/6/26 from 11:00 a.m. through 7:30 p.m. "I cooked lasagna roll-ups, garlic bread and a salad. I prepared everything to [R1's] specific diet as it should have been." An undated handwritten statement signed by NA-A identified "I cleared [R1's] plate on Sunday, 9/6/26 (meal or time of day was not identified) and the bread was not eaten at all." A handwritten and signed statement dated 9/6/26 at 6:38 p.m., identified NA-G was in dining room assisting with feeding supper and saw a staff nurse running and called 911. "[R1] was choking on meat. The Heimlich maneuver was done by two different people, but only a small piece of meat came out. [R1] was moved to another hallway, police officer (PO) arrived, then paramedics, [R1] was placed on gurney and left in ambulance." A handwritten and unsigned statement dated 9/6/26 at 7:00 p.m., indicated unidentified staff, "went to [R1's] dining room table, upper dentures had fallen out, and [writer] placed them back in. It was noticed [R1] was having difficulties breathing and color started to turn bluish. Heimlich maneuver was immediately started. Staff called 9-1-1. [R1] was removed from dining room, police arrived, [writer] told staff to get [R1] to front doors. This nurse came back to dining room and started charting." A typed statement dated 9/6/26, identified at 7:01 p.m., "Administrator received a call from DON (director of nursing). He was informed [R1] had an airway obstruction during dinner, police and ambulance called and [R1] passed away at local	21050		10/23/2026

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21050	Continued from page 8 hospital. At 7:08 p.m., administrator called facility and spoke with LPN who detailed what had happened. At 6:34 p.m., LPN noted [R1's] dentures had fallen out, went over and helped, noticed she was having a hard time breathing, started Heimlich maneuver and directed staff LPN to call ambulance at 6:34 p.m., NA took over Heimlich maneuver. At 6:35 p.m. police arrived, moved [R1] to front door. At 6:37 p.m., ambulance arrived, transferred to gurney and left in ambulance with EMS. LPN verified the prepared meal of lasagna was small and bite sized." R2 R2's comprehensive MDS dated 7/4/26, identified R2 had intact cognition without behaviors. R2 was independent with eating. R2's diagnoses included GERD. Mechanically altered diet was not identified on the MDS. R2's provider order signed on 8/20/26, identified: Regular diet. IDDSI Level 5 – Minced and moist texture (soft, moist foods with small lumps no larger than 4 millimeters that require minimal chewing and can be mashed with the tongue. Foods must hold their shape and be scoopable). Regular/Thin consistency, bit sized pieces, extra gravy, double protein. Order start date 8/5/26. R2's care plan dated 8/6/26, identified: Activities of daily living (ADLs) self-care performance deficit related to ataxia (a neurological condition: poor muscle control that leads to uncoordinated movements, affecting balance, speech and motor skills), stroke, legal blindness, and weakness. Date initiated: 6/7/23. Revised: 6/15/25. Staff were directed to provide milkshakes or liquid food supplements when [R2] refused or had difficulty with solid food. Provide nutritious food that can be taken from a cup or mug where appropriate. [R2] was able to eat independently after set-up. Date initiated: 6/7/23. Dietary: had the potential for nutritional problems including weight loss related to GERD. Date initiated: 4/26/23. Dated revised: 10/9/23. Staff were directed to serve diet as ordered. Monitor intake and record every meal. Date initiated: 4/26/23. Date revised: 9/16/26. Registered dietician (RD) to evaluate and make diet change recommendations. Date initiated: 4/26/23. R2's Kardex dated 9/18/26, identified Special	21050		10/23/2026

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21050	Continued from page 9 instructions: pills whole. monitor/record/report loss of appetite, refusal to eat, and weight loss. Eating/Nutrition: independently after set-up. Provide milkshakes or liquid food supplements when R2 refuses or has difficulty with solid food or provide nutritious foods that can be taken from a cup or mug where appropriate R2's Diet Card identified diet: minced/moist, level 5 IDDSI, liquid level thin, and no bread. R3 R3's comprehensive MDS dated 6/29/26, identified R3 had intact cognition without behaviors. R3 required set-up or clean-up assistance for meals. R3 's diagnoses included diabetes mellitus (DM), and multiple sclerosis (MS). R3 received a mechanically altered diet, required change in texture of food or liquids (e.g. pureed food, thickened liquids). R3's provider order signed on 8/6/26, identified: Regular diet. Mechanical soft texture, regular thin consistency. Extra gravy/sauce for all meats. Small bites/sips. Regular meat texture. Order start date 9/18/23. Speech Therapy Swallow. Order date: 7/10/26. R3's care plan dated 9/11/26, identified: Impaired ability to perform activities of daily living related to diagnoses MS, spastic quadriplegia (most severe form of spastic cerebral palsy, affecting all four limbs, the trunk and often the face), and diabetes mellitus (DM). Date initiated: 2/1/24. Date revised: 6/25/26. Eating set up assist. Revised 4/27/26. Dietary: had the potential for nutritional problems due to dysphagia, MS, and paraplegia. Date initiated: 6/15/23. Dated revised: 11/15/24. Staff were directed to provide adequate equipment for feeding as needed, provide and serve diet as ordered. Monitor intake and record every meal. Date initiated: 6/15/23. Registered dietician to evaluate and make diet change recommendations as needed (PRN). Date: initiated 6/15/23.	21050		10/23/2026

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21050	Continued from page 10 R3's Kardex dated 9/18/26, identified Eating /Nutrition: eating set-up assist. R3's Speech Language Pathologist evaluation and plan of treatment dated 7/14/26, identified diagnoses multiple sclerosis, DM, and dysphagia. R3 was known to the speech therapy department, was seen during bouts of speech therapy to determine appropriate diet textures with history of dysphagia related to multiple sclerosis (MS). R3 was observed coughing during meal(s) on two separate occasions. Plan of treatment recommended one time a week daily. Recommended liquid and diet for R3 to swallow safely was thin liquid (no modifications) and soft and bit sized food. Assessment of swallowing identified R3 required supervision/assistance at mealtime due to swallow safety 0 to 25% of the time. R3's Diet Card identified diet: minced/moist IDDSI level 5, liquid thin, no bread, hi-low scoop plate. During observation on 9/18/26 at 6:34 p.m., R3 sat in her recliner, alone in her room, with a cloth protector across her chest with approximately ½ of bun sandwich with sliced meat and cheese resting on the cloth protector. There was a plastic container, unopened, of grape tomatoes resting on R3's right thigh. R3 stated she just couldn't eat the food they gave to her for supper, so she went over to the grocery store, in her electric wheelchair, and bought the sandwich and tomatoes. R3 stated she had already eaten ½ of the sandwich and was not aware she was not supposed to eat bread. R3 verified there was sliced cold sandwich meat and a piece of cheese in between the bun. R3 stated she ate bread with all her meals (diet order: minced and moist IDDSI level 5, regular thing fluids, extra gravy/sauce for all meats. Small bites/sips, regular meat textures, no bread). R4 R4's quarterly MDS dated 7/13/26, indicated R4 had moderately impaired cognition and poor decision making. R4 was independent with eating. R4's diagnoses included non-Alzheimer's Dementia, traumatic brain injury, no mechanical diet was identified. R4 received speech-language pathology and audiology services. R4's hospital discharge orders dated 6/26/26, identified diet: bite size and soft and ensure plus or high protein.	21050		10/23/2026

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21050	Continued from page 11 R4's provider order signed on 9/10/26, identified: Regular diet. IDDSI Level 6 – soft and bite sized texture. Regular/thin consistency, soft diet, ground meats, thin liquids. Order start date: 6/26/26. Speech therapy to evaluate and treat swallow. Order date: 6/17/26. R4's Speech Language Pathologist evaluation plan of treatment dated 6/29/26, identified diagnoses dementia, sequelae (the long-term or lasting medical conditions and physical or cognitive deficits that remain after a person has an ischemic stroke) of cerebral infarction (stroke), and cognitive communication deficit. Treatment was recommended for cognitive skills development such as speech, language, voice, communication, and/or auditory processing two to three times a week for 12 weeks. There was no mention about diet and swallowing difficulties. R4's care plan dated 7/9/26, identified: Activities of daily living self-care deficit related to traumatic subdural hemorrhage, stroke, mild protein-calorie malnutrition, dysphagia, and weakness. Date initiated 10/6/23. Date revised: 11/14/23. [R4] was independent with eating after setup. Revised date: 7/21/25. R4's Kardex dated 9/18/26, identified Special instructions: medications, crush in pudding. Diet: eating/nutrition – independent after set-up. R4's Diet Card identified diet: soft/bite sized texture, regular thin liquids, level 6 IDDSI food level, no bread, and hi-low scoop plate. R5 R5's quarterly MDS dated 6/22/26, indicated R5 had severely impaired cognition. R5 required set-up or clean-up assistance for eating. R5's diagnoses included non-Alzheimer's Dementia, anxiety, and respiratory failure. R5 required a mechanically altered diet and change in texture of food or liquids (e.g., pureed food, thickened liquids). Received speech-language pathology and audiology services. R5's Hospital Discharge Summary dated 5/14/26,	21050		10/23/2026

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21050	Continued from page 12 identified discharge diagnosis: aspiration pneumonia of right lower lobe, unspecified aspiration pneumonia type. [R5] has had chronic intermittent aspiration pneumonia. Speech therapy consulted with [R5] for bedside evaluation. Diet changed after speech evaluation: mildly thicken liquids were recommended to prevent recurrent aspiration. R5's provider signed orders on 9/10/26, identified: Regular diet IDDSI Level 6 – soft and bite sized texture. IDDSI level 2 liquids– mildly thick (nectar) consistency. No straws, double protein with meals. Order start date: 8/5/26. R5's Speech Language Pathologist evaluation plan of treatment dated 6/3/26, identified diagnoses pneumonia due to inhalation of food and vomit and dysphagia. Assessment identified laryngeal (larynx (voice box)/pharyngeal (pharynx- the muscular throat region) performance impaired. Recommended liquid and diet for the patient to swallow safely: soft and bite-sized and mildly thick liquids. R5 required supervision/assistance at mealtime due swallow safety 50 to 75% of the time. The treatment plan recommended for swallowing dysfunction and/or oral function for feeding two to three times a week for eight weeks. R5's care plan dated 8/28/26, identified: ADL self-care performance deficit related to chronic obstructive pulmonary disease (COPD), cognitive/communication deficit, dementia, anxiety, and stroke. Revised on: 9/5/25. Staff were directed to provide set-up and assist of one for eating. Revised on 6/28/26. At risk for imbalanced nutrition. Dated initiated: 8/28/25. Date revised: 2/2/26. Staff were directed to provide diet as prescribed by provider, encourage fluids. Monitor weight routinely and PRN. Date initiated: 8/28/25. Family frequently brought in straws to [R5] despite staff education provided to family. Date initiated: 3/4/26. R5's Kardex dated 9/18/26, special instructions: medications whole in applesauce, mildly thick (nectar) consistency. Eating/Nutrition built up angled utensils. Eating: set-up assist of one. Encourage healthy choices.	21050		10/23/2026

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21050	Continued from page 13 R5's Diet Card identified diet: Soft bite-sized, liquid level mildly thick, no bread, no straws. Level 6 IDDSI food level. During interview on 9/17/26 on11:53 p.m., R5 stated he was on a soft and bite sized diet and had to have his liquids thickened. R5 stated he received whole pieces of meat for meals and had to ask staff to cut it up for him. R5 stated he received raw vegetables many times, "I ate them and it went ok." R5 stated he received toast with the crust on it most mornings for breakfast and it was occasionally cut up into smaller pieces. R5 stated he had received lettuce about one week ago and one other time (unable to remember how long ago), "I choked on it a little bit, but it did go down ok. It just made me cough." Facility dietary Anytime Menu dated 1/31/25, identified alternative food list: Peanut Butter and Jelly Sandwich Cold Cereal Fruit Cup Pudding Cup/Jello Cup Chicken Broth/Beef Broth Celery and Carrot sticks with ranch Cheese Sandwich (grilled or cold) *available until 6:00 p.m. Lettuce Salad *available until 6:00 p.m. Chicken noodle soup *available until 6:00 p.m. Vegetable Beef Noodle Soup *available until 6:00 p.m. Tomato Soup *available until 6:00 p.m. The Anytime Menu did not indicate which diet(s) the	21050		10/23/2026

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21050	Continued from page 14 alternative food(s) would be appropriate for. Facility menu for 9/15/26, dinner/lunch (12:00 p.m.) indicated: Lemon garlic pork loin Pasta alfredo Broccoli Garlic toast Blueberry dessert Milk. Mealtime During observation on 9/15/26 at 12:05 p.m., dishing food from the serving table onto plates was completed by dietary aide (DA)-A with plates of food delivered by DA-B. DA-A stated the pureed meals would be served first. The regional food service director (FSD) stood off to the side with a clip board observing the meal service and did not intervene when meal cards were not used and/or referenced by DA-A and DA-B. At 12:14 p.m., DA-A cut up pork loin into bite-sized pieces and placed them on a plate with meat juice poured over the top, noodles, broccoli, and a slice of garlic toast with crust for R2 (diet order: minced/moist, bite sized pieces extra gravy, IDDSI level 5, and double protein). The same items were dished up for R3 (diet order: minced/moist, extra gravy/sauce for all meats, small bites/sips, IDDSI level 5, and regular meat textures), and R4 (diet order: soft bite sized texture, IDDSI level 6, regular/thin consistency). During interview on 9/15/26 at 2:13 p.m., DA-B stated dietary staff were expected to use the diet cards when they prepared and served the meals to the residents to ensure the correct diet and restrictions were provided to each resident. DA-B stated there were some residents who had a hard time chewing and required special foods and/or textures, “We do not want any resident choking or getting hurt because they were served the wrong diet.” DA-B stated before lunch was served today, “The [DS] reminded me the diet cards should be implemented and used with every meal served so that every meal is double checked to make sure all	21050		10/23/2026

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21050	Continued from page 15 residents received the right foods." DA-B stated she did not use the diet cards today when she served lunch to the residents because she usually went off memory and was confident all residents received the right meal. DA-B stated she understood if a resident received the wrong diet and/or food consistency, "The resident may not swallow properly and could choke. I should have used the diet cards." DA-B stated, "Today after we served lunch, was the first time it was brought to my attention to use diet cards." No education was provided to DA-B since the incident with R1 on 9/6/26, regarding preventing choking or providing the correct diet and food consistency. During interview on 9/15/26 at 3:09 p.m., DA-A stated dietary staff were expected to use the dietary cards when serving meals. DA-A stated she did not use the dietary cards today and relied on her memory. "I should have used the cards because if I gave the wrong foods to a resident, especially pureed or minced and moist meat, they could choke and I would get into trouble. I had too much going on today, I got distracted. I tried to get back on track, had to focus on what I was giving the residents when food was dished up. My memory is good and I had to stay focused and pay attention to what I was doing." DA-A stated on 9/6/26, C-A dished up R1's meal and DA-A served R1 the plate of food. DA-A stated R1 was served lasagna, garlic bread, peaches and was unsure if R1 got lettuce or another salad. R1's diet was small soft bite/sized diet with thicken liquids. DA-A stated when she started to clean up the dining room, she noticed the nurse doing the Heimlich maneuver on R1. DA-A was unsure how much R1 had eaten. DA-A stated the garlic bread was soft and not cut up. Usually, when a diet order indicated small pieces, "We cut it up but R1's was not." DA-A stated she was unsure if R1 ate the garlic bread or had taken bites of it. DA-A stated she was not interviewed after R1's incident on 9/6/26. During interview on 9/15/26 at 3:57 p.m. the dietary supervisor (DS) stated all dietary staff were expected to use the diet cards when meals were served to make sure the diet order had not changed, avoid allergies, ensure residents received foods they enjoyed, and safely consumed nutrients. DS stated mildly thick (nectar) liquids and soft diet /small bites usually prescribed for those residents that had swallowing/dental/chewing issues. DS stated dietary staff had direct access to the electronic medical records on the computer to ensure they were able to serve meals to the residents safely. DS stated R1 should have been discouraged from having garlic	21050		10/23/2026

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21050	Continued from page 16 bread. Dietary staff were not allowed to make changes to a resident's diet. Changes to diets had to be pre-approved by therapy first. DS stated the IDDSI framework discouraged bread from being given and all diet orders should be followed. DS stated giving R1 garlic toast would have increased her risk for choking and did not follow R1's diet order. DS stated she was not interviewed regarding R1's choking incident. DS talked to DA-A and DA-B prior to lunch being served today and reminded them to use the dietary cards. DS stated dietary cards should be double checked when serving a meal to make sure each resident received their ordered diet, their ordered food and drink consistency and to prevent choking. During interview on 9/15/26 at 5:30 p.m., LPN-A stated on 9/6/26 she walked over to R1's table, leaned over and noticed R1 was struggling to breathe. LPN-A stated she immediately did the Heimlich maneuver and instructed LPN-B to call 9-1-1. R1 was still alert but unable to talk. LPN-A removed R1 from the dining room and a police officer arrived. The police officer assessed R1 for a carotid pulse (found in the neck). No pulse or verbal response was noted so R1 was brought to the front of the building. LPN-A stated one of the NA's said they saw a small piece of lasagna came out of R1's mouth and remembered R1 had just set the fork down. LPN-A did not recall what food was on R1's plate. LPN-A stated she called the hospital to let them know R1 was coming. EMS showed up and left with R1. The hospital called and asked if R1 had a DNR, that is when the hospital informed LPN-A, R1 had passed away. Facility menu for 9/16/26, breakfast (8:00 a.m.) included: Choice of juice Cereal Scrambled egg with ham Toast Margarine/jelly Milk	21050		10/23/2026

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21050	Continued from page 17 During observation on 9/16/26 at 8:40 a.m., the breakfast meal had already been served in the dining room. R4 had already left the dining room. NA-C verified R4's breakfast plate remained on the table with 15 small, bite sized pieces of toast, a small pile of scrambled eggs and approximately ½ a bowl of cream of wheat. At 8:43 a.m., R3 sat at the dining room table. R3 had just finished eating her breakfast and left the dining room. On her plate there were nine pieces of bite sized toast. At 8:53 a.m., R5 sat at a dining room table drinking his coffee. His breakfast plate had a small pile of scrambled eggs and pieces of meat, cream of wheat on edges of bowl, and two bite sized pieces of toast (diet order: soft bite-sized, IDDSI level 6, mildly thick (nectar) IDDSI level 2, no straws). During interview on 9/16/26 at 12:53 p.m., LPN-B stated on 9/6/26, during supper, LPN-A was trying to get her attention in the dining room. R1 was not breathing well, her face and lips were turning blue, she was still able to make eye contact but no verbal response and Heimlich maneuver was being done by LPN-A. LPN-B called 9-1-1, informed them there was a resident in the dining room choking, and the Heimlich maneuver was attempted without success. LPN-B waited by the front door, within one minute PO arrived and shortly after that EMS arrived. R1 was brought up to the front door in her wheelchair, and LPN-B assisted EMS with a transfer to the gurney. LPN-B did not remember looking at R1's plate on the table. LPN-B submitted a written statement to the administrator but was not interviewed. LPN-B stated she did not receive education regarding diets, choking or meal service after the incident on 9/6/26. An interview and education would have been important to make sure staff provided food according to the ordered diet. During interview on 9/16/26 at 1:56 p.m., registered dietician (RD) stated she reviewed the resident diets monthly and looked at high risk weight loss, tube feedings, and dialysis. The dietary staff would be expected to provide the proper meal for each resident according to their ordered diet. Dietary staff had a system they should follow which included referencing the residents' names and diet order. RD stated it was important for dietary staff to make sure each resident received the ordered diet due to allergies, weight problems, chewing/swallowing concerns, and requirements for adequate portions. During interview on 9/16/26 at 3:00 p.m. C-A stated he did not use diet cards because he knew what each residents' ordered diet, and what foods they	21050		10/23/2026

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21050	Continued from page 18 were to receive. If C-A had questions, he would check the paper documents with pictures of the tables with the resident name and type of diet listed on it or the diet cards. C-A stated, “Once we know the resident’s diet, [dietary staff] do not have to use the diet cards. The diet cards are there for those staff that are not sure of which diet to serve each resident.” C-A stated staff were expected to serve each resident the correct ordered diet to avoid a resident from receiving the wrong diet/food or consistency. If the proper diet was not served, it placed the residents at risk for choking. C-A stated, “If the dietary staff served the wrong diet to a resident, hopefully one of the nursing staff sitting at the table would catch it. If not, it would not be good.” C-A stated he did not use the diet cards on 9/6/26, when he served R1 her supper. “I went off memory. I pretty much knew what [R1’s] diet was and which foods to give her.” C-A stated when he served R1’s supper on 9/6/26, she received lasagna noodle roll up, with cheese and plain tomato sauce baked in the oven, and garlic bread that was minced and moist. “I chopped it up and added a little bit of water, so basically wet breadcrumbs. The crust was left on the garlic toast, I placed it in the blender and added water then put the contents on her plate to serve it to her. The garlic toast had some chunks in it and was okay for a soft diet. [R1] got pasta salad, it was not pureed. The food [R1] received was appropriate for her diet order.” C-A was not aware of previous swallowing or choking concerns for R1 prior to this incident. C-A was not in the dining room when R1 choked. C-A stated he was told to follow the diet cards and ask any questions. C-A stated dietary education he received for orientation was provided while he worked and he was shown what to do. C-A stated he thought R1’s ordered diet was mince and moist. C-A stated he had not received education regarding meals, how to use diet cards, or how to dish modified diets following the incident on 9/6/26 but was directed to follow diet cards. During interview on 9/16/26 at 3:55 p.m., speech language pathologist (SP) stated R1 was treated by SP between 6/17/26 and 7/10/26, for a total of 20 sessions. Then eight sessions between 7/17/26 through 8/17/26, upon return from the hospital. R1’s diet as of 4/11/26 was regular diet IDDSI level 6 soft bite size texture, level 2 mildly thick/nectar consistency and had not changed. SP did not trial R1 with bread because she knew R1’s chewing and swallowing abilities. R1 took bigger bites if food is not cut into bite size pieces, this placed R1 at risk for choking and aspiration. SP stated staff were	21050		10/23/2026

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21050	Continued from page 19 expected to follow the diet orders and not make changes without consulting with SP or another speech language pathologist (SLP). SP stated for a minced moist diet you can place toast/bread in a blender; it should be less than 4-millimeter piece. If liquid was added it may have gone down better but would depend on how big of a scoop R1 put in her mouth. The right amount of liquid needs to be added or it could potentially stick in a resident's throat and increase the risk of choking. SP stated, "A full piece of garlic bread should not have been given to [R1], it was not appropriate for her diet. [R1] could have choked and aspirated on a piece of garlic bread with crust still on it. The pasta noodle salad had ingredients other than pasta, if any of those ingredients were bigger than soft, bite sized, it would not have been appropriate for [R1's] diet order. If the vegetables in the pasta salad were raw, they would have been too hard for [R1] to chew and placed [R1] at a higher risk for choking and aspiration." SP stated the only residents without a modified diet can have cut up toast. Residents on a soft and bite-sized diet cannot have toast or sandwiches. Toast increased the risk of choking and aspiration. SP stated during the summer months she had noticed dietary staff would not serve soft meat or served bigger than bit sized pieces of meat to a resident on a soft and bite-sized diet with minced/moist meat ordered. SP stated she also noticed residents with an order for thickened liquids received mildly thicken liquids instead of the actually thickness ordered. SP would add more thickener to the liquids when she noticed this. SP brought these concerns to the dietary staff, "I told them to get it figured out." Additionally, SP was working with DS so dietary staff would receive more education, especially when hired do they did not rely on the cook for modified diets, that was the goal. During interview on 9/16/26 at 5:23 p.m., FSD stated prior to 9/6/26, he brought concerns to the interdisciplinary team meeting (IDT) regarding the need to evaluate those residents on modified diets. FSD stated the pasta salad ingredients included noodles, raw carrots (shredded but thicker than a regular piece of cheese), diced green peppers and diced cucumbers dice. FSD stated this pasta salad would not have been appropriate for R1's diet order due to the raw vegetables and would have increased R1's risk for choking. FSD stated he would have strongly recommended R1 did not receive garlic toast because the toast was not soft enough for R1 to chew, it and placed R1 at risk for choking. "Dietary staff should have been aware that [R1's] diet did not include garlic toast and placed her at	21050		10/23/2026

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21050	Continued from page 20 risk for choking." Garlic toast would need to be mechanically altered, placed in a food processor/blender with water until it blended smooth, the texture of pureed food. FSD stated regular toast was appropriate for level 7 IDDSI diets easy to chew and regular only. The minced and moist diet would be the same option as the garlic toast, blended to a pureed texture. Toast cut up into bite sized pieces for mince and moist diets would not be appropriate and placed those residents at risk for choking. FSD stated dietary staff were expected to use the dietary cards when they served meals, so they are able to review the diet order. When they hand off the plate of food to the other dietary staff the diet card should be handed off also for them to check for the correct diet. FSD stated it was important to ensure that the resident received the proper texture, liquid consistency, and any other modified diet information such as diabetic, low sodium, and allergies. FSD stated if the diet order was not followed the risks could include allergies, the wrong texture, increased risk for choking and lacking the proper nutritional needs. FSD stated on 9/15/26, during lunch meal service, he noticed the dietary staff did not use the dietary card and was concerned. FSD stated he did not intervene/say anything because the surveyor was watching and was unsure if he should intervene. Facility menu for 9/16/26, supper (6:00 p.m.) included: Egg roll casserole Buttered peas Breadstick Mandarin oranges Milk During observation on 9/16/26 at 6:00 p.m. to 7:00 p.m., Food was dished up by the C and served to the residents by DA-A. Diet cards were accessible and used by the C and DA-A. The C reviewed each resident's diet card prior to dishing up the meal, handed the plate of food and the diet card to DA-A, while stating the resident's name. The DA-A reviewed the diet card and the plate of food before delivering it to the residents. Each verified the	21050		10/23/2026

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21050	Continued from page 21 appropriate foods were provided for each resident's ordered diet. FSD monitored food service for the supper meal. During a follow-up interview on 9/17/26 at 10:50 a.m., the FSD stated he started an education binder in August 2026, regarding information on minced and moist diet orders. As of this interview, four out of 12 dietary staff had completed the education. The dietary staff had until the end of September 2026 to complete the education. FSD stated there were diet orders that seemed conflicting and ultimately the SLP and provider determine the orders. The FSD gave the following example: R2 had a diet order for minced and moist texture, like ground meat with gravy, the other part of R2's order was bite-sized pieces. "Those two textures are at different levels and needed to be reviewed to help prevent confusion among the dietary staff." FSD stated the alterative dietary menu was an anytime menu intended for any resident. Dietary staff would be responsible for deciding if the resident's choice was appropriate for their ordered diet. FSD gave the following example: a peanut butter and jelly sandwich would not be appropriate for the moist and minced diet and would increase their risk for aspiration and choking. FSD stated, "We currently do not have an alternative diet menu for special diets." During interview on 9/17/26 at 1:25 p.m., R1's primary provider (MD) stated the dietician recommended R1's diet and he did not believe he was aware of her swallowing problems. Staff would be expected to follow the diet orders and if R1 had concerns such as dysphagia and swallowing certain textures, then not providing the right foods, would have been concerning and placed her at risk for aspiration and choking. MD stated on 9/6/26, the DON was not working, and he was notified the following day on 9/7/26 about R1's choking event. MD was aware staff attempted the Heimlich maneuver, R1 was taken to the hospital and passed away from the event. During interview on 9/18/26 at 4:56 p.m., the DON stated the IDT met every Monday through Friday. Prior to 9/6/26, there had not been any information or conversation regarding concerns or the need to evaluate those residents on special diets. DON stated she expected dietary staff to serve the correct diet ordered and use the diet cards. DON stated if the dietary staff did not provide each resident with the correct consistency of foods and fluids, they would have increased risk for aspiration or choking. "Our facility process for investigating an incident	21050		10/23/2026

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21050	Continued from page 22 would be to review the written statements provided by staff and if questions, interview them." DON stated the administrator completed the investigation for the incident with R1. DON stated more questions should have been asked about the cook (C) serving the meal to R1. DON stated she was not aware R1 was served garlic toast and pasta salad with raw vegetables until the surveyor came to the facility. DON stated R1 was on a soft diet and neither of those two food items would have been appropriate. "It would be concerning for any resident to not have the right diet and would place them at risk for aspiration and choking." DON expected staff to ask the nurse if they were unsure if a diet did not seem appropriate for a resident and/or check the report sheets at the desk, where the diets are identified. During interview on 9/18/26 at 5:23 p.m., the administrator stated following the incident on 9/6/26, the cook, two LPNs, three NA's provided written statements. The DA-A did not provide a statement until the surveyor arrived and was made aware the DA-A served R1 an unmodified piece of garlic toast. The administrator stated he followed up with LPN-A on the phone on 9/6/26, before she wrote her statement and two out of the three NA's to see if anything had changed or if there was more to add to their statements. The administrator stated he was unaware the dietary aide delivered the plate of food to R1 and should have followed up with her prior to the surveyor arriving. Administrator stated he met with the C along with the FSD on 9/8/26, to verify R1's diet was followed. The administrator was unsure why C-A did not report the unmodified garlic toast was served to R1, when they met on 9/8/26. The administrator stated R1's care plan was not followed; she was not served the diet ordered. This placed R1 at an increased risk for aspiration and choking. "In retrospect, I feel comfortable with statements from [C-A] and [LPN-A] but I could have done more for the investigation, such as interviewing the dietary aide. It is hard when staff tell me one thing and then tell [the surveyor] something different. I need to be more persistent with my interview questions." During interview and observation 9/18/26 at 6:45 p.m., the DS confirmed R3's diet order and card indicated no bread. DS went to R3's room and confirmed R3 had eaten almost 1/2 of her bun sandwich and the other 1/2 of the sandwich remained with R3 in the room. At 6:50 p.m., the DON confirmed the facility did not use risk versus benefits documents. Nurse consultant (NC), also in the office, stated she had reviewed all R3's progress	21050		10/23/2026

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21050	Continued from page 23 notes and she did not identify a risk versus benefits had been covered with R3 regarding not following the ordered diet. The DON stated R3 was of sound mind, “She can make her own decisions. I plan on going to her room to complete the risk versus benefits with her now.” During a follow up interview on 9/22/26 at 3:15 p.m., the administrator stated he was recently made aware by FSD, the dietary staff were lacking in competencies and documentation regarding education on resident diets, what to serve, and an understanding of the diet types. There was no documentation they could provide regarding dietary staff education, other than what was provided. There was not a specific policy regarding this requirement either that they could find when dietary policies were requested. Facility policy Serving a Meal, date implemented 8/2025, date reviewed 9/2026, identified it is the policy of this facility to serve meals that meet the nutritional needs of residents. Policy explanation and Compliance Guidelines: Diets should be served in accordance with the physician’s order. Residents should be encouraged to eat in the dining room, however, requests to remain in the room should be honored. Mealtime service requires two dietary employees. One will dish up the resident plate, checking the plate against the diet cards with current textures, modified diet, and allergies. The second dietary employee will check the plate with the diet card for current textures, modified diets, and allergies. If plate meets the dietary orders serve the plate to the resident. Cut up meats and assist the resident. Use thickened liquids as provided by dietary department. The IDDSI framework used an 8-level continuum covering both drinks and foods (retrieved from www.iddsi.org on 9/22/26): Level 0 – Thin: Flows freely like water. Level 1 – Slightly Thick: Thicker than water; flows through a straw. Level 2 – Mildly Thick: Flows slower than a thin liquid; can be sipped from a cup or straw. Level 3 – Moderately Thick / Liquidized: Can be eaten with a spoon or drunk from a cup; flows off a spoon slowly. Level 4 – Extremely Thick / Pureed: Spoon-consumable; completely smooth with no	21050		10/23/2026

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21050	Continued from page 24 lumps and requires no chewing. Level 5 – Minced and Moist: Small, soft lumps (under 4 mm for adults); requires minimal chewing. Level 6 – Soft and Bite-Sized: Tender, moist pieces (1.5 cm cubes for adults) that break down easily with fork pressure. Level 7 – Easy to Chew / Regular: Normal, everyday soft foods that break easily under fork pressure, excluding hard, crunchy, or stringy items IDDSI level 5 minced and moist diet (www.iddsi.org) identified soft and moist with no liquid leaking/dripping from the food, biting is not required minimal chewing, lumps of 4 mm in size, lumps can be mashed with tongue, food can be easily mashed with just a little pressure from the fork and should be able to scoop food onto a fork, with no liquid dripping and not crumbs falling from fork. No regular dry bread due to high choking risk. Cooked vegetables, finely mashed or use blender to finely chop into 4mm lump size pieces with any excess liquid drained. Food characteristics to avoid:: crunchy foods such as raw carrots, raw apples, popcorn, floppy food: lettuce, cucumbers, baby spinach leaves, hard or dry food: raw vegetables (e.g. carrot, cauliflower, broccoli), dry cakes, bread, and dry cereal, and large or hard lumps of food: casserole pieces larger than 4 mm x 4 mm x 15 mm (4mm was slightly less than 0.2 inches, about the thickness of two standard wooden matchsticks stacked together); fruit, vegetable, meat, pasta, or other food pieces larger than those measurements. IDDSI level 6 soft and bite sized for adults (www.iddsi.org) identified as soft, tender, and moist but no thin liquid leaking/dripping from food. Ability to bit off a piece of food or use a knife to cut food was not required. Ability to chew bite-sized pieces is safe enough to swallow was required. Bite-sized pieces no bigger than 1.5 centimeter (cm) x 1.5 cm (about the size of a thumbnail or the width of a standard fork prong) in size. Vegetables steamed or boiled with final cooked size no bigger than 1.5 cm x 1.5 cm, stir fry vegetables are too firm and are not suitable. No regular bread due to high choking risk. Food characteristics to avoid crunchy foods such as raw carrots, raw apples, popcorn, floppy food: lettuce, cucumbers, baby spinach leaves, hard or dry food: nuts, raw vegetables (e.g. carrot, cauliflower, broccoli), dry cakes, bread, and dry cereal, and large or hard lumps of food: casserole pieces larger than 1.5 cm x 1.5 cm fruit, vegetable, meat, pasta, or other food pieces larger than those measurements.	21050		10/23/2026

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21050	Continued from page 25 Facility Abuse, Neglect, and Exploitation policy dated 7/28/26, identified the facility will develop and implement written policies and procedures to investigate any such allegations such as abuse, neglect, exploitation, and misappropriation of property, reporting procedures, and an immediate investigation would be warranted. Identification of staff responsible/involved and interviewing all involved persons, including the alleged victim (if possible), alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The investigation should have focused on determining if abuse, neglect, exploitation, and/or mistreatment has occurred and the extent and cause. A complete and thorough documentation of the investigation should have been provided. Taking all necessary actions as a result of the investigation which may include but not limited to defining how care provision will be changed and/or improved to protect resident receiving services, training staff on changes made and demonstration of staff competency after training was implemented and identify staff responsible for implementation of correction actions. The immediate jeopardy that began on 9/6/26, was removed on 9/22/26 at 3:15 p.m., when the facility took immediate corrective actions were taken which included: all residents with altered diets were reviewed; verification of dietary orders was completed; meal service was corrected to ensure residents received food consistent with ordered altered diets; any inappropriate meal trays or food items identified were removed and replaced with correct items; nursing and dietary staff were notified of the deficiency and instructed to stop serving altered diets from the memory alone; resident care plans and diet orders were reviewed and updated as needed; all dietary, nursing and tray-line staff received IDDSI diet education and training of safe altered diet service with competency checks by 9/18/26, or prior to next shift worked, upon hire, and annual refresher training; an audit was completed of all current residents with altered, modified-texture, therapeutic, or otherwise restricted diets and risk versus benefits completed for those residents who choose to not follow their ordered diet, and care plans for those residents were updated. Additionally, on 9/18/26, the facility immediately implemented a facility risk/benefit decision making process. All staff, nursing, dietary, and activities, will be educated prior to their next shift worked regarding this process. Daily monitoring audits were initiated and scheduled for 30 days, then	21050		10/23/2026

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21050	Continued from page 26 weekly monitoring audits for the next 60 days. SUGGESTED METHOD OF CORRECTION: The registered dietician or designated person can review all diets to ensure the nutritional needs of each resident are met, can review menus to ensure options for modified diets are included, can review instructions for preparation of modified diets meet the needs of residents, can review and/or modify facility policies on modified diets to ensure they align with standards of practice and can provide education to all staff responsible for preparing and serving modified diets. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21050		10/23/2026