STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165797	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Iowa Healthcare Center	3140 Plank Road Keokuk, IA 52632

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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, record review, hospital record review, facility investigative file review, employee file review staff interviews and policy review the facility failed to prepare and serve the recommended therapeutic meal in a form designed to safely meet the resident's needs and according to physician orders for 1 of 3 residents reviewed (Resident #1). This resulted in Resident #1 choking on a peanut butter and jelly uncrustable, she became unconscious, CPR was initiated, the resident gained consciousness and was sent to the hospital. She was found to have a pneumothorax. Resident #1 was given an improper textured diet when she asked for a snack; she was ordered to receive a puree diet. The facility reported a census of 50 residents. On June 26, 2026 at 10:32 AM the State Agency informed the facility the staff's failure to properly prepare and serve the therapeutic meal per orders creating an Immediate Jeopardy situation which began on June 26, 2026. The facility removed the immediacy on June, 26, 2026 at 2:57 PM when the facility staff implanted the following Corrective Actions:On June 23, 2026:The employee that was directly involved with the incident received discipline on not being more aware of residents' diets and what food related items are conforming to a given diet.A written identification system was instituted that identified the current diets each resident is on so proper food related items that are conforming to a prescribed diet are offered, will be safe for the resident to consume. This change was in effect for any staff utilizing the snack cart, starting on June 23, 2026.The DON provided education/instruction to all staff working the evening of June 23, 2026, including the staff member directly involved in the incident. This training for those individuals working that night addressed resident diet sheets (the diet identification system), which residents are on modified diets and what they are, clarification of each modified diet (foods that match the diet), the identification systems will remain on the cart, ordered (prescribed diets) shall be followed by staff.On June 24, 2026:The Administrator provided education/instruction to those personnel from the nursing, dietary and activities departments to address new diet identification system, going over diets residents are on and what those diets are, food related items that conform to a prescribed diet, accessibility by staff to the identification system on the cart, following prescribed diets by the staff.The Administrator convened a QAPI meeting to address resident diets, communication processes how diets are conveyed to employees, care planning regarding dietary related manners.The Administrator directed the Dietary Manager to review all resident care plans and directly put into the care plans the specific diet composition for a resident.The Administrator and Risk Management Director met to address resident diets and risk management identifiers regarding diets, to address quality assurance of these areas.The Administrator developed a policy/procedure regarding snack cart utilization which included staff providing snack food are expected to be aware of any resident diet and being aware of conforming food related items that can be served with it. This policy/procedure was in effect on June 24, 2026.On June 26, 2026, all employees who may be involved in passing out snacks received the education/instruction regarding diets and therefore, are considered trained effective June 26, 2026.For the next 3 months, the facility will do the following: Dietary Director or designee, shall conduct random audits of the snack cart to ensure the diet identification system being used is found on the snack cart, as expected. Dietary Director or (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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	designee, shall conduct random audits to ensure all potential changes in diets have been updated on the diet sheets in the cart diet identification system being used, so they are accurate.The scoped lowered from J to D at the time of the survey after ensure the facility implemented education about their policies and procedures. Findings include:According to quarterly Minimum Data Set (MDS) assessment tool with a reference date of 5/14/2026, Resident #1 had a Brief Interview of Mental Status (BIMS) score of 5. A BIMS score of 5 suggested she had severe cognitive impairment. Resident #1 was dependent on staff for eating and had received a mechanically altered diet within the 7-day review period. The MDS listed the following diagnoses: schizophrenia, diabetes mellitus, stroke, and anxiety. A Care Plan Problem Area with start date of 7/12/2023 documented Resident #1 received a therapeutic and mechanically altered diet. On 3/27/2024 Resident #1 had an order for a puree diabetic diet with regular liquids. Resident #1 required supervision/cueing with meals. On 7/3/2025 staff were directed to observe Resident #1 closely for difficulty chewing, pocketing food, eating very slowly or leaving meals uneaten. A second Care Plan Problem Area with start date of 6/24/2026 documented Resident #1 was at risk for swallowing issues when consuming food related items. Resident #1 was ordered to have a mechanically altered diet: puree diabetic diet. The Care Plan documented she will cooperate with staff guidance on consuming food related items that meet the parameters of her pureed diet.Review of Resident #1's Electronic Health Record (EHR) revealed the following diet order: regular liquids and house diabetic/puree. The diet order had a start date of 3/20/2024.The following Progress Notes were documented for Resident #1:On 6/23/2026 at 9:54 PM Staff A Licensed Practical Nurse (LPN) documented at 8:45 PM Resident #1 was witnessed sitting in the recliner eating a snack. At 8:50 PM this nurse heard resident state I can't breathe, and started to grab her throat. This nurse ran over to resident and alerted Staff B Certified Nursing Assistant (CNA), she's choking. Resident stood up out of recliner via assistance of two staff and the Heimlich maneuver started immediately with approximately 20 unsuccessful attempts. Staff A heard Resident #1 experiencing stridor (high pitched or whistling breathing sound) during this time. Back thrust's initiated while resident was still conscious. At 8:51 PM 911 was called. Resident #1 sat in the chair leaning forward due to her losing strength to her lower extremities. Resident leaned forward with the assistance of two staff. Oxygen (o2) checked and read 66% on room air. Supplemental o2 via nasal canula (NC) applied at 5 liters (L). Resident #1 then began to turn pallor, unresponsive, and lost consciousness. No pulse present upon palpation to left carotid artery. At 8:53 PM Resident #1 was lowered to the ground via assistance of two staff. This nurse initiated cardiopulmonary resuscitation (CPR) immediately. A blanket placed slightly under head to prevent injury to the back of head. Compressions continued as automated external defibrillator (AED) was obtained and applied by Director of Nursing (DON) but shock was not advised and 8 cycles of CPR initiated. At 8:56 PM Resident #1 regained pulse via palpation to left carotid artery by Staff C LPN, CPR was stopped. Resident also heard speaking inaudible words. Stridor resumed and o2 had read 92% on 5L NC. At 8:57 PM the ambulance arrived and cares resumed per 2 EMT's and 2 Firefighters. During this time, resident received suctioning, high flow supplemental o2 via NC, an intravenous (IV) was started and fluids initiated. Stridor continued with movement to bilateral upper and lower extremities were noted. At 9:10 PM the resident left the building with the ambulance crew. On 6/23/2026 at 10:45 PM Staff C documented as she was walking up the hall, she noted two staff holding Resident #1 up stating she was choking. They then sat the resident down and leaned her forward. This nurse grabbed a pulse/ox and obtained the resident's o2 and it was at 66% on room air. Supplemental oxygen was administered at 5L via NC. Resident #1 became pallor and lost consciousness and her pulse was not palpable at that time. Resident was then lowered to the floor and CPR was started. After 8 cycles of CPR, a pulse was obtained, o2 reading at that time was 92%. The EMS staff arrived and took over. On 6/24/2026 at 2:04 AM Staff A documented at 1:09 AM the nurse called to get an update on Resident #1. Hospital staff reported Resident #1 was stable upon arrival, became hypotensive after awhile and was given two pressures bags which raised her blood pressure. A chest x-ray showed a small pneumothorax and (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	snack following being given ice cream and when she requested a peanut butter and jelly sandwich specifically, Staff A have her that snack. Staff B's statement was obtained and a written warning was given for lack of awareness of resident diet. Education was provided following receiving all statements. A list of resident diets was placed on the snack cart for reference for all staff. Consecutive Employee Warning Report for Staff B. On 6/23/2026 Resident #1's care plan was not followed regarding resident's diet while passing snacks. Action taken included education and diet lists added to snack cart. Staff B and the DON signed and dated the report on 6/23/2026.Review of Staff B's employee file revealed had orientation on 9/23/2024 at 8:30 AM. Staff B signed the Job Description Agreement on 9/23/2024. The agreement documented: I have received my current job description for my position at the facility. I understand that I am responsible for performing all of the duties and responsibilities of my job description. If I do not demonstrate these requirements competently as I am assigned, I will be subject to termination. The job description indicated a CNA: is responsible for providing personal care and assistance for residents in the facility, may be called upon to help residents with feeding, providing assistance with serving meals and snacks, feeding residents if needed, have the consistent ability to reasonably conform to all rules and polices of the facility, follow instructions well and complete daily assignments as assigned, and provide between the meal nourishment when indicated (distribute supplemental nourishment as assigned).The facility was asked to provide an orientation checklist for Staff B upon hire. On 7/1/2026 at 8:36 AM in an email correspondent with the Administration he stated they do not utilize a formal checklist but could more to the route to be more formalized. There is a setlist of curriculum the CNA training supervisor goes over with new hires for on-boarding and that curriculum does include: Care Plans, accessing the EHR for charting, introductions to residents, diets and meal serving.On 6/25/2026 at 5:20 PM Staff B stated on 6/23/2026 at about 8:00 PM she was passing snacks from the snack cart. Resident #1 had some ice cream then stated she was hungry for another. Staff C told her to give the resident a fudge round but they did not have one. Resident #1 stated she wanted a peanut butter and jelly sandwich, so she gave her one. Staff B stated about 5-10 minutes later Resident #1 was choking. Her and Staff B started to do the Heimlich maneuver, then Staff B had to initiate CPR, staff called 911 and Resident #1 went to the hospital. Staff B stated Resident #1 shakes really bad when attempting to feed herself, so she assisted her with eating the ice cream. She was able to hold the peanut butter and jelly sandwich with both hands. When asked if the resident was being supervised while eating the peanut butter and jelly sandwich, she stated the resident was sitting upright in her recliner, in the commons area where they had eyes on her at all times. Staff B denied knowing Resident #1 was on a puree diet and indicated there were not diet lists posted for staff to look at until after this incident happened. They now have the resident diet lists on the snack carts. When asked if resident diets should be followed for snacks in addition to meals, she acknowledged they should be followed for meals and snacks. Staff B acknowledged she received education on the night of 6/23/2026 about resident diets and the implementation putting the diet lists on the snack carts. The DON educated her and she signed a piece of paper indicating she received this education. When asked if the peanut butter and jelly sandwich she gave Resident #1 would be considered part of a puree diet, she stated she was not sure, she had never seen pureed food and was not sure what food would be considered pureed for residents. When she passed out snacks that night, they did not have labels on the snacks to indicate who they went to or what consistency they were. On 6/25/2026 at 5:44 PM Staff C stated on 6/23/2026 she walked up the hall to go to the medication cart when she saw Staff A and Staff B with Resident #1 holding her up. They said the resident was choking so she grabbed the pulse/oximeter because she looked pale; her oxygen saturation ready 66%, so she went to the medication room to obtain and oxygen tank. They were able to sit the resident in the chair and had her leaning forward. They had already attempted the Heimlich maneuver and back thrusts; they were unsuccessful. Staff C stated she was not present when those interventions were attempted. When she returned with the oxygen tank the resident was not responding so they laid her on the floor. Staff A felt no pulse, so she (continued on next page)

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Since the incident, the added a diet sheet on the snack cart and ensured one is on the clips boards on the medication carts. The kitchen has also been informed they need to have different pureed snacks prepared for those on a pureed diet. What asked what kind of education had been provided, she stated they talked about the diet sheets being on the snack and mediation carts, what the residents can have based on their diet orders and what diets they are on. She received the education from the DON on the night of the incident, after they did a debriefing. On 6/25/2026 at 5:53 PM Staff A stated Staff B has just fed Resident #1 ice cream when she heard the resident stating she was still hungry which was typical for her to get more than one snack. After that she was unsure what they came up with for her additional snack. Staff A went to the nurse's station to chart, she got up to grabbed a clip board from the other medication cart. She looked over at Resident #1 and she stated she could not breathe. As she was walking over to her, Resident #1 put her hands around her throat; the universal sign for choking. She ran to the resident and yelled at Staff B that Resident #1 was choking. Staff B came to assist and that is when Staff A noticed a peanut butter and jelly uncrustable. They stood Resident #1 up and attempted the Heimlich maneuver roughly 20 times, which was unsuccessful. She added they tried everything; back thrusts, tried looking in her mouth to see if there was anything in there. As time went on the DON walked in and they told her Resident #1 was choking. At that time Resident #1 was losing strength in her legs, they sat her down, someone called 911, her oxygen saturation was 66%, she then went unconscious, turned pallor, eyes became fixed and had no pulse at that time. The put her on the floor for a flat surface and started CPR. Staff A stated they did about 8 rounds of CPR, Staff B obtained the ambubag, the DON retrieved and applied the AED, Staff C put an oxygen mask on Resident #1's face and was giving breaths. The resident remained unconscious, the AED did not advise shocks to be given, so they continued with CPR but after about 3 minutes they were able to find a pulse. They tried to keep her as comfortable as possible, were talking with her just to keep her with them until the EMTs arrived. When they arrived, they started an IV, suctioned her out, hooked her up to their AED then took her to the hospital. Prior to this incident there was a sheet of the resident's diets at the nurse's desk, but it had disappeared and had not been there for a while. She kind of knows what diets residents are on but you can look it up in the EHR and dietary start knows what diets the residents are to receive. Since this incident the DON got on the computer that night, revised the diet list on her computer and implemented three-page list of the resident diets to go on the snack cart and thought they kitchen staff were going to start passing out snacks instead of the CNAs doing it. She did received education that night on residents needing feeding assistance, residents eating in the dining room for supervision purposes, and what diets the residents are on. When asked if a peanut better and jelly uncrustable was considered part of a puree diet, she stated it was not puree consistency. On 6/26/2026 at 8:12 AM Staff D LPN stated before the incident with Resident #1 they had a list of resident diets at the nurse's desk, the diets were on the resident's care plans, she would double check the resident's chart or even ask other staff members if she had questions about diet orders. Since the incident they kept the current things in place, just added a list of resident diets on the snack cart, the list also includes adaptive equipment needed when assisting residents with their meals. She acknowledged she received education on double checking the resident's care plans, asking staff about resident diets, check the list and know what food is given prior to giving it to the (continued on next page)

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Today, she was educated on resident diets, thickened liquids and checking the MAR for diet orders.On 6/26/2026 at 8:25 AM Staff H [NAME] and Staff I [NAME] stated prior Resident #1 choking they assumed the diet orders could be found on the resident's Care Plan but heard it was hard to find where the diet order was on them. They also had a list of resident diet orders at the nurse's stations. Since the incident the kitchen staff will provide additional puree snacks for the snack cart. They are labeled what diet consistency they are and are in a tub in the refrigerator. The kitchen staff assembles the snack carts for the nursing staff to pass out the snacks to the residents at about 8:00 PM. A list of resident diets is also on the snack cart at all times for staff to utilize. On 6/26/2026 at 9:19 AM the DON stated she was working on the night of the incident with Resident #1. As she was leaving, she noticed Staff A was doing the Heimlich maneuver, Staff C came over to assess the resident's oxygen saturation then go the oxygen tank and another nurse called 911. The DON stated Resident #1 ended up losing consciousness and they were unable to find a pulse. The DON stated she got the AED and put the pads on Resident #1. By the time the EMTs arrived at the facility the resident had regained consciousness. When asked what the resident was choking on, the DON stated a peanut butter and jelly uncrustable. The DON stated Resident #1 was on a puree diet at the time of the incident. The DON indicated the bread part of the sandwich maybe considered puree but not the peanut butter and jelly part. When they obtained statements from staff that night, Staff B indicated she gave Resident #1 the sandwich because she the resident requested it after she had finished her ice cream. When asked if Staff B new of the resident being on a puree diet, the DON stated the staff member did not say if she knew or not. The DON assumed Staff B knew the resident was to receive pureed food items, she assumed she knew because she had just given her ice cream prior. When asked how was responsible for passing snacks after supper, she stated the evening shift CNAs. The dietary staff set up the snacks on the cart for the CNAs to pass them out to residents. Prior to this incident they had papers at each nurse's station of resident diets, they can also be found in the resident's EHR, the diet orders were in several places. DON acknowledged CNAs do have access to the resident profile, care plans and tasks. When asked what was all on a resident profile, she stated it's a simplified version of a care plan. It goes through things staff would need to know about the resident. She added the nursing staff do have access to the resident's diet orders. Immediately after this incident they have a revamped diet list on the snack cart. The first page is a list of residents on a puree diet, next page consists of residents on a mechanical soft diet and the last pages are residents on a regular diet. She educated all staff that were working on the night of the incident then had two staff meetings the next day with the new information. If staff were not present of those meetings they were updated prior to their next shift. The DON stated at the time of the incident nursing staff were passing snacks to residents and they will continue to do it. On 6/26/2026 at 10:37 AM the Dietary Director stated prior to his incident they printed out the resident diet list once a month unless an order changed. He would pass out the list to all the directors, left a list in the kitchen and at each nurse's station. He stated the kitchen staff get the snack cart ready and the nursing staff pass out snacks at night to the residents. Since the incident they have added the diet list to the snack cart for the nursing staff. They have started to do more puree snacks and leaving them in the refrigerator; labeled either puree or mechanical soft. Nursing staff will still pass out snacks to residents. Currently they have three residents that receive a (continued on next page)

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	puree diet. When asked if a peanut butter and jelly uncrustable would considered part of puree diet, he said not but they could have pureed it for the resident. On 6/26/2026 at 11:35 AM Staff J CNA stated she had recently been educated on resident diets and what they have with each diet. They have a paper list of diets located at the nurse's station and in the kitchen. When asked what she would do if she did not know what diet a resident was on, she stated she would ask the kitchen staff, look at the list in the kitchen, ask the nurse or go the clip board where the diet lists are and look at that. The facility provided a document titled Dietary Orders with a vision date of 10/18/2025. The purpose of this document is to have a process in place that addresses the expectation of following resident dietary orders. The facility personnel who are in the role of providing medical based care regarding dietary orders, are expected to provide directe care communicated via a written dietary order. If there is concern regarding a dietary order, the dietary manager and/or the consulting dietitian, shall be consulted with the concern regarding the order. The dietary manager and/or consulting dietitian shall then contact the physician or designee, to discuss the concern regarding the order. The physician or designee, shall be the final arbiter in determining if a dietary order is changed, modified, delayed, or remains as directed. If a resident declines to participate with a specific diet order, the physician or designee, shall be notified of the resident's decision to refrain from participating with the order. The resident's decision to decline in participating with a diet order shall be documented in the clinical chart of the resident. If a resident has a BIMS score 13 or higher, education shall be attempted to persuade a resident to participate with the given order.The facility provided a document titled Dietary Diets with a revision date of 6/29/2026. The purpose of this document is to have a process in place that addresses the expectation of following resident prescribed diets. A resident's prescribed diet (regular, mechanical soft, pureed) shall be followed by staff working with the resident. An offered food item to a resident shall be conforming to the resident's current diet. Prescribed diets shall be directed by those individuals qualified by the State of Iowa to prescribe diets. Staff members shall receive education on diets starting at hiring orientation and when deemed necessary, continued education on diets shall also be provided. Residents shall be informed by the dietary director or dietitian or speech therapist, what type of diet is being used and discuss how that diet affects the resident individually. Resident Representatives shall also be notified if there is any change to a current diet of a resident. The facility provided a document titled MDS Care Plan with a revision date of 10/18/2025. The document indicated the MDS care plan shall also be developed by the facility's care team with resident/resident representative involvement. The MDS care plan shall be reflective of assessment results from the MDS and/or current clinical functioning of the resident. The care plan will identify the potential problems, goals to be achieved, and intervention strategies to be employed (by whom or by when) to meet the goals, alleviate problems and determine if new problems are occurring in order to be addressed by the overall care team. Facility staff shall be expected to follow the identified care plan for any specific resident that has a care plan(s).The facility provided a document titled Physician Orders with a revision date of 10/18/2025. The purpose of the document was to have a process in place that addresses the expectation of following physician orders. The facility personnel who are in the role of providing physician directed medical care, based upon documented physician order, are expected to provide by the best of one's ability and available existing resources, the physician directed care communicated via a physician order. If there is concern regarding a physician's order, the DON or designee, shall be consulted with the concern and the DON or designee, shall then contact the physician or designee, to discuss the concern regarding the order. The physician or designee, shall be the final arbiter in determining if an order is changed, modified, delayed, or remains as directed. If a resident declines to participate with a specific physician order, the physician or designee, shall be notified of the resident's decision to refrain from participating with the order. The resident's decision to decline in participating with a phys[TRUNC