STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145339	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grove of Elmhurst, The	127 West Diversey Elmhurst, IL 60126

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. Based on observation, interview and record review, the facility failed to follow its policy and perform AHA (American Heart Association) CPR (Cardiopulmonary Resuscitation).This failure resulted in Immediate Jeopardy. The Immediate Jeopardy began on 5/7/26 at 5:04 PM when the facility failed provide timely rescue breaths and placement of the available AED (Automatic External Defibrillator) on an unresponsive resident designated as full code.This applies to 82 of 83 residents (R1, R3-R83) reviewed for quality of care in the sample of 83.V1 (Administrator), V2 (Director of Nursing), and V36 (Corporate Consultant) were notified of the Immediate Jeopardy on 6/9/26 at 5:50 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 6/9/26 at 8:57 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training and plan implementation.The findings include:Facility Order Listing Report, printed 6/9/26, shows R3-R83 had physician orders for full code.Face sheet, dated 6/5/26, shows R1's diagnoses included Huntington's disease, dysphagia, chorea, personal history of sudden cardiac arrest, dementia, lack of coordination, signs/symptoms involving the musculoskeletal system, and abnormality of gait/mobility. POS (Physician Order Sheet), printed 6/5/26, shows R1's had a physician order for full code dated 12/30/22.On 6/6/26 at 2:30 PM with V1 (Administrator) and V2 (Director of Nursing), facility camera footage of R1 prior to R1's death on 5/7/26 was reviewed in V1's office. The footage showed at 4:58 PM R1 sat in the dining room alone during dinner with a tray of food in front of her. Between 4:58 PM and 5:00 PM R1 appeared to pick up food items with her hands (in spite of experiencing involuntary movements of her arms) and lifted them toward her head while leaning her torso forward. At 5:02 PM, R1 became significantly more animated, began thrashing in her chair left to right, kicked her legs off of her leg rests, and reached her right hand toward the resident sitting across from her eating his dinner. At 5:04 PM, R1 ceased all movement and remained motionless in her chair. At 5:17 PM, V12 (Activity Aide) approached R1 and immediately called V15 (CNA- Certified Nursing Assistant) to attend to R1. R1 was whisked into the hallway in her wheelchair and V5 (LPN - Licensed Practical Nurse) was called to assess R1. R1 was immediately placed on the floor of the hallway and V5 began chest compressions on R1. Review of the camera showed at 5:18 PM an oxygen tank was placed near R1. At 5:19 PM V5 applied oxygen to R1 via a nasal canula and the crash cart was wheeled down the hall and positioned near R1. The crash cart was originally positioned a few resident rooms down from where R1 was laying on the floor. At 5:21 PM, V8 (Assistant Director of Nursing) began to suction R1 and V7 (Respiratory Therapist) then began administering rescue breaths using an AMBU (Artificial Manual Breathing Unit). At 5:25 PM, paramedics arrived and took over recue activities. Review of the footage showed no AED (Automated External Defibrillator) was utilized on R1 during the facility's attempts to revive R1.On 6/8/26 at 1:35 PM, V5 (LPN) when she received R1 unresponsive sitting in her wheelchair, R1 had a faint pulse but when R1 was transferred to the floor R1 no longer had a pulse and was not breathing. V5 stated she put a nasal canula on R1 to deliver oxygen because she wanted to deliver oxygen to R1 despite the AMBU bag being available on the crash cart near R1. V5 stated eventually V7 began delivering rescue breaths using an AMBU bag. V5 stated she also had an AED machine available on her crash cart at the (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	time R1 was found to be unresponsive. V5 stated V8 brought a second AED from the first floor when he responded to R1's emergency. V5 stated staff failed to utilize either of the two available AED machines on R1 while they were performing chest compressions and/or rescue breaths before paramedics took over CPR. V5 stated they did not utilize the AED before paramedics arrived because .it was all so fast. V5 stated she was CPR certified.On 6/5/26 at 12:57 PM V15 (CNA) stated she was called to assist R1 by V12 and V15 took R1 to the hall and helped place her on the floor. V15 stated she began chest compressions on R1. V15 stated another staff later took over chest compressions for R1 and V15 then called 911. V15 stated V5 brought the crash cart to R1 during the event. On 6/5/26 at 12:15 PM, V10 (CNA) stated when she arrived while R1 was receiving chest compressions V5 brought an oxygen tank and V10 placed a nasal canula on R1. V10 stated she checked R1's radial pulse and could feel a feeble pulse. V10 stated V5 asked her to check R1's blood pressure and the blood pressure was very low. V10 stated someone asked her to take over chest compressions and after she became tired another staff took over chest compressions until the paramedics arrived. On 6/8/26 at 1:59 PM, V8 (Assistant Director of Nursing) stated he responded to R1's episode of unresponsiveness and brought an AED machine from the first floor. V8 stated when he arrived staff were performing chest compressions on R1 and R1 had a nasal cannula connected to an oxygen tank applied to her nose. V8 stated when he arrived he was unable to determine if and AED was already applied to R1 because there were many people helping R1 and he did not have a clear visual of R1. V8 stated he was asked to suction R1's mouth which he performed and V7 (Respiratory Therapist) applied the AMBU bag to R1 to provide rescue breaths. On 6/5/26 at 11:13 AM, V8 stated after he suctioned R1 he was present with R1 until the paramedics arrived and ensured everything was being done for R1. On 6/8/26 at 2:05 PM, V7 (Respiratory Therapist) stated when she arrived she could not see R1's chest rising and R1 had a nasal canula on her face. V7 stated she obtained the AMBU bag from the crash cart, switched the nasal canula for the AMBU bag, and began delivering rescue breaths to R1. R7 stated she did not recall staff utilizing the AED on R1.On 6/5/26 at 10:38 AM, V6 (RN- Registered Nurse) stated she assisted staff responding to R1 and took over performing chest compressions on R1 from another staff. V6 stated V8 suctioned R1 and V7 utilized an AMBU bag for rescue breaths.On 6/5/26 at 11:34 AM, V9 (CNA- Certified Nursing Assistant) stated he called 911 and remained nearby as staff attended to R1's emergency.Review of American Heart Association Basic Life Support CPR documentation shows V5 (LPN), V6 (RN), V7 (Respiratory Therapist) V8 (ADON), V10 (CNA) and V15 (CNA) all successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program and their certifications were current at the time R1 became unresponsive and needed CPR.On 6/9/26 at 10:28 AM, V2 (Director of Nursing) stated it was her expectation that the facility staff follow the AHA CPR and AED protocol. V2 stated if a resident is full code and unresponsive, has no pulse, and is not breathing, staff are expected to immediately start chest compressions, immediately apply the AMBU bag and provide rescue breaths, and apply the AED as soon as able. V2 stated there was no reason for the staff not apply the AED to R1 when they were unresponsive. On 6/9/26 at 4:31 PM, V26 (Physician) stated after initiating chest compressions, facility staff were required to begin rescue breaths with an AMBU bag if available. V26 also stated if the facility had an AED available, they should use the device on any collapsed patient. On 6/8/26 at 6:58 PM, V26 (Physician) stated the facility staff were expected to follow the AHA CPR BLS protocols per their CPR training on residents requiring CPR. V26 stated, Why didn't they use the AMBU bag right away - that is a valid question.On 6/8/26 at 10:53 AM, V25 (Paramedic) stated utilizing a nasal cannula for oxygen administration on an unresponsive resident did not make sense because the resident was not breathing oxygen in through their nose. V25 stated staff should immediately start chest compressions, apply an AED if available, and provide rescue breaths using an AMBU bag or CPR mask. V25 stated she was told by facility staff that the facility did not have an AED machine available. V25 stated if R1's heart was initially in a shockable rhythm, not providing oxygen would provide more strain on a resident's heart which could (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have been why she was no longer in a shockable rhythm when paramedics arrived. On 6/8/26 at 10:28 AM, V24 (Paramedic) stated R1's initial emergency response call was dispatched as R1 was not conscious, not breathing and CPR was ongoing. V24 stated utilizing oxygen via a nasal canula on a non-breathing resident was not effective because the oxygen only remained in the nasal passage. V24 stated after beginning chest compressions the next staff to arrive should use the AMBU bag to provide rescue breaths. On 6/9/26 at 10:51 AM, V1 and V2 stated they provided clinical staff training on emergency care guidelines including CPR as of 5/12/26 including responding to unresponsive residents, providing CPR and administering AED. V2 stated the staff were not required to provide return demonstration of the skills and competencies that were reviewed during the trainings.Facility CPR Policy, revised 6/30/26, shows, It is the policy of this facility to provide basic life support including CPR to any resident requiring such emergency procedure subject to the resident's advance directives and physician orders and in accordance with the standard of practice. 1)Basic Life Support and/or CPR will be immediately provided to a resident requiring cardiac, respiratory, or cardiopulmonary resuscitation subject to the physician orders and resident's advance directivesFacility CPR Procedure, revised 6/30/25, shows, The CPR procedure will be based on AHA's 2022 Interim Guidance to Healthcare Providers for Basic and Advanced Cardiac Life Support to provide safe and effective CPR to a resident who suffers from cardiopulmonary arrest. Code Blue & CPR Procedure: 1) When a resident is found unresponsive, check code/DNR status first. 2) If resident is a Full Code, then call for nearby help by calling Code Blue. 3) Call 911 next. 4) Get the AED and crash cart (or send someone to do it). 6) Look for no breathing or only gasping and check pulse (simultaneously) within 10 seconds. If pulse is not felt, perform CPR without delay. 7) Actively ventilate using a bag-mask device with HEPA filter on the device's ventilation exhaust port, to capture aerosolized particles. 8) Perform cardiac compressions of 30 compressions and 2 breaths using bag-mask device with HEPA filter and tight seal. 9) Attach AED once available, while CPR is being performed. 10) Stop CPR and do not touch the resident when AED is on and is assessing the resident's status. 11) Follow AED's direction whether Shock is advised or not. 12. Resume CPR until 911 paramedics arrive to take over. The procedure shows the staff is to follow the Adult Basic Life Support Algorithm for Healthcare Providers. AHA Adult Basic Life Support Algorithm for Health Care Professionals shows staff are expected to perform chest compressions and rescue breaths use an AED as soon as it is available if a resident is not breathing and has no pulse.Facility Emergency Care Guidelines - Choking document, revised 6/30/25, shows, Unconscious Resident- Lying Down (or When Unable to Reach Around the Resident) Ease the resident as gently as possible to the floor. 1. Call for help if assistance is not already present, call 911 via mobile device if appropriate, get AED and crash cart but do not leave the resident unattended. 2. Position the resident on the back with the arms at the side. 3. Inspect resident's mouth for obstruction, proceed with finger sweep if the obstruction is visible. 4. Start CPR and at the end of each CPR cycle, inspect resident's mouth for obstruction, proceed with finger sweep if the obstruction is visible 7. If obstruction is not removed, continue CPR and check for obstruction at the end of each cycle. Do a finger sweep only if the obstruction is visible. 8. Provide CPR in accordance with the resident's CODE STATUS. If the resident is a Full Code, provide CPR and document including whether AED was applied or not.Facility Code Blue policy/procedure shows, b. Emergency crash cart will be brought to the site of emergency. C. The assigned nurse will initiate the medical emergency interventions (for full code status) per facility's protocol after evaluating the signs and symptoms of cardiopulmonary arrest. D. The nurse/other staff will start the CPR if indicated.F. Other staff will initiate other emergency measures such as IV Line, suction, secretions, take turns with the CPR intervention. G. The Nursing Supervisor or designee will facilitate in maintaining a non-chaotic emergency care environment.The facility presented an abatement plan to remove the immediacy on 6/9/26. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a revised abatement plan on 6/9/26, and the survey team (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	accepted the abatement plan on 6/9/26.The Immediate Jeopardy that began on 5/7/26 at 5:04 PM and was removed on 6/9/26 at 8:57 PM, when the facility took the following actions to remove the immediacy:1) R1 was assessed immediately when identified as unresponsive, suctioned the mouth, CPR initiated, 911 called.2) In-services conducted with all certified CPR staff, CNAs, Nurses, and RT regarding policy and procedure on emergency guidelines and on CPR including AED application on 5/8/26, 5/9/26, 5/11/26, 5/12/26. Return demonstration of understanding this policy and procedure conducted by way of a quiz with completion of 6/9/263) The DON and/designee will conduct an audit of 5 staff 3 times a week for 12 weeks on different shifts to ensure that clinical staff have proper knowledge of the CPR policy and procedure.4) The incident and removal plan has been discussed and reviewed with the facility medical director on 5/7/26 and again on 6/9/26 and the medical director was in agreement with the removal plan and policy and procedure on CPR. 5) An emergency QA meeting was scheduled to discuss the incident and plans of correction with the IDT team including the medical director on 6/9/26.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide 1:1 supervision at a meal to a resident who had physician orders for 1:1 feeding assistance.This failure resulted in R1 consuming food during a meal while unsupervised and becoming unresponsive for 13 minutes before being assisted.This applies to 1 of 3 residents (R1) reviewed for meal supervision in a sample of 83.The findings include: Face sheet, dated 6/5/26, shows R1's diagnoses included Huntington's disease, dysphagia, chorea, personal history of sudden cardiac arrest, dementia, lack of coordination, signs/symptoms involving the musculoskeletal system, and abnormality of gait/mobility. Nurse practitioner progress notes, dated 4/24/26, shows R1 was at risk for aspiration and required aspiration precautions.POS (Physician Order Sheet), printed 6/5/26, shows R1 had an order dated 4/3/26 for a Mechanical Soft diet with 1:1 feeding assistance. The order shows R1 also had physician orders for swallowing precautions which included taking small bites, offering food at a slow rate, alternating liquids and solids, and ensuring R1 cleared the food in her mouth prior to taking another bite. The physician orders show R1's had a physician order for full code dated 12/30/22. Speech Pathology progress notes, dated 4/17/26, show R1 was provided 1:1 assistance with her food intake and R1 attempted to put two bites of food in her mouth quickly but was receptive to verbal cues to slow down while eating. Notes, dated 4/22/25, show R1 occasionally held food in her mouth and was receptive to verbal cues to swallow. The note shows R1 required 1:1 assistance at meals because R1 could be impulsive at times. The note shows R1 was provided maximum assistance at meals with food intake to maximize function and safety, and staff were to ensure oral food clearance prior to R1 taking another bite of food. Notes, dated 4/20/26, show R1 was provided maximum assistance with oral intake and the dining room staff were reminded to assist R1 given her risk of aspiration. The note shows R1 held food in her mouth at times and was receptive to cues for R1 to swallow. The note shows R1 required 1:1 feeding assistance at meals.On 6/5/26 at 2:19 PM, V17 (CNA) stated on 5/7/26 she escorted R1 to the neurologist and R1 received Botox injections in each cheek to reduce her drooling. V17 stated when she returned to the facility with R1, she placed R1 in the dining room and V15 was in the dining room feeding a resident. V17 stated she placed R1's tray in front of her and removed the food lid exposing the food on R1's plate. V17 then notified staff R1 was back from her appointment and ready to eat dinner. V17 stated she was not aware if R1 required 1:1 feeding assistance.On 6/9/26 at 9:02 AM, V28 (Neurology Physician Assistant) stated on 5/7/26 she injected Botox in each or R1's cheeks to attempt to decrease R1's chronic drooling. V28 stated there was a theoretical risk for difficulty swallowing after patients have their cheeks injected with Botox. On 6/6/26 at 2:30 PM with V1 (Administrator) and V2 (Director of Nursing), facility camera footage of R1 prior to R1's death on 5/7/26 was reviewed in V1's office. The footage showed at 4:58 PM, R1 sat in the dining room alone during dinner with a tray of food in front of her. Between 4:58 PM and 5:00 PM R1 appeared to pick up food items with her hands (in spite of experiencing involuntary movements of her arms) and lifted them toward her head while leaning her torso forward. The food items in R1's hand appeared smaller each time R1 moved her hand away from her face. At 5:02 PM, R1 became significantly more animated, began thrashing in her wheelchair left to right, kicked her legs off of her wheelchair leg rests, and reached her right hand toward the resident sitting across from her eating his dinner. At 5:04 PM, R1 ceased all movement and remained motionless in her chair. At 5:17 PM, V12 (Activity Aide) approached R1, attempted to arouse R1, and immediately called V15 (CNA- Certified Nursing Assistant) to attend to R1. R1 was whisked into the hallway in her wheelchair and V5 (LPN - Licensed Practical Nurse) was called to assess R1. R1 was immediately placed on the floor of the hallway and V5 began chest compressions on R1. At 5:21 PM, V8 (Assistant Director of Nursing) began to suction R1 and V7 (Respiratory Therapist) then began administering rescue breaths using an AMBU (Artificial Manual Breathing Unit). At 5:25 PM, paramedics arrived and took over recue (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	activities. On 6/5/26 at 12:48 PM, V15 (CNA) stated on 5/7/26 during dinner she knew R1 needed feeding assistance, but she was assisting another resident in the dining room. V15 stated her back was turned to R1 while she was feeding the other resident. V15 stated she did not have visual contact with R1 while R1 was sitting at the dinner table because her back was turned to R1 while feeding a resident. V15 also stated she looked around the room while feeding her resident. V15 stated she did not place any liquids in R1's cup because R1 was going to wait to eat until V15 was done feeding another resident. V15 stated she asked R1 if she was ok while V15 was feeding the other resident but was unsure if R1 responded. V15 stated she was unsure if R1 fed herself any food while she was unsupervised and stated it would not be unusual for R1 to try to feed herself if food was in front of her. V15 stated when the noticed R1 was unresponsive she brought R1 to the nurse in the hall and immediately began chest compressions.On 5/6/26 at 12:32 PM, V12 (Activity Aide) stated on 5/7/26 during dinner he assisted passing dinner trays in the dining room. V12 stated V15 (CNA) was the only staff in the dining when he went into help. V12 stated he left the dining room for approximately 15 minutes and when he returned he saw R1 sitting at her table in the middle of the dining room with her dinner tray in front of her. V12 stated R1 had no staff with her at the table and V15 was focused on feeding another resident in the corner of the dining room. V12 stated R1 was slouching in her chair and R1 did not respond to attempts to arouse her. V12 stated he called V15 for help and they brought R1 to the nurse. V12 stated he looked at R1's tray after the incident and it appeared R1 ate a small portion of mac and cheese. V12 stated there was no biscuit but there were biscuit crumbs on the tray. On 6/5/26 at 9:41 AM, V1 (Administrator) stated the paramedics arrived while R1 was receiving CPR and were unable to revive R1. V1 stated the paramedics pronounced R1 dead at the scene. V1 stated she observed R1's tray in the dining room after R1 expired and there was a biscuit missing from her dinner tray. V1 stated there were a few crumbs of biscuit left on R1's tray as well as a plastic bag in which the biscuit was served. V1 stated it was possible R1 got to the biscuit. On 6/6/26 at 3:24 PM V1 (Administrator) provided a picture of R1's plate taken on 5/7/26 at dinner after R1 expired showing what appeared to be crumbs of biscuit on the tray / plate and an empty baggie on the table near the tray.On 6/5/26 at 10:06 AM, V5 (LPN - Licensed Practical Nurse) stated on 5/7/26 when R1 was brought to her unresponsive, the staff attempted chest compressions immediately, but she was unsure if anyone performed a finger sweep of R1's mouth during the emergency. V5 stated she examined R1's meal tray after R1 expired and saw an empty baggie at her tray.On 6/5/26 at 10:38 AM, V6 (Registered Nurse) stated on 5/7/26 during the emergency she arrived to see R1 on the floor and staff were performing chest compressions and she was not sure if staff swept R1's mouth for food prior to her arrival.On 6/5/26 at 11:13 AM, V8 (Assistant Director of Nursing) stated when he arrived R1 was already receiving chest compressions and he suctioned R1's mouth prior to V7 (Respiratory Therapist) began applying the AMBU (Artificial Manual Breathing Unit) bag to provide rescue breaths. V8 stated he did not see any staff perform a finger sweep of R1's mouth prior to his suctioning.On 6/5/26 at 10:59 AM, V7 (Respiratory Therapist) stated when she arrived R1 was already receiving chest compressions. V7 stated V8 suctioned R1's mouth prior to her applying the AMBU bag.On 6/8/26 at 10:28 AM, V24 (Paramedic) stated the initial call to 911 dispatch was of a person choking, not conscious and not breathing and in cardiac or respiratory arrest. V24 stated when they arrived and treated R1, they did not see anything in R1's airway and staff could have dislodged something in her airway prior to their arrival while they were performing chest compressions. On 6/8/26 at 10:53 AM, V25 (Paramedic) stated she was not told R1 was eating a biscuit prior to her unresponsiveness and was told by the facility she was incapable of doing anything on her own. V25 stated the paramedics were initially told by 911 dispatch that R1 was experiencing a choking emergency but when they arrived at the facility they were told by facility staff that there was a miscommunication and R1 was not choking. V24 stated if she was told R1 was choking she would have utilized different equipment to suction R1's respiratory system deeper.On 6/5/26 at 12:20 PM, V11 (Speech Language Pathologist) stated he treated R1 for dysphagia and R1 required 1:1 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assistance form staff during meals for dysphagia. V11 stated R1 would feed herself but was not always successful due to her Huntington's disease and involuntary movements. V11 stated when he worked with R1 she was feeding herself and drinking from her adaptive cup which she would drop at times. V11 stated getting food out of a baggie may be difficult for her but she might be able to do it eventually. On 6/10/26 at 10:09 AM, V11 stated if R1 did not have 1:1 feeding assistance she may not be able to tolerate her mechanical soft diet. V11 stated he would provide R1 liquids to help with food residuals left in her mouth and R1 required 1:1 staff assistance at meals for safe swallowing. V11 stated he sometimes had to cue R1 to swallow the food in her mouth and R1 required staff to monitor her rate of eating, her bite sizes, to encourage her to alternate between liquids and solids, and to facility safe swallowing guidelines. On 6/10/26 at 11:38 AM, V34 (CNA) stated R1 required staff to remind her to take sips of liquid because she would hold food in her mouth and the food would build up in her mouth. V34 stated R1 could sometimes be impulsive when she ate. V34 stated R1 would put food into her mouth fast, the food would build up in her mouth, and R1 would start coughing. V34 stated if staff were not near R1 when R1 ate she would be concerned R1 would feed herself too much too fast and possibly choke. On 6/10/26 at11:16 AM, V31 (Activity Aide) stated if R1 had food placed in front of her she would be able to physically put food into her mouth. V31 stated staff were not always providing R1 1:1 feeding assistance when R1 had food in front of her at the table.On 6/6/26 at 12:41 PM, V23 (CNA) stated when assisting R1 at meals V23 would tell R1 to take small bites because R1 would try to put larger portions of food in her mouth.On 6/6/26 at 12:36 PM, V22 (LPN - Licensed Practical Nurse) stated during meals the staff would have to cue R1 to eat slower, take smaller bites, and take small sips.On 6/5/26 at 12:40 PM, V13 (RN - Registered Nurse) stated R1 could pick up food items by herself and eat them. V13 stated staff assisted R1 with eating because her involuntary movements made it difficult for R1 to feed herself. On 6/9/26 at 10:37 AM, V2 (Director of Nursing) stated R1 was expected to have 1:1 feeding assistance from staff when she was presented food.Review of R1's progress notes show R1 expired at the facility after CPR was provided for approximately 23 minutes. Facility Dysphagia and Aspiration - Clinical Guidelines, effective 7/17/25, shows, The staff and physician will identify individuals whose swallowing capabilities decline, fluctuate, or result in clinically significant complications and will adjust diet and food consistency and make other appropriate interventions.