

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Aviata at the Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Highlands Blvd N Palm Harbor, FL 34684	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident's right to be free from neglect for one resident (#3) out of two residents reviewed for neglect and abuse. The facility neglected to provide Resident #3 with the correct physician ordered diet and resulted in the resident choking, which required staff to execute the Heimlich maneuver. Resident #3's care plan and speech therapy evaluation showed the resident needed assistance with dining and supervision as needed. Observations of the resident during the lunch dining on 11/17/25 and 11/18/25 revealed he was not in the upright position when eating, which increased the risk of choking, and one to one supervision was not observed. These failures created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on 11/18/25. The findings of Immediate Jeopardy were determined to be removed on 11/20/25 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings Included: 1. On 11/17/25 at 11:39 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60-65 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Further observations of Resident #3 revealed he ate his meal without assistance from staff. On 11/18/25 at 11:50 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Staff were observed setting up the meal tray in front of him. Resident #3 began consuming his meal unassisted by staff. He was observed having difficulty getting food onto the fork. After four attempts, Resident #3 was able to get a dime-sized amount of food on the fork. Staff E, Certified Nursing Assistant (CNA) stated to Staff F, CNA, He [Resident #3] keeps doing that because he can't see his food. Staff F, CNA was observed looking at Resident #3's meal tray and stated, Well, he's almost done. A review of Resident #3's admission record revealed he was admitted on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, muscle weakness (generalized), muscle wasting and atrophy, anxiety disorder, major depressive disorder, unspecified convulsions, persistent mood [affective] disorder, and constipation. A review of Resident #3's quarterly Minimum Data Set (MDS), dated [DATE], revealed the following: - Section C - Cognitive Patterns, Brief Interview for Mental Status (BIMS) . BIMS Summary Score 03, indicating severe impairment.- Section GG - Functional Abilities, . A. Eating: . 05. Setup or clean-up assistance .- Section K - Swallowing/Nutritional Status, . C. Mechanically altered diet - require change in texture of food or liquids (e.g. [example], pureed food, thickened liquids) Yes . D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Yes . A review of Resident #3's current diet orders revealed the following: - Consistent Carbohydrates (CCD) diet, Pureed texture, Regular / Thin consistency. Directions: no salt packets, with a start date of 11/11/25 and revised on 11/11/25. A review of Resident #3's discontinued diet orders revealed the following:- CCHO [consistent/constant carbohydrate diet], Low (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Fat, Low Chol [cholesterol], NAS [no added salt] diet, Regular texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/10/24 and an end date on 4/11/24. - CCHO, Low Fat, Low Chol, NAS diet, Mechanical Soft texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/11/24 and an end date on 4/11/24. - CCHO (Controlled Carbohydrates) diet, Mechanical Soft texture, Regular / Thin consistency. Directions: NAS; fortified foods TID [three times a day]. Status: Discontinued, with a start date of 4/11/24, revised date of 5/7/24, and an end date on 6/2/24. - CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency. Directions NAS., with a start date of 6/2/24, revised date of 7/9/25, and an end date on 11/11/25.A review of Resident #3's care plan revealed the following: - [Resident name] is at risk for Malnutrition r/t [related to] psychotropics, therapeutic diet, T2DM [type 2 diabetes mellitus], dementia, metabolic encephalopathy, HTN [hypertension], CKD [chronic kidney disease] stage 3, mechanically altered diet, needs assist with meals MNA[malnutrition assessment]=10 Date Initiated: 04/11/2024 Revision on: 09/16/2025., with interventions to include the following, Monitor and report to the physician: . Chewing/swallowing problems Date Initiated: 04/11/2024 . or for signs and symptoms of aspiration such as coughing, choking, pocketing, runny nose, watery eyes spitting food out, wet vocal quality, wet lungs. Notify SLP [speech language pathologist] if any symptoms are present Date Initiated: 04/11/2024 . Provide diet as ordered, monitor and record intake- Dysphagia Puree Texture/thin liquids Date Initiated: 04/11/2024 Revision on: 11/11/2025. Set up trays/supervise/cue/assist as needed with meals and allow adequate time to consume food/fluids provided Date Initiated: 04/11/2024 .- [Resident name] has a communication problem due to: Brain injury, Cognitive impairment, Expressive Aphasia, Receptive Aphasia Date Initiated: 04/23/2024 Revision on: 04/23/2024.A review of Resident #3's progress notes revealed the following:- 11/9/25 health status note 12:15, Patient in dining room for lunch, patient observed eating and choking on food. Patient assessed and vitals stable at this time. Patient skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 physician progress note, . DOS [date of service]: 11/10/2025 Effective Time: 10:30 AM CC [chief complaint]: Dysphagia / Choking Episode . HPI [history of present illness]: Nursing reports that yesterday the patient was in the dining room eating and had an episode where he was unable to swallow food. He reportedly did not get the correct food consistency for his meal. Staff performed the Heimlich maneuver on him and the food was abruptly dislodged. He did not experience any observed respiratory distress after the incident. Nursing reports after the incident he has been at his baseline cognitively and functionally. He denies any shortness of breath, coughing, fevers/chills/night sweats, sputum production, n/v/d [nausea, vomiting, diarrhea], sore throat, acute pain, dizziness, lightheadedness, headaches, vision changes, increased weakness. CXR [chest x-ray] reviewed: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. CBC/CMP [complete blood count/comprehensive metabolic panel] in AM [morning] to check for leukocytosis ST [speech therapy] eval [evaluation] Continue Diet: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency Upright 90 degrees for all PO [by mouth] intake Staff to ensure pt. [patient] receives correct food consistency Monitor Atelectasis CXR indicative of probable atelectasis in the absence of fevers/leukocytosis ., created by Staff C, Nurse Practitioner (NP). - 11/10/25 health status note 12:05, Note Text: Late Entry: At time of assessing the resident after choking his bilateral lungs were clear, Resp [respiratory] even and nonlabored, O2 [oxygen] sat [saturation] at 98% on r.a. [room air] Res. [resident] was taken back to his room and was sitting up in chair without s/s [signs and symptoms] of distress, created by Staff D, Nurse Supervisor. - 11/10/25 health status note 13:04, Note Text: At the time of assessment of patient, vitals taken: B/P [blood pressure] 126/80, pulse 98, temp 97.9, respirations 18, and O2 95 on room air. Patient alert and in no apparent distress. Lung sounds clear and patient observed to have normal respiratory effort, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 health (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	status note 13:32, CXR reviewed: IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025. 1) Vitals every shift for 3 days 2) CBC/CMP in AM.- 11/11/25 health status note, Labs reviewed, stable without any leukocytosis. Stable anemia and DM II [diabetes mellitus two] are noted. No new orders.- 11/11/25 health status note 21:12, LATE ENTRY Note Text: Resident is alert with confusion and is assisted totally with ADL's [activities of daily living]. Transfers to and from Geri chair with Hoyer lift and 2 assist [two person assist]. Resident is assisted with meals, encouraged to eat meal. Incontinent of B&B [bladder and bowel]. No s/s of acute distress and no c/o [complaints of] pain voiced at this time. - 11/12/25 health status note, Note Text: IDT [interdisciplinary] reviewed for s/p [status post] choking incident. IDT reviewed chart along with labs and chest xray all noted to be unremarkable. Resident is alert with confusion, total care for ADL's incontinent of b/b mechanical lift for transfers. Sits in a Geri-chair for proper positioning. Resident was eating in MDR [main dining room] where he consumes his food independently. Pt [patient] choked on a piece of ham, Heimlich was successfully preformed and ham was expelled. Skin assessment completed today to assess for any discoloration r/t Heimlich. Skin was clear without redness or discoloration. NO s/s of discomfort or pain was noted. Lungs clear today and no cough noted. Ate in MDR with no s/s of difficulty eating or consuming fluids. MD [medical doctor] and family continue to be aware of all changes.- 11/13/25 health status note, V/S [vital signs] taken on 11/9/2025 s/p [status post] incident in MDR 126/89, 98, 18, 97.9 with O2 sat 95 on RA, created by the Director of Nursing (DON). A review of Resident #3's assessments revealed the following: - 11/9/25 17:50 [5:50 p.m.] situation, background, assessment, recommendation (SBAR) summary for providers, . 31. Other change in condition . 1a. List the other change: Res. [resident] was choking on his lunch tray . 2. This started on: 11/9/25 3. What time of day did this start? 2. Afternoon . Mental Status Evaluation 7. No changes observed Functional Status Evaluation 6. No changes observed. Since the change in condition occurred have the symptoms or signs gotten: 2. Better . Res. coughed up food that was chocking him . Res. was observed chocking on his lunch tray, Heimlich maneuver performed and res. expelled food. Res. assessed and vitals stable at this time. Res. skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room. Family notified- [family member name] Date: 11/09/2025 Time: 6:00 PM . Date and time of clinician notification: 11/9/2025 13:30 [1:30 p.m.] . New orders for 2 view CXR per [Staff C, NP], created by Staff D, Nurse Supervisor. Further review of the SBAR communication form revealed the vital signs documented were from 10/7/25. - 9/16/25 nutrition assessment form, . B. Dietary Intake 1. Current Diet Order/Enteral orders/Supplement Order: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency, NAS Med Pass 2.0 120ml [milliliters] TID . Ability to Chew/Swallow: 5. None of the above . E. Neuropsychological problems 0. Severe dementia or depression . Comment/Summary: [NAME] is at risk for Malnutrition r/t psychotropics, therapeutic diet, T2DM, dementia, metabolic encephalopathy, HTN, CKD stage 3, mechanically altered diet, needs assist with meals MNA=10 . Review of Resident #3's x-ray results revealed the following:- 4/21/25 chest, single view, Clinical Information: follow up left infiltrate Test Procedure: . CHEST, SINGLE VIEW Findings: Comparison: 03/15/2025 The cardiac silhouette and mediastinal contours are normal. The lungs are free of infiltrates and focal consolidations. No pleural fluid or masses are noted. No pneumothorax is present. Impressions: No acute intrathoracic disease process. - 11/10/25 chest, 2 views, Date of Service: 11/10/2025 Clinical Information: . Pneumonitis due to inhalation of food and vomit possible aspiration Test Procedure: . CHEST, 2 VIEWS Findings: . No acute osseous or soft tissue abnormality. Cardiac and mediastinal contours are within normal limits. Normal pulmonary vasculature. No pneumothorax. Bilateral intrapillar airspace opacity is present. Peribronchial distention with peribronchial cuffing is present. This nonspecific finding indicates chronic or acute perihilar inflammation. IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025. A review of a resource from the American Lung Association revealed the following, Atelectasis happens when the tiny air sacs or alveoli in your lungs are blocked, and it causes a partial or full collapse of one or more lobes or sections of the lungs. Other causes may include A small object blocking the airways (like food or toy) . Lung infection like pneumonia . Your healthcare provider will discuss treatment options if atelectasis is caused by a tumor, an aspirated foreign body, or other chronic lung conditions. Serious complications may occur if atelectasis remains untreated. Complications can include low oxygen levels, pneumonia, or lung failure. The reference was reviewed on the following website https://www.lung.org/lung-health-diseases/lung-disease-lookup/atelectasis. A review of Resident #3's speech therapy (ST) notes revealed the following:- SLP evaluation and plan of treatment, dated 11/11/25, Diagnoses Nontraumatic subacute subdural hemorrhage onset 11/11/25 Dysphagia, oropharyngeal phase onset 11/11/25 . Reason for Referral/ Current Illness: Patient is a 91 year LTC [long term care] resident of this facility referred to ST due to reported aspiration episode. Patient is currently on a puree diet with thin liquids. Prior Level of Function Intake/Diet Level = Puree consistencies, Thin liquids, Successive Swallows; Swallowing Abilities = Severe; Self Feeding = Total Dependence without attempts to initiate . Oral Exam Oral Motor Structure and Function = Impaired . Cognition Cognitive-Communicative Skills = Impaired . Cognition Follows Directions = Max(A) [Assistance], responsive to cues . Clinical Bedside Assessment of Swallowing Overall Abilities = Severe . Solids Assessed During Eval = Puree consistencies . Assessment Summary Clinical Impression: Patient seen for dysphagia evaluation at bedside. Per nursing and chart review, patient has known history of advanced dementia with limited cognitive-linguistic function. Spontaneous oral movements appear functional for current diet level. No overt signs/symptoms of aspiration (no coughing, throat clearing, or wet vocal quality) observed during limited trials. Deficits include impaired cognition impacting ability to follow commands, implement swallow strategies, or adjust to texture changes. Current diet of puree solids and thin liquids appears appropriate and safe at this time based on bedside observation and nursing report. Provide 1:1 feeding assistance and slow rate of intake. Ensure upright positioning of 90 degrees during and 30 minutes after meals. No further swallow study indicated due to advanced dementia and inability to participate in treatment. Supervision for Oral Intake = Close supervision .On 11/17/25 at 10:10 a.m., an interview was conducted with Resident #10. He confirmed he witnessed the incident with Resident #3 on 11/9/25. He stated, He [Resident #3] choked. Resident #10 said the meal tickets are on the food trays. He said the CNAs passed the trays and double checked the meal ticket matched the food. Resident #10 stated that day, A new person was helping. Resident #10 said the new staff member gave Resident #3 a tray with a regular diet. He said Resident #3 was in a recliner chair. Resident #10 said the staff were patting his back, but it was not helping. Resident #10 described the staff present as, Frantic. He said Resident #9 wheeled himself to the hallway outside of the dining room stating, Help, Help and putting his hands up. Resident #10 said he recalled the staff present saying, What do we do, what do we do, I will call for the nurse. He confirmed there was no nurse present in the dining room during the lunch meal on 11/9/25. Resident #10 said a nurse never came to assess Resident #3. He said staff took Resident #3 to his room after the lunch meal was completed. Resident #10 confirmed he stayed for the duration of the lunch. He said other departments are now helping in the dining room and a nurse is present. A review of Resident #10 quarterly MDS, dated [DATE], under section C - cognitive patterns revealed a BIMS score of 15, indicating cognitively intact. On 11/17/25 at 1:29 p.m., an interview was conducted with the Food Service Director. He said he had been in this position since August 2025. He said Staff G, Dietary Aide was at the end of the tray line and the last one to touch the tray in the kitchen on 11/9/25 during lunch. The Food Service Director said he was not present for the incident, but he learned Resident #3 choked in the dining room on 11/9/25. He said two other staff members, Staff H, [NAME] and Staff I, Dietary Aide were also on the tray line. He said Staff I, Dietary Aide was (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at the beginning of the tray line and called the ticket out to include the diet, such as mechanical or regular. The Food Service Director said Staff G, Dietary Aide was at the end of the line and repeated back what was provided to her by the cook. He said Staff I, Dietary Aide was telling Staff H, [NAME] what she needed to plate, and Staff G, Dietary Aide double checked the meal on the tray was correct. He said Staff G, Dietary Aide called him on 11/9/25 and told him what happened. The Food Service Director stated he talked to Staff G, Dietary Aide the following day and asked for more information about what happened. He said she told him, I [Staff G, Dietary Aide] don't remember, there were people coming in, when you're not here they come in and do whatever they want and not sure what happened. The Food Service Director said Resident #3's diet on 11/9/25 was dysphagia, mechanical soft which meant ground consistency for the protein, pureed vegetables, and a pureed starch. He said he could not provide the residents meal ticket for that day, as he did not have access to do that, but he could provide an example meal ticket of a dysphagia, mechanical texture for the meal that day. He said the mechanical and pureed diets are the same consistency, except for the protein. He said he changed Resident #3's diet to pureed consistency on 11/10/25 in the meal tracker system. The Food Service Director said he did not have documentation of in-services or training regarding meal ticket accuracy for dietary staff prior to August 2025. He said since he has been at the facility he has not needed to provide an in-service on meal ticket accuracy. The Food Service Director said he completed audits and an in-service on meal ticket accuracy to all the dietary staff on 11/10/25. On 11/17/25 at 1:49 p.m., an interview was conducted with Staff G, Dietary Aide. She said on 11/9/25, during lunch, Staff I, Dietary Aide and Staff H, cook were on the tray line. Staff G, Dietary Aide stated she was at the end of the tray line as the, The double checker. She said she called out every ticket and made sure it is the correct food. Staff G, Dietary Aide said the cook knows the diets because of the first person on tray line who tells them. She said the first person called out the diet, the cook puts the food on the plate, and she puts the plate on the resident's tray. Staff G, Dietary Aide said the meal ticket is already on the tray, and she made sure it had the correct beverage, condiments, diet, and the meal matches. She said she did not remember Resident #3 getting a regular diet and believed he received pureed consistency. Staff G, Dietary Aide stated, It's possible it could have happened, and said she had taken accountability if the resident received the wrong diet. She said staff kept interrupting them during the tray line for lunch that day. She said she recalled being told the nurses aids were short staffed on 11/9/25. She said she recalled the dining room cart went out, then the first cart for the south unit went out, then she left the kitchen, came back and when she returned there were two staff members in the kitchen. Staff G, Dietary Aide said one staff member had a tray with a plate and the other staff had the meal ticket in their hand. She said they told her the resident had choked and something serious could have happened. Staff G, Dietary Aide said she recalled walking in the dining room between 11:45 a.m. and 12:00 p.m. and had not seen any resident choking. She said she recalled seeing the two staff members sitting down in the dining room. Staff G, Dietary Aide said when the tray line was almost done is when the two staff members approached her about the choking incident. She said after the two staff approached her, she immediately called the Food Service Director and told him the resident choked and staff were blaming her for the incident. Staff G, Dietary Aide stated the Food Service Director told her no one had called him and, They would see about it on Monday when he comes in. She confirmed that the Nursing Home Administrator (NHA) asked her what happened and she provided a statement. She confirmed she had meal ticket accuracy education, before 11/9/25, from the Food Service Director. On 11/17/25 at 2:29 p.m., a phone interview was conducted with Staff I, Dietary Aide. She said she was typically the first person working on the tray line. She described the, A2 and A1, roles. She stated the person as A1 is preparing the tray with items such as milk and juice, then the tray goes to the person as A2. She stated, A2 putting plate with food exactly what is required with ticket is talking about. Regarding the incident on 11/9/25 she stated, I remember person who was A2 making mistake . that person [Resident #3] has mechanical. Mechanically it is supposed to be bread and meat ground. She [A2] exchanged for regular diet. She (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said the person in the A2 role did not pay attention and gave Resident #3 the wrong meal. Staff I, Dietary Aide said when she starts the line she puts the ticket on the tray, looks at the diet and says loudly if the meal ticket says mechanical or pureed. She said when she first started, at the end of June 2025, she was educated on the tray line and meal ticket accuracy process by the former food service director and one of the dietary aides. A follow-up interview was conducted with the Food Service Director on 11/17/25 at 2:44 p.m. He said there's been no change to the process on the tray line after the choking incident on 11/9/25. He said the only change made was to the dining meal times. The Food Service Director stated they haven't implemented anything new but, Thought about extra set of eyes to help the tray line process. He said he wanted to put an extra dietary staff in the middle of the tray line, so the last person could focus on checking the trays. The Food Service Director said the nurses and CNAs are supposed to check the tray when meal passing. He stated, It's supposed to be happening, but it fluctuates. A review of a meal ticket on 11/9/25 revealed the following, Dys [Dysphagia] Mech [Mechanical] . Ground Glazed Baked Ham, [NAME] Gravy, Black-Eyed Peas, Fortified Mashed Potatoes, Chopped Greens, Chop, Pureed Dinner Roll/Bread . Vanilla Ice Cream . The Food Service Director confirmed the meal ticket reflected what Resident #3 would have received. An interview was conducted on 11/17/25 at 1:40 p.m. with Staff J, CNA. Staff J, CNA said there was never a nurse in the dining room for meals. She said she typically was the only person in the dining room for lunch and often times at dinner as well. Staff J, CNA said she had complained multiple times about being the only person in the dining room and asked for more assistance, but no one ever came to help. She said the day Resident #3 choked she was in the dining room for lunch time. She said Staff K, receptionist came to the dining room to help pass trays. Staff J, CNA said she knew the residents and their diets well. She said Resident #3 received a meal tray with a regular diet, and he should have received a pureed diet. She said the day of the incident, Resident #3 was feeding himself and she heard him gasping for air. Staff J, CNA said she looked over and saw he was choking. She said his eyes were watering and demonstrated he had his hands on the chest/neck area while gasping. Staff J, CNA and Staff K, receptionist both went to assist him and yelled out for reception to get a nurse. Staff J, CNA said she leaned him forward to pat him on the back. She said it was difficult because he was reclined and leaning back in a Geri chair. She confirmed Staff K, receptionist performed the Heimlich maneuver on Resident #3. She said she assisted with twisting the resident to the side that way Staff K, receptionist could get behind him. Staff J, CNA said she is not cardiopulmonary resuscitation (CPR) certified. She said by the time Staff D, Nurse Supervisor arrived the food had been dislodged, and the resident was breathing. Staff J, CNA said Staff D, Nurse Supervisor asked what happened and said they should not have done anything because only a nurse should do the Heimlich. She said Staff D, Nurse Supervisor asked them if the resident was ok and said she had to go back to the unit to finish what she was doing, then left. Staff J, CNA said she did not observe an assessment completed on Resident #3 in the dining room and no vital signs were taken at that time. She said Resident #3 stayed in the dining room for another hour and ate some ice cream. She said meals in the dining room started around 11:15 a.m. to 11:30 a.m., and Resident #3 choked around 11:45 a.m. Staff J, CNA said he did not leave the dining room until after 12:45 p.m. On 11/18/25 at 1:50 p.m., an interview was conducted with Staff K, receptionist. She said she typically worked as a receptionist, but she picked up a shift for activities on 11/9/25. She said she helped pass the meal trays out sometimes. She said she went to help Staff J, CNA in the dining room because she was the only staff member there. She said she did not know she had to check the diets on the meal tickets when passing the trays. Staff K, receptionist confirmed she gave Resident #3 his tray and he started to eat the meal. She said she heard Resident #3 gasping and they tried to pat his back. She confirmed there was no nurse present, so they called out for reception to get a nurse. She said while all this was happening, Resident #9 was scared, and he wheeled down the hall yelling for a nurse to help. She said Resident #3's gasping was getting worse therefore, she did five abdominal thrusts from the front while he was in the Geri-chair. She said the thrusts did not do (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	anything. Staff K, receptionist said herself and Staff J, CNA were able to twist the resident to the side, that way she could get her arms around the resident to perform the Heimlich maneuver. Staff K, receptionist said she did three abdominal thrusts and the lodged food came out of the resident's throat. She stated what came out of the resident's throat was a, Thick piece of ham. Staff K, receptionist said she is not a clinical staff member at the facility, but she is CPR certified. On 11/18/25 at 2:03 p.m., a phone interview was conducted with Staff D, Nurse Supervisor. She stated, That day [11/9/25] I was the only supervisor in building, which is normal. Staff D, Nurse Supervisor said she was on the south wing assessing a patient who was complaining of chest pain. She stated while she was, Getting that under control, she heard yelling that a nurse was needed for an assessment. She said she ran to the dining room and confirmed the incident happened during lunch time. Staff D, Nurse Supervisor said Resident #3 was sitting up in the chair, there were approximately four staff members there, and she heard he choked. She stated, Whatever they did it was already taken care of, by the time she got to the dining room. Staff D, Nurse Supervisor confirmed the staff present said they did the Heimlich. She stated, He was calm, peaceful, nothing wrong with him. Staff D, Nurse Supervisor confirmed she assessed Resident #3 to include listening to his lungs and looking at him. She stated it was a Quick look, listen, and go, as she had another emergency she was handling. She said she saw he was okay; then went to the kitchen and asked what and how the incident happened. Staff D, Nurse Supervisor said, The head person in the kitchen stated someone was on their phone while fixing the tray. She said she told the kitchen staff they needed to be careful, and Resident #3 could have died. She did not recall the names of the kitchen staff present. She said the resident went back to his room but could not confirm who took him there. She said she called and let her manager know about the incident. Staff D, Nurse Supervisor confirmed Staff B, LPN was his assigned nurse. She stated, She [Staff B, LPN] was on the floor, not in the dining room. She said she does not know Resident #3 well but knows he was on a pureed diet and assumed he had a swallowing difficulty. She confirmed she assisted with educating staff after the incident. She said immediately after the incident, they started making sure a nurse and/or management is in the dining room during mealtimes. When asked which residents in the dining room needed assistance with eating, she stated, Nobody in the dining room needs assistance with eating. Not even Resident #3 needs assistance with eating. Staff D, Nurse Supervisor said staff know their residents and are aware if they needed assistance when eating. She stated, If they don't know, the nurse knows. She said she is not sure where to find information about a resident who needed assistance with eating. Staff D, Nurse Supervisor stated, I'm thinking, that's a good question, never thought of the process. She stated she has been at the facility since March 2025 and it, Never crossed my mind to ask that question about where to look. At 2:46 p.m., a follow-up interview with Staff D, Nurse Supervisor was conducted by phone. She said it was the Kardex where they find information about residents who need assistance with eating. She stated, I stick by my answer of staff knowing their residents, if they need assistance with eating. On 11/18/25 at 2:31 p.m., a phone interview was conducted with Staff B, LPN. She said on 11/9/25, Resident #3 went to the dining room for lunch and came back to his room. She said she assessed him to include vitals and lung sounds. She confirmed she documented her assessment in the electronic health record. Staff B, LPN stated, He was perfectly fine back in the room and breathing with no difficulty. She said she was told he received the wrong meal or got the wrong tray, he choked, and the Heimlich was performed. Staff B, LPN said Resident #3 was on a pureed diet. She said when he got back to his room that is when she was told about what happened. She confirmed she would have expected to be notified and would have evaluated him sooner since she was his assigned nurse. Staff B, LPN said lunch in the dining room is around 11:00 am. When asked what time she assessed Resident #3 she stated, Pretty much whatever time I documented is when I evaluated him, it was probably a few minutes before. Staff B,		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were free from avoidable accidents for two residents (#3 and #2) out of three residents reviewed for accidents. The facility failed to provide Resident #3 with the correct physician ordered diet and resulted in the resident choking, which required staff to execute the Heimlich maneuver. Resident #3's care plan and speech therapy evaluation showed the resident needed assistance with dining and one to one supervision. Observations of the resident during the lunch dining on 11/17/25 and 11/18/25 revealed he was not in the upright position when eating, which increased the risk of choking, and one to one supervision was not observed. These failures created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on 11/18/25. The findings of Immediate Jeopardy were determined to be removed on 11/20/25 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings Included: 1. On 11/17/25 at 11:39 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60-65 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Further observations of Resident #3 revealed he ate his meal without assistance from staff. On 11/18/25 at 11:50 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Staff were observed setting up the meal tray in front of him. Resident #3 began consuming his meal unassisted by staff. He was observed having difficulty getting food onto the fork. After four attempts, Resident #3 was able to get a dime-sized amount of food on the fork. Staff E, Certified Nursing Assistant (CNA) stated to Staff F, CNA, He [Resident #3] keeps doing that because he can't see his food. Staff F, CNA was observed looking at Resident #3's meal tray and stated, Well, he's almost done. A review of Resident #3's admission record revealed he was admitted on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, muscle weakness (generalized), muscle wasting and atrophy, anxiety disorder, major depressive disorder, unspecified convulsions, persistent mood [affective] disorder, and constipation. A review of Resident #3's quarterly Minimum Data Set (MDS), dated [DATE], revealed the following:- Section C - Cognitive Patterns, Brief Interview for Mental Status (BIMS) . BIMS Summary Score 03, indicating severe impairment.- Section GG - Functional Abilities, . A. Eating: . 05. Setup or clean-up assistance .- Section K - Swallowing/Nutritional Status, . C. Mechanically altered diet - require change in texture of food or liquids (e.g. [example], pureed food, thickened liquids) Yes . D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Yes . A review of Resident #3's current diet orders revealed the following:- Consistent Carbohydrates (CCD) diet, Pureed texture, Regular / Thin consistency. Directions: no salt packets, with a start date of 11/11/25 and revised on 11/11/25. A review of Resident #3's discontinued diet orders revealed the following:- CCHO [consistent/constant carbohydrate diet], Low Fat, Low Chol [cholesterol], NAS [no added salt] diet, Regular texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/10/24 and an end date on 4/11/24.- CCHO, Low Fat, Low Chol, NAS diet, Mechanical Soft texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/11/24 and an end date on 4/11/24.- CCHO (Controlled Carbohydrates) diet, Mechanical Soft texture, Regular / Thin consistency. Directions: NAS; fortified foods TID [three times a day]. Status: Discontinued, with a start date of 4/11/24, revised date of 5/7/24, and an end date on 6/2/24.- CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency. Directions NAS., with a start date of 6/2/24, revised date of 7/9/25, and an end (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	date on 11/11/25.A review of Resident #3's care plan revealed the following:- [Resident name] is at risk for Malnutrition r/t [related to] psychotropics, therapeutic diet, T2DM [type 2 diabetes mellitus], dementia, metabolic encephalopathy, HTN [hypertension], CKD [chronic kidney disease] stage 3, mechanically altered diet, needs assist with meals MNA[malnutrition assessment]=10 Date Initiated: 04/11/2024 Revision on: 09/16/2025., with interventions to include the following, Monitor and report to the physician: . Chewing/swallowing problems Date Initiated: 04/11/2024 . or for signs and symptoms of aspiration such as coughing, choking, pocketing, runny nose, watery eyes spitting food out, wet vocal quality, wet lungs. Notify SLP [speech language pathologist] if any symptoms are present Date Initiated: 04/11/2024 . Provide diet as ordered, monitor and record intake- Dysphagia Puree Texture/thin liquids Date Initiated: 04/11/2024 Revision on: 11/11/2025. Set up trays/supervise/cue/assist as needed with meals and allow adequate time to consume food/fluids provided Date Initiated: 04/11/2024 .- [Resident name] has a communication problem due to: Brain injury, Cognitive impairment, Expressive Aphasia, Receptive Aphasia Date Initiated: 04/23/2024 Revision on: 04/23/2024.A review of Resident #3's progress notes revealed the following:- 11/9/25 health status note 12:15, Patient in dining room for lunch, patient observed eating and choking on food. Patient assessed and vitals stable at this time. Patient skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 physician progress note, . DOS [date of service]: 11/10/2025 Effective Time: 10:30 AM CC [chief complaint]: Dysphagia / Choking Episode . HPI [history of present illness]: Nursing reports that yesterday the patient was in the dining room eating and had an episode where he was unable to swallow food. He reportedly did not get the correct food consistency for his meal. Staff performed the Heimlich maneuver on him and the food was abruptly dislodged. He did not experience any observed respiratory distress after the incident. Nursing reports after the incident he has been at his baseline cognitively and functionally. He denies any shortness of breath, coughing, fevers/chills/night sweats, sputum production, n/v/d [nausea, vomiting, diarrhea], sore throat, acute pain, dizziness, lightheadedness, headaches, vision changes, increased weakness. CXR [chest x-ray] reviewed: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. CBC/CMP [complete blood count/comprehensive metabolic panel] in AM [morning] to check for leukocytosis ST [speech therapy] eval [evaluation] Continue Diet: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency Upright 90 degrees for all PO [by mouth] intake Staff to ensure pt. [patient] receives correct food consistency Monitor Atelectasis CXR indicative of probable atelectasis in the absence of fevers/leukocytosis ., created by Staff C, Nurse Practitioner (NP).- 11/10/25 health status note 12:05, Note Text: Late Entry: At time of assessing the resident after chocking his bilateral lungs were clear, Resp [respiratory] even and nonlabored, O2 [oxygen] sat [saturation] at 98% on r.a. [room air] Res. [resident] was taken back to his room and was sitting up in chair without s/s [signs and symptoms] of distress, created by Staff D, Nurse Supervisor.- 11/10/25 health status note 13:04, Note Text: At the time of assessment of patient, vitals taken: B/P [blood pressure] 126/80, pulse 98, temp 97.9, respirations 18, and O2 95 on room air. Patient alert and in no apparent distress. Lung sounds clear and patient observed to have normal respiratory effort, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 health status note 13:32, CXR reviewed: IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025. 1) Vitals every shift for 3 days 2) CBC/CMP in AM.- 11/11/25 health status note, Labs reviewed, stable without any leukocytosis. Stable anemia and DM II [diabetes mellitus two] are noted. No new orders.- 11/11/25 health status note 21:12, LATE ENTRY Note Text: Resident is alert with confusion and is assisted totally with ADL's [activities of daily living]. Transfers to and from Geri chair with Hoyer lift and 2 assist [two person assist]. Resident is assisted with meals, encouraged to eat meal. Incontinent of (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B&B [bladder and bowel]. No s/s of acute distress and no c/o [complaints of] pain voiced at this time.- 11/12/25 health status note, Note Text: IDT [interdisciplinary] reviewed for s/p [status post] choking incident. IDT reviewed chart along with labs and chest xray all noted to be unremarkable. Resident is alert with confusion, total care for ADL's incontinent of b/b mechanical lift for transfers. Sits in a Geri-chair for proper positioning. Resident was eating in MDR [main dining room] where he consumes his food independently. Pt [patient] choked on a piece of ham, Heimlich was successfully preformed and ham was expelled. Skin assessment completed today to assess for any discoloration r/t Heimlich. Skin was clear without redness or discoloration. NO s/s of discomfort or pain was noted. Lungs clear today and no cough noted. Ate in MDR with no s/s of difficulty eating or consuming fluids. MD [medical doctor] and family continue to be aware of all changes.- 11/13/25 health status note, V/S [vital signs] taken on 11/9/2025 s/p [status post] incident in MDR 126/89, 98, 18, 97.9 with O2 sat 95 on RA, created by the Director of Nursing (DON).A review of Resident #3's assessments revealed the following:- 11/9/25 17:50 [5:50 p.m.] situation, background, assessment, recommendation (SBAR) summary for providers, . 31. Other change in condition . 1a. List the other change: Res. [resident] was choking on his lunch tray . 2. This started on: 11/9/25 3. What time of day did this start? 2. Afternoon . Mental Status Evaluation 7. No changes observed Functional Status Evaluation 6. No changes observed. Since the change in condition occurred have the symptoms or signs gotten: 2. Better . Res. coughed up food that was choking him . Res. was observed choking on his lunch tray, Heimlich maneuver performed and res. expelled food. Res. assessed and vitals stable at this time. Res. skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room. Family notified- [family member name] Date: 11/09/2025 Time: 6:00 PM . Date and time of clinician notification: 11/9/2025 13:30 [1:30 p.m.] . New orders for 2 view CXR per [Staff C, NP], created by Staff D, Nurse Supervisor. Further review of the SBAR communication form revealed the vital signs documented were from 10/7/25.- 9/16/25 nutrition assessment form, . B. Dietary Intake 1. Current Diet Order/Enteral orders/Supplement Order: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency, NAS Med Pass 2.0 120ml [milliliters] TID . Ability to Chew/Swallow: 5. None of the above . E. Neuropsychological problems 0. Severe dementia or depression . Comment/Summary: [NAME] is at risk for Malnutrition r/t psychotropics, therapeutic diet, T2DM, dementia, metabolic encephalopathy, HTN, CKD stage 3, mechanically altered diet, needs assist with meals MNA=10 .Review of Resident #3's x-ray results revealed the following:- 4/21/25 chest, single view, Clinical Information: follow up left infiltrate Test Procedure: . CHEST, SINGLE VIEW Findings: Comparison: 03/15/2025 The cardiac silhouette and mediastinal contours are normal. The lungs are free of infiltrates and focal consolidations. No pleural fluid or masses are noted. No pneumothorax is present. Impressions: No acute intrathoracic disease process.- 11/10/25 chest, 2 views, Date of Service: 11/10/2025 Clinical Information: . Pneumonitis due to inhalation of food and vomit possible aspiration Test Procedure: . CHEST, 2 VIEWS Findings: . No acute osseous or soft tissue abnormality. Cardiac and mediastinal contours are within normal limits. Normal pulmonary vasculature. No pneumothorax. Bilateral intrapillar airspace opacity is present. Peribronchial distention with peribronchial cuffing is present. This nonspecific finding indicates chronic or acute perihilar inflammation. IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025.A review of a resource from the American Lung Association revealed the following, Atelectasis happens when the tiny air sacs or alveoli in your lungs are blocked, and it causes a partial or full collapse of one or more lobes or sections of the lungs. Other causes may include A small object blocking the airways (like food or toy) . Lung infection like pneumonia . Your healthcare provider will discuss treatment options if atelectasis is caused by a tumor, an aspirated foreign body, or other chronic lung conditions. Serious complications may occur if atelectasis remains untreated. Complications can include low oxygen levels, pneumonia, or lung failure. The reference was reviewed (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on the following website https://www.lung.org/lung-health-diseases/lung-disease-lookup/atelectasis. A review of Resident #3's speech therapy (ST) notes revealed the following:- SLP evaluation and plan of treatment, dated 11/11/25, Diagnoses Nontraumatic subacute subdural hemorrhage onset 11/11/25 Dysphagia, oropharyngeal phase onset 11/11/25 . Reason for Referral/ Current Illness: Patient is a 91 year LTC [long term care] resident of this facility referred to ST due to reported aspiration episode. Patient is currently on a puree diet with thin liquids. Prior Level of Function Intake/Diet Level = Puree consistencies, Thin liquids, Successive Swallows; Swallowing Abilities = Severe; Self Feeding = Total Dependence without attempts to initiate . Oral Exam Oral Motor Structure and Function = Impaired . Cognition Cognitive-Communicative Skills = Impaired . Cognition Follows Directions = Max(A) [Assistance], responsive to cues . Clinical Bedside Assessment of Swallowing Overall Abilities = Severe . Solids Assessed During Eval = Puree consistencies . Assessment Summary Clinical Impression: Patient seen for dysphagia evaluation at bedside. Per nursing and chart review, patient has known history of advanced dementia with limited cognitive-linguistic function. Spontaneous oral movements appear functional for current diet level. No overt signs/symptoms of aspiration (no coughing, throat clearing, or wet vocal quality) observed during limited trials. Deficits include impaired cognition impacting ability to follow commands, implement swallow strategies, or adjust to texture changes. Current diet of puree solids and thin liquids appears appropriate and safe at this time based on bedside observation and nursing report. Provide 1:1 feeding assistance and slow rate of intake. Ensure upright positioning at 90 degrees during and 30 minutes after meals. No further swallow study indicated due to advanced dementia and inability to participate in treatment. Supervision for Oral Intake = Close supervision .On 11/17/25 at 10:10 a.m., an interview was conducted with Resident #10. He confirmed he witnessed the incident with Resident #3 on 11/9/25. He stated, He [Resident #3] choked. Resident #10 said the meal tickets are on the food trays. He said the CNAs passed the trays and double checked the meal ticket matched the food. Resident #10 stated that day, A new person was helping. Resident #10 said the new staff member gave Resident #3 a tray with a regular diet. He said Resident #3 was in a recliner chair. Resident #10 said the staff were patting his back, but it was not helping. Resident #10 described the staff present as, Frantic. He said Resident #9 wheeled himself to the hallway outside of the dining room stating, Help, Help and putting his hands up. Resident #10 said he recalled the staff present saying, What do we do, what do we do, I will call for the nurse. He confirmed there was no nurse present in the dining room during the lunch meal on 11/9/25. Resident #10 said a nurse never came to assess Resident #3. He said staff took Resident #3 to his room after the lunch meal was completed. Resident #10 confirmed he stayed for the duration of the lunch. He said other departments are now helping in the dining room and a nurse is present. A review of Resident #10 quarterly MDS, dated [DATE], under section C - cognitive patterns revealed a BIMS score of 15, indicating cognitively intact. On 11/17/25 at 1:29 p.m., an interview was conducted with the Food Service Director. He said Staff G, Dietary Aide was at the end of the tray line and the last one to touch the tray for Resident #3 in the kitchen on 11/9/25 during lunch. The Food Service Director said he was not present for the incident and he learned Resident #3 choked in the dining room on 11/9/25. He said two other staff members, Staff H, [NAME] and Staff I, Dietary Aide were also on the tray line. He said Staff I, Dietary Aide was at the beginning of the tray line and called the ticket out to include the diet. The Food Service Director said Staff G, Dietary Aide was at the end of the line and repeated back what was provided to her by the cook. He said Staff I, Dietary Aide was telling Staff H, [NAME] what she needed to plate, and Staff G, Dietary Aide double checked the meal on the tray to assure it was correct. He said Staff G, Dietary Aide called him on 11/9/25 and told him what happened. The Food Service Director stated he talked to Staff G, Dietary Aide the following day and asked for more information about what happened. He said she told him, I [Staff G, Dietary Aide] don't remember, there were people coming in, when you're not here they come in and do whatever they want and not sure what happened. The Food Service Director said Resident #3's diet on 11/9/25 (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was dysphagia, mechanical soft which meant ground consistency for the protein, pureed vegetables, and a pureed starch. He said the mechanical and pureed diets are the same consistency, except for the protein. He said he changed Resident #3's diet to pureed consistency on 11/10/25 in the meal tracker system. On 11/17/25 at 1:49 p.m., an interview was conducted with Staff G, Dietary Aide. She said on 11/9/25, during lunch, Staff I, Dietary Aide and Staff H, cook were on the tray line. Staff G, Dietary Aide stated she was at the end of the tray line as The double checker. She said she called out every ticket and made sure it was the correct food. Staff G, Dietary Aide said the cook knows the diets because of the first person on tray line who tells them. She said the first person called out the diet, the cook puts the food on the plate, and she puts the plate on the resident's tray. Staff G, Dietary Aide said the meal ticket is already on the tray. She said she did not remember Resident #3 getting a regular diet and believed he received pureed consistency. Staff G, Dietary Aide stated, It's possible it could have happened, and said she had taken accountability if the resident received the wrong diet. She said staff kept interrupting them during the tray line for lunch that day. She said she recalled being told the nurses aides were short staffed on 11/9/25. She said she recalled the dining room cart went out, then the first cart for the south unit went out, then she left the kitchen, came back and when she returned there were two staff members in the kitchen. Staff G, Dietary Aide said one staff member had a tray with a plate and the other staff had the meal ticket in their hand. She said they told her the resident had choked and something serious could have happened. Staff G, Dietary Aide said she recalled walking in the dining room between 11:45 a.m. and 12:00 p.m. and had not seen any resident choking. She said she recalled seeing the two staff members sitting down in the dining room. Staff G, Dietary Aide said when the tray line was almost done is when the two staff members approached her about the choking incident. She said after the two staff approached her she immediately called the Food Service Director. Staff G, Dietary Aide stated the Food Service Director told her, They would see about it on Monday when he comes in. On 11/17/25 at 2:29 p.m., a phone interview was conducted with Staff I, Dietary Aide. She said she was typically the first person working on the tray line. She described the, A2 and A1, roles. She stated the person as A1 is preparing the tray with items such as milk and juice, then the tray goes to the person as A2. She stated, A2 putting plate with food exactly what is required with ticket is talking about. Regarding the incident on 11/9/25 she stated, I remember the person who was A2 making mistake. that person [Resident #3] has mechanical. Mechanically it is supposed to be bread and meat ground. She [A2] exchanged for regular diet. She said the person in the A2 role did not pay attention and gave Resident #3 the wrong meal. Staff I, Dietary Aide said when she starts the line she puts the ticket on the tray, looks at the diet and says loudly if the meal ticket says mechanical or pureed. A follow-up interview was conducted with the Food Service Director on 11/17/25 at 2:44 p.m. He said there's been no change to the process on the tray line after the choking incident on 11/9/25. He said the only change made was to the dining meal times. The Food Service Director stated they haven't implemented anything new but, Thought about extra set of eyes to help the tray line process. He said he wanted to put an extra dietary staff in the middle of the tray line, so the last person could focus on checking the trays. The Food Service Director said the nurses and CNAs are supposed to check the tray when meal passing. He stated, It's supposed to be happening, but it fluctuates. A review of a meal ticket on 11/9/25 revealed the following, Dys [Dysphagia] Mech [Mechanical] . Ground Glazed Baked Ham, [NAME] Gravy, Black-Eyed Peas, Fortified Mashed Potatoes, Chopped Greens, Chop, Pureed Dinner Roll/Bread . Vanilla Ice Cream . The Food Service Director confirmed the meal ticket reflected what Resident #3 would have received. An interview was conducted on 11/17/25 at 1:40 p.m. with Staff J, CNA. Staff J, CNA said there was never a nurse in the dining room for meals. She said she typically was the only person in the dining room for lunch and often times at dinner as well. Staff J, CNA said she had complained multiple times about being the only person in the dining room and asked for more assistance, but no one ever came to help. She said the day Resident #3 choked she was in the dining room for lunch time. She said Staff K, receptionist came to the dining room to help pass trays. Staff (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	J, CNA said she knew the residents and their diets well. She said Resident #3 received a meal tray with a regular diet, and he should have received a pureed diet. She said the day of the incident, Resident #3 was feeding himself and she heard him gasping for air. Staff J, CNA said she looked over and saw he was choking. She said his eyes were watering and demonstrated he had his hands on the chest/neck area while gasping. Staff J, CNA and Staff K, receptionist both went to assist him and yelled out for reception to get a nurse. Staff J, CNA said she leaned him forward to pat him on the back. She said it was difficult because he was reclined and leaning back in a Geri chair. She confirmed Staff K, receptionist performed the Heimlich maneuver on Resident #3. She said she assisted with twisting the resident to the side that way Staff K, receptionist could get behind him. Staff J, CNA said she is not cardiopulmonary resuscitation (CPR) certified. She said by the time Staff D, Nurse Supervisor arrived the food had been dislodged, and the resident was breathing. Staff J, CNA said Staff D, Nurse Supervisor asked what happened and said they should not have done anything because only a nurse should do the Heimlich. She said Staff D, Nurse Supervisor asked them if the resident was ok and said she had to go back to the unit to finish what she was doing, then left. She said Resident #3 stayed in the dining room for another hour and ate some ice cream. On 11/18/25 at 1:50 p.m., an interview was conducted with Staff K, receptionist. She said she typically worked as a receptionist, but she picked up a shift for activities on 11/9/25. She said she helped pass the meal trays out sometimes. She said she went to help Staff J, CNA in the dining room because she was the only staff member there. She said she did not know she had to check the diets on the meal tickets when passing the trays. Staff K, receptionist confirmed she gave Resident #3 his tray and he started to eat the meal. She said she heard Resident #3 gasping and they tried to pat his back. She confirmed there was no nurse present, so they called out for reception to get a nurse. She said while all this was happening, Resident #9 was scared, and he wheeled down the hall yelling for a nurse to help. She said Resident #3's gasping was getting worse therefore, she did five abdominal thrusts from the front while he was in the Geri-chair. She said the thrusts did not do anything. Staff K, receptionist said herself and Staff J, CNA were able to twist the resident to the side, that way she could get her arms around the resident to perform the Heimlich maneuver. Staff K, receptionist said she did three abdominal thrusts and the lodged food came out of the resident's throat. She stated what came out of the resident's throat was a, Thick piece of ham. Staff K, receptionist said she is not a clinical staff member at the facility, but she is CPR certified. On 11/18/25 at 2:03 p.m., a phone interview was conducted with Staff D, Nurse Supervisor. She stated, That day [11/9/25] I was the only supervisor in building, which is normal. Staff D, Nurse Supervisor said she was on the south wing assessing a patient who was complaining of chest pain. She stated while she was, Getting that under control, she heard yelling that a nurse was needed for an assessment. She said she ran to the dining room and confirmed the incident happened during lunch time. Staff D, Nurse Supervisor said Resident #3 was sitting up in the chair, there were approximately four staff members there, and she heard he choked. She stated, Whatever they did it was already taken care of, by the time she got to the dining room. Staff D, Nurse Supervisor confirmed the staff present said they did the Heimlich. She stated, He was calm, peaceful, nothing wrong with him. Staff D, Nurse Supervisor confirmed she assessed Resident #3 to include listening to his lungs and looking at him. She stated it was a, Quick look, listen, and go, as she had another emergency she was handling. She said she saw he was okay; then went to the kitchen and asked what and how the incident happened. Staff D, Nurse Supervisor said, The head person in the kitchen stated someone was on their phone while fixing the tray. She said she told the kitchen staff they needed to be careful, and Resident #3 could have died. She did not recall the names of the kitchen staff present. She said the resident went back to his room but could not confirm who took him there. She said she called and let her manager know about the incident. Staff D, Nurse Supervisor confirmed Staff B, LPN was his assigned nurse. She stated, She [Staff B, LPN] was on the floor, not in the dining room. She said she does not know Resident #3 well but knows he was on a pureed diet and assumed he had a swallowing difficulty. She said immediately after the incident, they (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	started making sure a nurse and/or management is in the dining room during mealtimes. When asked which residents in the dining room needed assistance with eating, she stated, Nobody in the dining room needs assistance with eating. Not even Resident #3 needs assistance with eating. Staff D, Nurse Supervisor said staff know their residents and are aware if they needed assistance when eating. She stated, If they don't know, the nurse knows. She said she is not sure where to find information about a resident who needed assistance with eating. Staff D, Nurse Supervisor stated, I'm thinking, that's a good question, never thought of the process. She stated she has been at the facility since March 2025 and it, Never crossed my mind to ask that question about where to look. At 2:46 p.m., a follow-up interview with Staff D, Nurse Supervisor was conducted by phone. She said it was the Kardex where they find information about residents who need assistance with eating. She stated, I stick by my answer of staff knowing their residents, if they need assistance with eating. On 11/18/25 at 2:31 p.m., a phone interview was conducted with Staff B, LPN. She said on 11/9/25, Resident #3 went to the dining room for lunch and came back to his room. She said she assessed him to include vitals and lung sounds. Staff B, LPN stated, He was perfectly fine back in the room and breathing with no difficulty. She said she was told he received the wrong meal or got the wrong tray, he choked, and the Heimlich was performed. Staff B, LPN said Resident #3 was on a pureed diet. She said when he got back to his room that is when she was told about what happened. She confirmed she would have expected to be notified and would have evaluated him sooner since she was his assigned nurse. Staff B, LPN said nurses are checking meal tickets to make sure they match with the meal on the tray. She stated, They are stricter now, but the process was the same before. On 11/18/25 at 3:45 p.m., an interview was conducted with the DON and NHA to review their response to the incident with Resident #3. The NHA said the incident happened on 11/9/25. She said she was made aware during the morning meeting on 11/10/25 that Resident #3 choked in the dining room. The NHA said Staff D, Nurse Supervisor notified her Resident #3 had the wrong lunch tray and choked on a small piece of ham. The NHA said Resident #3 was fine, he had no change in condition, was at baseline, and the physician was notified who ordered a chest x-ray. She said Staff K, receptionist who was assisting with passing meal trays gave the resident the tray. The NHA said Staff D, Nurse Supervisor told her she did not see the tray provided to Resident #3 due to her being with two other resident emergencies. The NHA said she asked the dietary team about Resident #3's meal ticket that day and she was advised it was the right ticket on the tray. She said the dietary staff confirmed they provided the right tray, meal, and verified the meal before the tray exited the kitchen area. She said through her interview with Staff K, receptionist she confirmed she did not verify the meal before giving it to Resident #3. The NHA said after the Heimlich was performed, Resident #3's tray was taken back to the kitchen and confirmed he had the wrong tray. The NHA said he was provided a regular diet to include regular consistency of ham, black eyed peas, and greens. She said through their investigation they are not sure if it was the dietary staff or the staff passing trays that provided the wrong meal to Resident #3. The NHA stated it is, Still unknown where the error and confusion happened. She said Resident #3 was assessed again on 11/10/25 and had no signs of distress and labs completed showed he did n		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents were provided the correct physician ordered therapeutic diet for one resident (#3) out of twenty-three residents sampled with texture-modified diets. The facility failed to provide Resident #3 with the correct physician ordered diet which resulted in the resident choking, and required staff to execute the Heimlich maneuver. Resident #3's physician ordered diet on 11/9/25 was a controlled carbohydrates (CCHO) diet, pureed texture, and regular/thin consistency due to advanced dementia and swallowing difficulties. The resident was provided a regular consistency meal for lunch. These failures created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on 11/18/25. The findings of Immediate Jeopardy were determined to be removed on 11/20/25 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings Included: 1. A review of Resident #3's admission record revealed he was admitted on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, muscle weakness (generalized), muscle wasting and atrophy, anxiety disorder, major depressive disorder, unspecified convulsions, persistent mood [affective] disorder, and constipation. A review of Resident #3's quarterly Minimum Data Set (MDS), dated [DATE], revealed the following: - Section C - Cognitive Patterns, Brief Interview for Mental Status (BIMS) . BIMS Summary Score 03, indicating severe impairment. - Section K - Swallowing/Nutritional Status, . C. Mechanically altered diet - require change in texture of food or liquids (e.g. [example], pureed food, thickened liquids) Yes . D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Yes . A review of Resident #3's current diet orders revealed the following: - Consistent Carbohydrates (CCD) diet, Pureed texture, Regular / Thin consistency. Directions: no salt packets, with a start date of 11/11/25 and revised on 11/11/25. A review of Resident #3's discontinued diet orders revealed the following:- CCHO [consistent/constant carbohydrate diet], Low Fat, Low Chol [cholesterol], NAS [no added salt] diet, Regular texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/10/24 and an end date on 4/11/24.- CCHO, Low Fat, Low Chol, NAS diet, Mechanical Soft texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/11/24 and an end date on 4/11/24.- CCHO (Controlled Carbohydrates) diet, Mechanical Soft texture, Regular / Thin consistency. Directions: NAS; fortified foods TID [three times a day]. Status: Discontinued, with a start date of 4/11/24, revised date of 5/7/24, and an end date on 6/2/24.- CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency. Directions NAS., with a start date of 6/2/24, revised date of 7/9/25, and an end date on 11/11/25. A review of Resident #3's care plan revealed the following:- [Resident name] is at risk for Malnutrition r/t [related to] psychotropics, therapeutic diet, T2DM [type 2 diabetes mellitus], dementia, metabolic encephalopathy, HTN [hypertension], CKD [chronic kidney disease] stage 3, mechanically altered diet, needs assist with meals MNA[malnutrition assessment]=10 Date Initiated: 04/11/2024 Revision on: 09/16/2025., with interventions to include the following, Monitor and report to the physician: . Chewing/swallowing problems Date Initiated: 04/11/2024 . or for signs and symptoms of aspiration such as coughing, choking, pocketing, runny nose, watery eyes spitting food out, wet vocal quality, wet lungs. Notify SLP [speech language pathologist] if any symptoms are present Date Initiated: 04/11/2024 . Provide diet as ordered, monitor and record intake- Dysphagia Puree Texture/thin liquids Date Initiated: 04/11/2024 Revision on: 11/11/2025. Set up trays/supervise/cue/assist as needed with meals and allow adequate time to consume food/fluids provided Date Initiated: 04/11/2024 .- [Resident name] has a communication problem due to: Brain injury, Cognitive impairment, Expressive Aphasia, Receptive Aphasia Date Initiated: 04/23/2024 Revision on: 04/23/2024. A review of Resident #3's progress notes revealed the following:- 11/9/25 (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health status note 12:15, Patient in dining room for lunch, patient observed eating and choking on food. Patient assessed and vitals stable at this time. Patient skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 physician progress note, . DOS [date of service]: 11/10/2025 Effective Time: 10:30 AM CC [chief complaint]: Dysphagia / Choking Episode . HPI [history of present illness]: Nursing reports that yesterday the patient was in the dining room eating and had an episode where he was unable to swallow food. He reportedly did not get the correct food consistency for his meal. Staff performed the Heimlich maneuver on him and the food was abruptly dislodged. He did not experience any observed respiratory distress after the incident. Nursing reports after the incident he has been at his baseline cognitively and functionally. He denies any shortness of breath, coughing, fevers/chills/night sweats, sputum production, n/v/d [nausea, vomiting, diarrhea], sore throat, acute pain, dizziness, lightheadedness, headaches, vision changes, increased weakness. CXR [chest x-ray] reviewed: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. CBC/CMP [complete blood count/comprehensive metabolic panel] in AM [morning] to check for leukocytosis ST [speech therapy] eval [evaluation] Continue Diet: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency Upright 90 degrees for all PO [by mouth] intake Staff to ensure pt. [patient] receives correct food consistency Monitor Atelectasis CXR indicative of probable atelectasis in the absence of fevers/leukocytosis ., created by Staff C, Nurse Practitioner (NP).- 11/12/25 health status note, Note Text: IDT [interdisciplinary] reviewed for s/p [status post] choking incident. IDT reviewed chart along with labs and chest xray all noted to be unremarkable. Resident is alert with confusion, total care for ADL's incontinent of b/b mechanical lift for transfers. Sits in a Geri-chair for proper positioning. Resident was eating in MDR [main dining room] where he consumes his food independently. Pt [patient] choked on a piece of ham, Heimlich was successfully preformed and ham was expelled. Skin assessment completed today to assess for any discoloration r/t Heimlich. Skin was clear without redness or discoloration. NO s/s of discomfort or pain was noted. Lungs clear today and no cough noted. Ate in MDR with no s/s of difficulty eating or consuming fluids. MD [medical doctor] and family continue to be aware of all changes.A review of Resident #3's assessments revealed the following:- 11/9/25 17:50 [5:50 p.m.] situation, background, assessment, recommendation (SBAR) summary for providers, . 31. Other change in condition . 1a. List the other change: Res. [resident] was choking on his lunch tray . 2. This started on: 11/9/25 3. What time of day did this start? 2. Afternoon . Mental Status Evaluation 7. No changes observed Functional Status Evaluation 6. No changes observed. Since the change in condition occurred have the symptoms or signs gotten: 2. Better . Res. coughed up food that was chocking him . Res. was observed chocking on his lunch tray, Heimlich maneuver performed and res. expelled food. Res. assessed and vitals stable at this time. Res. skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room. Family notified- [family member name] Date: 11/09/2025 Time: 6:00 PM . Date and time of clinician notification: 11/9/2025 13:30 [1:30 p.m.] . New orders for 2 view CXR per [Staff C, NP], created by Staff D, Nurse Supervisor. Further review of the SBAR communication form revealed the vital signs documented were from 10/7/25.- 9/16/25 nutrition assessment form, . B. Dietary Intake 1. Current Diet Order/Enteral orders/Supplement Order: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency, NAS Med Pass 2.0 120ml [milliliters] TID . Ability to Chew/Swallow: 5. None of the above . E. Neuropsychological problems 0. Severe dementia or depression . Comment/Summary: [NAME] is at risk for Malnutrition r/t psychotropics, therapeutic diet, T2DM, dementia, metabolic encephalopathy, HTN, CKD stage 3, mechanically altered diet, needs assist with meals MNA=10 .A review of Resident #3's speech therapy (ST) notes revealed the following:- SLP evaluation and plan of treatment, dated 11/11/25, Diagnoses Nontraumatic subacute subdural hemorrhage onset 11/11/25 Dysphagia, oropharyngeal phase onset 11/11/25 . Reason for Referral/ (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Current Illness: Patient is a 91 year LTC [long term care] resident of this facility referred to ST due to reported aspiration episode. Patient is currently on a puree diet with thin liquids. Prior Level of Function Intake/Diet Level = Puree consistencies, Thin liquids, Successive Swallows; Swallowing Abilities = Severe; Self Feeding = Total Dependence without attempts to initiate . Oral Exam Oral Motor Structure and Function = Impaired . Cognition Cognitive-Communicative Skills = Impaired . Cognition Follows Directions = Max(A) [Assistance], responsive to cues . Clinical Bedside Assessment of Swallowing Overall Abilities = Severe . Solids Assessed During Eval = Puree consistencies . Assessment Summary Clinical Impression: Patient seen for dysphagia evaluation at bedside. Per nursing and chart review, patient has known history of advanced dementia with limited cognitive-linguistic function. Spontaneous oral movements appear functional for current diet level. No overt signs/symptoms of aspiration (no coughing, throat clearing, or wet vocal quality) observed during limited trials. Deficits include impaired cognition impacting ability to follow commands, implement swallow strategies, or adjust to texture changes. Current diet of puree solids and thin liquids appears appropriate and safe at this time based on bedside observation and nursing report. Provide 1:1 feeding assistance and slow rate of intake. Ensure upright positioning at 90 degrees during and 30 minutes after meals. No further swallow study indicated due to advanced dementia and inability to participate in treatment. Supervision for Oral Intake = Close supervision .On 11/17/25 at 10:10 a.m., an interview was conducted with Resident #10. He confirmed he witnessed the incident with Resident #3 on 11/9/25. He stated, He [Resident #3] choked. Resident #10 said the meal tickets are on the food trays. He said the CNAs passed the trays and double checked the meal ticket matched the food. Resident #10 stated that day, A new person was helping. Resident #10 said the new staff member gave Resident #3 a tray with a regular diet. He said Resident #3 was in a recliner chair. Resident #10 said the staff were patting his back, but it was not helping. Resident #10 described the staff present as, Frantic. He said Resident #9 wheeled himself to the hallway outside of the dining room stating, Help, Help and putting his hands up. Resident #10 said he recalled the staff present saying, What do we do, what do we do, I will call for the nurse. A review of Resident #10 quarterly MDS, dated [DATE], under section C - cognitive patterns revealed a BIMS score of 15, indicating cognitively intact. On 11/17/25 at 1:29 p.m., an interview was conducted with the Food Service Director. He said he had been in this position since August 2025. He said Staff G, Dietary Aide was at the end of the tray line and the last one to touch the tray in the kitchen on 11/9/25 during lunch. The Food Service Director said he was not present for the incident, but he learned Resident #3 choked in the dining room on 11/9/25. He said two other staff members, Staff H, [NAME] and Staff I, Dietary Aide were also on the tray line. He said Staff I, Dietary Aide was at the beginning of the tray line and called the ticket out to include the diet, such as mechanical or regular. The Food Service Director said Staff G, Dietary Aide was at the end of the line and repeated back what was provided to her by the cook. He said Staff I, Dietary Aide was telling Staff H, [NAME] what she needed to plate, and Staff G, Dietary Aide double checked the meal on the tray was correct. He said Staff G, Dietary Aide called him on 11/9/25 and told him what happened. The Food Service Director stated he talked to Staff G, Dietary Aide the following day and asked for more information about what happened. He said she told him, I [Staff G, Dietary Aide] don't remember, there were people coming in, when you're not here they come in and do whatever they want and not sure what happened. The Food Service Director said Resident #3's diet on 11/9/25 was dysphagia, mechanical soft which meant ground consistency for the protein, pureed vegetables, and a pureed starch. He said he could not provide the residents meal ticket for that day, as he did not have access to do that, but he could provide an example meal ticket of a dysphagia, mechanical texture for the meal that day. He said the mechanical and pureed diets are the same consistency, except for the protein. He said he changed Resident #3's diet to pureed consistency on 11/10/25 in the meal tracker system. The Food Service Director said he did not have documentation of in-services or training regarding meal ticket accuracy for dietary staff prior to August 2025. He said since he has been at the facility he has not needed to provide an in-service on (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	meal ticket accuracy. The Food Service Director said he completed audits and an in-service on meal ticket accuracy to all the dietary staff on 11/10/25. On 11/17/25 at 1:49 p.m., an interview was conducted with Staff G, Dietary Aide. She said on 11/9/25, during lunch, Staff I, Dietary Aide and Staff H, cook were on the tray line. Staff G, Dietary Aide stated she was at the end of the tray line as the, The double checker. She said she called out every ticket and made sure it is the correct food. Staff G, Dietary Aide said the cook knows the diets because of the first person on tray line who tells them. She said the first person called out the diet, the cook puts the food on the plate, and she puts the plate on the resident's tray. Staff G, Dietary Aide said the meal ticket is already on the tray, and she made sure it had the correct beverage, condiments, diet, and the meal matches. She said she did not remember Resident #3 getting a regular diet and believed he received pureed consistency. Staff G, Dietary Aide stated, It's possible it could have happened, and said she had taken accountability if the resident received the wrong diet. She said staff kept interrupting them during the tray line for lunch that day. She said she recalled being told the nurses aids were short staffed on 11/9/25. She said she recalled the dining room cart went out, then the first cart for the south unit went out, then she left the kitchen, came back and when she returned there were two staff members in the kitchen. Staff G, Dietary Aide said one staff member had a tray with a plate and the other staff had the meal ticket in their hand. She said they told her the resident had choked and something serious could have happened. Staff G, Dietary Aide said she recalled walking in the dining room between 11:45 a.m. and 12:00 p.m. and had not seen any resident choking. She said she recalled seeing the two staff members sitting down in the dining room. Staff G, Dietary Aide said when the tray line was almost done is when the two staff members approached her about the choking incident. She said after the two staff approached her, she immediately called the Food Service Director and told him the resident choked and staff were blaming her for the incident. Staff G, Dietary Aide stated the Food Service Director told her no one had called him and, They would see about it on Monday when he comes in. She confirmed that the Nursing Home Administrator (NHA) asked her what happened and she provided a statement. She confirmed she had meal ticket accuracy education, before 11/9/25, from the Food Service Director. On 11/17/25 at 2:29 p.m., a phone interview was conducted with Staff I, Dietary Aide. She said she was typically the first person working on the tray line. She described the, A2 and A1, roles. She stated the person as A1 is preparing the tray with items such as milk and juice, then the tray goes to the person as A2. She stated, A2 putting plate with food exactly what is required with ticket is talking about. Regarding the incident on 11/9/25 she stated, I remember person who was A2 making mistake . that person [Resident #3] has mechanical. Mechanically it is supposed to be bread and meat ground. She [A2] exchanged for regular diet. She said the person in the A2 role did not pay attention and gave Resident #3 the wrong meal. Staff I, Dietary Aide said when she starts the line she puts the ticket on the tray, looks at the diet and says loudly if the meal ticket says mechanical or pureed. She said when she first started, at the end of June 2025, she was educated on the tray line and meal ticket accuracy process by the former food service director and one of the dietary aides. A follow-up interview was conducted with the Food Service Director on 11/17/25 at 2:44 p.m. He said there's been no change to the process on the tray line after the choking incident on 11/9/25. He said the only change made was to the dining meal times. The Food Service Director stated they haven't implemented anything new but, Thought about extra set of eyes to help the tray line process. He said he wanted to put an extra dietary staff in the middle of the tray line, so the last person could focus on checking the trays. The Food Service Director said the nurses and CNAs are supposed to check the tray when meal passing. He stated, It's supposed to be happening, but it fluctuates. A review of a meal ticket on 11/9/25 revealed the following, Dys [Dysphagia] Mech [Mechanical] . Ground Glazed Baked Ham, [NAME] Gravy, Black-Eyed Peas, Fortified Mashed Potatoes, Chopped Greens, Chop, Pureed Dinner Roll/Bread . Vanilla Ice Cream . The Food Service Director confirmed the meal ticket reflected what Resident #3 would have received. An interview was conducted on 11/17/25 at 1:40 p.m. with Staff J, CNA. Staff J, CNA said there was never a nurse in the dining room for meals. She said she (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	typically was the only person in the dining room for lunch and often times at dinner as well. Staff J, CNA said she had complained multiple times about being the only person in the dining room and asked for more assistance, but no one ever came to help. She said the day Resident #3 choked she was in the dining room for lunch time. She said Staff K, receptionist came to the dining room to help pass trays. Staff J, CNA said she knew the residents and their diets well. She said Resident #3 received a meal tray with a regular diet, and he should have received a pureed diet. She said Resident #3 stayed in the dining room for another hour and ate some ice cream. She said meals in the dining room started around 11:15 a.m. to 11:30 a.m., and Resident #3 choked around 11:45 a.m. Staff J, CNA said he did not leave the dining room until after 12:45 p.m. On 11/18/25 at 1:50 p.m., an interview was conducted with Staff K, receptionist. She said she typically worked as a receptionist, but she picked up a shift for activities on 11/9/25. She said she helped pass the meal trays out sometimes. She said she went to help Staff J, CNA in the dining room because she was the only staff member there. She said she did not know she had to check the diets on the meal tickets when passing the trays. Staff K, receptionist confirmed she gave Resident #3 his tray and he started to eat the meal. She said she heard Resident #3 gasping and they tried to pat his back. She confirmed there was no nurse present, so they called out for reception to get a nurse. She said while all this was happening, Resident #9 was scared, and he wheeled down the hall yelling for a nurse to help. She said Resident #3's gasping was getting worse therefore, she did five abdominal thrusts from the front while he was in the Geri-chair. She said the thrusts did not do anything. Staff K, receptionist said herself and Staff J, CNA were able to twist the resident to the side, that way she could get her arms around the resident to perform the Heimlich maneuver. Staff K, receptionist said she did three abdominal thrusts and the lodged food came out of the resident's throat. She stated what came out of the resident's throat was a, Thick piece of ham. Staff K, receptionist said she is not a clinical staff member at the facility, but she is CPR certified. On 11/18/25 at 3:45 p.m., an interview was conducted with the DON and NHA to review their response to the incident with Resident #3. The NHA said the incident happened on 11/9/25. She said she was made aware during the morning meeting on 11/10/25 that Resident #3 choked in the dining room. The NHA said Staff D, Nurse Supervisor notified her Resident #3 had the wrong lunch tray and choked on a small piece of ham. She said Staff D, Nurse Supervisor obtained statements from the dietary staff, CNA and receptionist who were in the dining area at the time of the incident. The NHA said Resident #3 was fine, he had no change in condition, was at baseline, and the physician was notified who ordered a chest x-ray. She said Staff K, receptionist who was assisting with passing meal trays gave the resident the tray. The NHA said Staff D, Nurse Supervisor told her she did not see the tray provided to Resident #3 due to her being with two other resident emergencies. The NHA said she asked the dietary team about Resident #3's meal ticket that day and she was advised it was the right ticket on the tray. The NHA said the dietary staff confirmed what meals went out to the dining room and what Resident #3 received, which was a pureed diet. She said the dietary staff confirmed they provided the right tray, meal, and verified the meal before the tray exited the kitchen area. She said through her interview with Staff K, receptionist she confirmed she did not verify the meal before giving it to Resident #3. The NHA said after the Heimlich was performed, Resident #3's tray was taken back to the kitchen and confirmed he had the wrong tray. She said the tray ticket showed he had a pureed diet to include puree ham, mashed potato and puree black eyed peas. The NHA said he was provided a regular diet to include regular consistency of ham, black eyed peas, and greens. She said through their investigation they are not sure if it was the dietary staff or the staff passing trays that provided the wrong meal to Resident #3. The NHA stated it is, Still unknown where the error and confusion happened. When asked who can change a diet order, the NHA and DON said a nurse can downgrade, the speech therapist is the only one who can upgrade, the dietitian can upgrade and downgrade the diet, and kitchen managers cannot change the diets. The DON stated, They [kitchen managers] cannot touch the diets. The NHA and DON said there were no changes made to the tray line process. They said the kitchen staff will not provide the dining room (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	trays unless a nurse is in the dining room. A review of the food consistency audits conducted in the dining room revealed the following:- On 11/10/25, an audit was completed for one meal, however, the meal time was not documented.- On 11/12/25, an audit was completed for two meals, however, the meal times were not documented.- On 11/14/25, a meal audit was not completed for dinner.- On 11/15/25, a meal audit was not completed for breakfast.- On 11/17/25, a meal audit was not completed for lunch.A review of Resident #3's Kardex revealed the following:- As of 11/18/25, .Eating/Nutrition Arrange meals in patients visual field, Offer food substitutions when meal is refused or an alternate is requested, Offer snacks prn, Offer/encourage fluids of choice, Provide diet as ordered, monitor and record intake - Dysphagia Puree Texture/thin liquids, Set up trays/supervise/cue/assist as needed with meals and allow adequate time to consume food/fluids provided.- As of 11/19/25, .Eating/Nutrition Arrange meals in patients visual field, Offer food substitutions when meal is refused or an alternate is requested, Offer snacks prn Offer/encourage fluids of choice, Provide diet as ordered, monitor and record intake - Dysphagia Puree Texture/thin liquids, Set up meal tray allow to eat independently assist if needed, Set up trays adequate time to consume food/fluids provided.On 11/19/25 at 10:18 a.m., a phone interview was conducted with Staff L, SLP. Staff L, SLP said Resident #3 was referred to her because he had an episode of aspiration. She said he had been on a pureed diet due to advanced dementia and determined that was the safest consistency for him. Staff L, SLP said she was told Resident #3 was given a piece of ham and choked but did not know he was provided a regular tray in the dining room. She said she did not know Resident #3 until he was referred to her. Staff L, SLP said when she looked in the electronic health record she saw he was on a pureed diet and might have been on a mechanical texture at some point. She stated, Pureed is least restrictive and safer for him and because of his cognition. Staff L, SLP said when she made recommendations, she immediately lets the nurse on duty know what they are.On 11/19/25 at 11:20 a.m., an interview with Resident #9 was conducted. He was observed wheeling himself from the dining room, down the hall, and to his room. He said he was scared after the incident with Resident #3 and confirmed he was in the dining room when it happened. Resident #9 said there was no nurse that day, but now there is.A review of Resident #9's quarterly MDS, dated [DATE], under section C - cognitive patterns revealed a BIMS score of 12, indicating moderately impaired. On 11/19/25 at 11:33 a.m., a follow-up phone interview was conducted with Staff K, receptionist. She said she had no training on passing meal trays or reading meal tickets prior to 11/9/25. She confirmed it was not the first time she had helped in the dining room.On 11/19/25 at 11:44 a.m., an interview was conducted with Staff C, NP. He said Resident #3 was in the dining room and staff gave him the wrong tray or food consistency. Staff C, NP said to his understanding the resident is supposed to be on a mechanical soft, dysphagia diet. He stated, Mechanical soft dysphagia is basically puree consistency. He said staff did the Heimlich maneuver and the food dislodged. He confirmed he saw Resident #3 on 11/10/25. Staff C, NP said he presumed Resident #3 may have, Fear of choking, as it was an unpleasant experience, but he had no medical consequences. He said he looked at Resident #3's speech therapy evaluation and could not find diagnostic proof of dysphagia. Staff C, NP said the risks and concerns with receiving a regular diet is choking and aspiration. He said his expectation is for the right diet to be served to residents.On 11/19/25 at 2:53 p.m., a follow-up interview was conducted with Staff J, CNA. She said she knows the residents' diets because they provide food in activities. She said the kitchen manager provides her with the diet slip and allergy list. Staff J, CNA said she had no training or education prior to 11/9/25 to check the resident's food tray for meal ticket accuracy. She said the facility is now training staff about reviewing the food and checking the meal ticket before leaving the food tray, as well as a nurse being present during dining to check the meal tickets. She stated, Everything they should have been doing, they are doing now. On 11/20/25 at 10:03 a.m., an interview was conducted with Staff O, Cook, Staff G, Dietary Aide, and Staff P, Dietary Aide. They confirmed staff come to the kitchen door requesting something right away which interrupts them on the tray line. Staff O, [NAME] and Staff P, Dietary Aide said they tell staff (continued on next page)		

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to give them time as the residents need to receive their meals first. Staff P, Dietary Aide said staff sometimes stop them when they are taking the meal carts to the floor. Staff G, Dietary Aide confirmed there were distractions when she was on the lunch tray line on 11/9/25. Staff P, Dietary Aide said staff also call by phone requesting things. She stated, We can't step off the line to answer the phone. Staff O, Cook, Staff G, Dietary Aide and Staff P, Dietary Aide said there are less distractions now, but staff are still coming in or calling the kitchen during the meal service. (Photographic evidence obtained)A review of the facility's procedure and in-service documentation titled, Texture Modification Inservice, revealed the following: .Purpose: To educate all new hires and current employees on the importance of and guidelines for proper texture modification. Importance of Texture Modification . Proper preparation and delivery of texture-modified diets is critical for resident safety and wellness. Dysphagia Puree Consistency All foods (ex. meats, breads, starches, fruits, vegetables, and desserts) must be pureed to a mousse-like texture. Cannot receive hard, dry meats . or foods that cannot be pureed into a smooth mousse-like texture. A review of the facility's policy titled, Meal Distribution, with an original date of 5/2014 and a revised date of 2/2023, revealed the following: Procedures1. All meals will be assembled in accordance with the individualized diet order, plan of care, and preferences. 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. 5. For point-of-service dining, the Dining Services Department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient. The facility's immediate actions to remove the Immediate Jeopardy included:- On 11/10/2025, the Nursing Home Administrator, educated unlicensed staff that served the wrong diet consistency tray was suspended and educated on abuse and neglect.- On 11/10/25 dietary employee that prepared the wrong diet consistency tray was suspended and educated on abuse and neglect as well as tray accuracy by the CDM district dietary manager.- On 11/10/25 an ADHOC Quality Improvement Performance Committee meeting was held to review the recommendations made from the root cause analysis. The following team members were in attendance: Medical Director (via telephone), Executive Director, Director of Nursing (via telephone), and management staff.- On 11/10/25, a Performance Improvement Plan was developed and initiated based upon Root Cause Analysis (RCA) as determined by Quality Assurance Performance Improvement committee (QAPI). Root cause analysis identified as dietary staff prepared the incorrect diet consistency for Resident #3 and an unlicensed staff member served the incorrect meal tray.- On 11/10/25 The ADHOC QAPI Committee approved the following recommendations:1. Resident was assessed, MD was notified & chest x-ray was ordered.2. Current residents in the facility diet orders in [electronic health record vendor] were checked against meal tickets in the kitchen to ensure all were accurate.3. Education was completed for dietary employees on following the correct diet when preparing resident meal trays.4. Nursing staff were educated on checking the meal tickets with diet being served.5. Nursing staff completed competencies on meal tray serving.6. Current facility staff were		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure licensed nursing staff were knowledgeable and competent to provide care and services for three residents (#3, #11, and #2) out of eleven residents sampled related to: 1) failure to prevent accidents resulting in a choking and a fall incident; 2) failure to follow physician orders and care plan for therapeutic diets and positioning; and 3) failure to follow speech therapy recommendations for positioning and assistance when eating. The facility failed to provide Resident #3 with the correct physician ordered diet and resulted in the resident choking, which required staff to execute the Heimlich maneuver. Resident #3's care plan and speech therapy evaluation showed the resident needed assistance with dining and one to one supervision. Observations of the resident during the lunch dining on 11/17/25 and 11/18/25 revealed he was not in the upright position when eating, which increased the risk of choking, and one to one supervision was not observed. These failures created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to Resident #3 and resulted in the determination of Immediate Jeopardy on 11/18/25. The findings of Immediate Jeopardy were determined to be removed on 11/20/25 and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings Included: 1. On 11/17/25 at 11:39 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60-65 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Further observations of Resident #3 revealed he ate his meal without assistance from staff. On 11/18/25 at 11:50 a.m., an observation of the main dining room during lunch revealed Resident #3 was seated at the table in a Geri-chair positioned at approximately 60 degrees. An observation of the food tray and meal provided revealed a pureed consistency. Staff were observed setting up the meal tray in front of him. Resident #3 began consuming his meal unassisted by staff. He was observed having difficulty getting food onto the fork. After four attempts, Resident #3 was able to get a dime-sized amount of food on the fork. Staff E, Certified Nursing Assistant (CNA) stated to Staff F, CNA, He [Resident #3] keeps doing that because he can't see his food. Staff F, CNA was observed looking at Resident #3's meal tray and stated, Well, he's almost done. A review of Resident #3's admission record revealed he was admitted on [DATE] with diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, need for assistance with personal care, muscle weakness (generalized), muscle wasting and atrophy, anxiety disorder, major depressive disorder, unspecified convulsions, persistent mood [affective] disorder, and constipation. A review of Resident #3's quarterly Minimum Data Set (MDS), dated [DATE], revealed the following: - Section C - Cognitive Patterns, Brief Interview for Mental Status (BIMS) . BIMS Summary Score 03, indicating severe impairment. - Section GG - Functional Abilities, . A. Eating: . 05. Setup or clean-up assistance . - Section K - Swallowing/Nutritional Status, . C. Mechanically altered diet - require change in texture of food or liquids (e.g. [example], pureed food, thickened liquids) Yes . D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Yes . A review of Resident #3's current diet orders revealed the following: - Consistent Carbohydrates (CCD) diet, Pureed texture, Regular / Thin consistency. Directions: no salt packets, with a start date of 11/11/25 and revised on 11/11/25. A review of Resident #3's discontinued diet orders revealed the following:- CCHO [consistent/constant carbohydrate diet], Low Fat, Low Chol [cholesterol], NAS [no added salt] diet, Regular texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/10/24 and an end date on 4/11/24.- CCHO, Low Fat, Low Chol, NAS diet, Mechanical Soft texture, Regular / Thin consistency. Status: Discontinued., with a start date of 4/11/24 and an end date on 4/11/24.- CCHO (Controlled Carbohydrates) diet, Mechanical Soft texture, Regular / Thin consistency. Directions: NAS; fortified (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	foods TID [three times a day]. Status: Discontinued, with a start date of 4/11/24, revised date of 5/7/24, and an end date on 6/2/24.- CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency. Directions NAS., with a start date of 6/2/24, revised date of 7/9/25, and an end date on 11/11/25.A review of Resident #3's care plan revealed the following:- [Resident name] is at risk for Malnutrition r/t [related to] psychotropics, therapeutic diet, T2DM [type 2 diabetes mellitus], dementia, metabolic encephalopathy, HTN [hypertension], CKD [chronic kidney disease] stage 3, mechanically altered diet, needs assist with meals MNA[malnutrition assessment]=10 Date Initiated: 04/11/2024 Revision on: 09/16/2025., with interventions to include the following, Monitor and report to the physician: . Chewing/swallowing problems Date Initiated: 04/11/2024 . or for signs and symptoms of aspiration such as coughing, choking, pocketing, runny nose, watery eyes spitting food out, wet vocal quality, wet lungs. Notify SLP [speech language pathologist] if any symptoms are present Date Initiated: 04/11/2024 . Provide diet as ordered, monitor and record intake- Dysphagia Puree Texture/thin liquids Date Initiated: 04/11/2024 Revision on: 11/11/2025. Set up trays/supervise/cue/assist as needed with meals and allow adequate time to consume food/fluids provided Date Initiated: 04/11/2024 .- [Resident name] has a communication problem due to: Brain injury, Cognitive impairment, Expressive Aphasia, Receptive Aphasia Date Initiated: 04/23/2024 Revision on: 04/23/2024.A review of Resident #3's progress notes revealed the following:- 11/9/25 health status note 12:15, Patient in dining room for lunch, patient observed eating and choking on food. Patient assessed and vitals stable at this time. Patient skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 physician progress note, . DOS [date of service]: 11/10/2025 Effective Time: 10:30 AM CC [chief complaint]: Dysphagia / Choking Episode . HPI [history of present illness]: Nursing reports that yesterday the patient was in the dining room eating and had an episode where he was unable to swallow food. He reportedly did not get the correct food consistency for his meal. Staff performed the Heimlich maneuver on him and the food was abruptly dislodged. He did not experience any observed respiratory distress after the incident. Nursing reports after the incident he has been at his baseline cognitively and functionally. He denies any shortness of breath, coughing, fevers/chills/night sweats, sputum production, n/v/d [nausea, vomiting, diarrhea], sore throat, acute pain, dizziness, lightheadedness, headaches, vision changes, increased weakness. CXR [chest x-ray] reviewed: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. CBC/CMP [complete blood count/comprehensive metabolic panel] in AM [morning] to check for leukocytosis ST [speech therapy] eval [evaluation] Continue Diet: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency Upright 90 degrees for all PO [by mouth] intake Staff to ensure pt. [patient] receives correct food consistency Monitor Atelectasis CXR indicative of probable atelectasis in the absence of fevers/leukocytosis ., created by Staff C, Nurse Practitioner (NP).- 11/10/25 health status note 12:05, Note Text: Late Entry: At time of assessing the resident after choking his bilateral lungs were clear, Resp [respiratory] even and nonlabored, O2 [oxygen] sat [saturation] at 98% on r.a. [room air] Res. [resident] was taken back to his room and was sitting up in chair without s/s [signs and symptoms] of distress, created by Staff D, Nurse Supervisor.- 11/10/25 health status note 13:04, Note Text: At the time of assessment of patient, vitals taken: B/P [blood pressure] 126/80, pulse 98, temp 97.9, respirations 18, and O2 95 on room air. Patient alert and in no apparent distress. Lung sounds clear and patient observed to have normal respiratory effort, created by Staff B, Licensed Practical Nurse (LPN).- 11/10/25 health status note 13:32, CXR reviewed: IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025. 1) Vitals every shift for 3 days 2) CBC/CMP in AM.- 11/11/25 health status note, Labs reviewed, stable without any leukocytosis. Stable anemia and DM II [diabetes mellitus two] are noted. No new orders.- 11/11/25 (continued on next page)		

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health status note 21:12, LATE ENTRY Note Text: Resident is alert with confusion and is assisted totally with ADL's [activities of daily living]. Transfers to and from Geri chair with Hoyer lift and 2 assist [two person assist]. Resident is assisted with meals, encouraged to eat meal. Incontinent of B&B [bladder and bowel]. No s/s of acute distress and no c/o [complaints of] pain voiced at this time.- 11/12/25 health status note, Note Text: IDT [interdisciplinary] reviewed for s/p [status post] choking incident. IDT reviewed chart along with labs and chest xray all noted to be unremarkable. Resident is alert with confusion, total care for ADL's incontinent of b/b mechanical lift for transfers. Sits in a Geri-chair for proper positioning. Resident was eating in MDR [main dining room] where he consumes his food independently. Pt [patient] choked on a piece of ham, Heimlich was successfully preformed and ham was expelled. Skin assessment completed today to assess for any discoloration r/t Heimlich. Skin was clear without redness or discoloration. NO s/s of discomfort or pain was noted. Lungs clear today and no cough noted. Ate in MDR with no s/s of difficulty eating or consuming fluids. MD [medical doctor] and family continue to be aware of all changes.- 11/13/25 health status note, V/S [vital signs] taken on 11/9/2025 s/p [status post] incident in MDR 126/89, 98, 18, 97.9 with O2 sat 95 on RA, created by the Director of Nursing (DON).A review of Resident #3's assessments revealed the following:- 11/9/25 17:50 [5:50 p.m.] situation, background, assessment, recommendation (SBAR) summary for providers, . 31. Other change in condition . 1a. List the other change: Res. [resident] was choking on his lunch tray . 2. This started on: 11/9/25 3. What time of day did this start? 2. Afternoon . Mental Status Evaluation 7. No changes observed Functional Status Evaluation 6. No changes observed. Since the change in condition occurred have the symptoms or signs gotten: 2. Better . Res. coughed up food that was chocking him . Res. was observed chocking on his lunch tray, Heimlich maneuver performed and res. expelled food. Res. assessed and vitals stable at this time. Res. skin warm and dry, no respiratory distress noted, and patient removed from dining room and back in room. Family notified- [family member name] Date: 11/09/2025 Time: 6:00 PM . Date and time of clinician notification: 11/9/2025 13:30 [1:30 p.m.] . New orders for 2 view CXR per [Staff C, NP], created by Staff D, Nurse Supervisor. Further review of the SBAR communication form revealed the vital signs documented were from 10/7/25.- 9/16/25 nutrition assessment form, . B. Dietary Intake 1. Current Diet Order/Enteral orders/Supplement Order: CCHO (Controlled Carbohydrates) diet, Pureed texture, Regular / Thin consistency, NAS Med Pass 2.0 120ml [milliliters] TID . Ability to Chew/Swallow: 5. None of the above . E. Neuropsychological problems 0. Severe dementia or depression . Comment/Summary: [NAME] is at risk for Malnutrition r/t psychotropics, therapeutic diet, T2DM, dementia, metabolic encephalopathy, HTN, CKD stage 3, mechanically altered diet, needs assist with meals MNA=10 .Review of Resident #3's x-ray results revealed the following:- 4/21/25 chest, single view, Clinical Information: follow up left infiltrate Test Procedure: . CHEST, SINGLE VIEW Findings: Comparison: 03/15/2025 The cardiac silhouette and mediastinal contours are normal. The lungs are free of infiltrates and focal consolidations. No pleural fluid or masses are noted. No pneumothorax is present. Impressions: No acute intrathoracic disease process.- 11/10/25 chest, 2 views, Date of Service: 11/10/2025 Clinical Information: . Pneumonitis due to inhalation of food and vomit possible aspiration Test Procedure: . CHEST, 2 VIEWS Findings: . No acute osseous or soft tissue abnormality. Cardiac and mediastinal contours are within normal limits. Normal pulmonary vasculature. No pneumothorax. Bilateral intrapillar airspace opacity is present. Peribronchial distention with peribronchial cuffing is present. This nonspecific finding indicates chronic or acute perihilar inflammation. IMPRESSION: Early changes of intrapillar atelectasis or pneumonia. Findings favor atelectasis in the absence of leukocytosis. Perihilar inflammation, acute or chronic. Correlate risk factors for infection. Slightly worse compared to 4/21/2025.A review of a resource from the American Lung Association revealed the following, Atelectasis happens when the tiny air sacs or alveoli in your lungs are blocked, and it causes a partial or full collapse of one or more lobes or sections of the lungs. Other causes may include A small object blocking the airways (like food or toy) . Lung infection like pneumonia . Your healthcare provider will (continued on next page)		

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The Food Service Director said he did not have documentation of in-services or training regarding meal ticket accuracy for dietary staff prior to August 2025. He said since he has been at the facility he has not needed to provide an in-service on meal ticket accuracy. The Food Service Director said he completed audits and an in-service on meal ticket accuracy to all the dietary staff on 11/10/25. On 11/17/25 at 1:49 p.m., an interview was conducted with Staff G, Dietary Aide. She said on 11/9/25, during lunch, Staff I, Dietary Aide and Staff H, cook were on the tray line. Staff G, Dietary Aide stated she was at the end of the tray line as the, The double checker. She said she called out every ticket and made sure it is the correct food. Staff G, Dietary Aide said the cook knows the diets because of the first person on tray line who tells them. She said the first person called out the diet, the cook puts the food on the plate, and she puts the plate on the resident's tray. Staff G, Dietary Aide said the meal ticket is already on the tray, and she made sure it had the correct beverage, condiments, diet, and the meal matches. She said she did not remember Resident #3 getting a regular diet and believed he received pureed consistency. Staff G, Dietary Aide stated, It's possible it could have happened, and said she had taken accountability if the resident received the wrong diet. She said staff kept interrupting them during the tray line for lunch that day. She said she recalled being told the nurses aids were short staffed on 11/9/25. She said she recalled the dining room cart went out, then the first cart for the south unit went out, then she left the kitchen, came back and when she returned there were two staff members in the kitchen. Staff G, Dietary Aide said one staff member had a tray with a plate and the other staff had the meal ticket in their hand. She said they told her the resident had choked and something serious could have happened. Staff G, Dietary Aide said she recalled walking in the dining room between 11:45 a.m. and 12:00 p.m. and had not seen any resident choking. She said she recalled seeing the two staff members sitting down in the dining room. Staff G, Dietary Aide said when the tray line was almost done is when the two staff members approached her about the choking incident. She said after the two staff approached her, she immediately called the Food Service Director and told him the resident choked and staff were blaming her for the incident. Staff G, Dietary Aide stated the Food Service Director told her no one had called him and, They would see about it on Monday when he comes in. She confirmed that the Nursing Home Administrator (NHA) asked her what happened and she provided a statement. She confirmed she had meal ticket accuracy education, before 11/9/25, from the Food Service Director. On 11/17/25 at 2:29 p.m., a phone interview was conducted with Staff I, Dietary Aide. She said she was typically the first person working on the tray line. She described the, A2 and A1, roles. She stated the person as A1 is preparing the tray with items such as milk and juice, then the tray goes to the person as A2. She stated, A2 putting plate with food exactly what is required with ticket is talking about. Regarding the incident on 11/9/25 she stated, I remember person who was A2 making mistake . that person [Resident #3] has mechanical. Mechanically it is supposed to be bread and meat ground. She [A2] exchanged for regular diet. She said the person in the A2 role did not pay attention and gave Resident #3 the wrong meal. Staff I, Dietary Aide said when she starts the line she puts the ticket on the tray, looks at the diet and says loudly if the meal ticket says mechanical or pureed. She said when she first started, at the end of June 2025, she was educated on the tray line and meal ticket accuracy process by the former food service director and one of the dietary aides. A follow-up interview was conducted with the Food (continued on next page)		

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