STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	501 Eighth Avenue Southeast Rochester, MN 55904

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement and monitor known aspiration precautions for residents with dysphagia, including ensuring correct diet texture, prescribed liquid consistency, supervision during meals, and safe meal positioning. This resulted in an Immediate Jeopardy (IJ) for R1 when the facility failed to ensure these requirements were consistently communicated to and followed by nursing and dietary staff for R1 which resulted in R1's hospitalization for diagnoses of pneumonitis due to inhalation of food and vomit and following hospitalization, the facility failed to follow R1's prescribed diet putting R1 at risk for additional choking and or aspiration events. Additionally, the facility failed to ensure the correct liquid consistency was provided according to the dietary order and failed to comprehensively assess and monitor R6 following a coughing episode for signs and symptoms of aspiration, placing R6 at risk for aspiration-related complications.The IJ began on 3/26/26, when R1 with known dysphagia and aspiration precautions, was permitted to eat unsupervised in bed and experienced a suspected aspiration event requiring hospitalization. The facility failed to implement corrective action which resulted in incorrect diet type served to R1 on 4/8/26 and 4/9/26. The Administrator and director of nursing (DON) were notified of the IJ on 4/10/26 at 2:26 p.m. The IJ was removed on 4/11/26, but non-compliance remained at the lower scope and severity level D, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardyFindings include Mechanical soft diet: texture-modified diet designed for people who have difficulty chewing or swallowing, such as those with dysphagia (difficulty swallowing) or missing teeth. Mechanical soft diet allows foods that are soft, moist, and easy to manipulate in the mouth. Foods are typically cut into small pieces no larger than 1/4 to 1/2 inch or blended to a soft consistency. Meats, vegetables and fruits can be chopped, minced, or ground. Foods should be moistened with gravies, sauces, milk, or cooking liquids to make them easier to swallow. Breads and cereal can be softened with milk, yogurt, or sauces to create a slurry-like consistency.Mildly thick liquids: are slightly thicker than water, designed to flow more slowly for safer swallowing, and often used for people with dysphagia. This reduces the risk of choking or aspiration for people with swallowing difficulties. Generally, one tablespoon of powdered thickener to four ounces of liquid stirred vigorously will create the desired consistency.R1's face sheet dated 4/9/26, identified diagnoses of stroke, dysphasia, and hemiplegia (complete paralysis on one side of body) and hemiparesis (weakness on one side of body) affecting left side of body.R1's hospital After Visit Summary dated 2/23/26, identified R1 admitted to the hospital due to stroke. R1 was discharged to facility with a diet of mildly thick liquids and mechanical soft food. Safety precautions included raised head of bed, awake/alert, slow rate, small bites/sips, and frequent oral care. Medication was recommended whole with puree. Speech language pathologist (SLP) to continue to follow for cognitive-communication and dysphagia management.During an interview on 4/8/26 at 10:59 a.m., RN-B stated prior to a resident admitting to the facility, the nurse would receive a phone call from the nurse at the hospital that informed the facility staff which diet the resident required. The facility admission packet included a form the admitting nurse would fill out (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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	else. DM-A's dietary computer system identified R1 had mechanically soft textured food and nectar thickened liquids. DM-A stated she updated the order on 4/8/26, the day after R1 had returned from a hospital stay. DM-A was unsure why R1's diet ticket stated pureed and ground texture. DM-A reviewed the information in the computer, printed a diet ticket, and the ticket printed pureed. It is saying mechanical soft so why it is printing pureed anything is beyond me. DM-A stated she was going to remove R1 from the system, add him again, print off the ticket, and review the diet ticket with CK-A. DM-A reviewed the diet ticket from 3/26/26, and stated R1 had ground Philly steak with a pureed hot dog bun. DM-A stated she did not have access to the facility electronic health record and relied on nursing staff to bring a handwritten diet communication form to her when a resident admitted or had a diet change. DM-A was currently training a dietary aide on the computer system to add residents and diet orders so that she was not the only one doing it.During an interview on 4/9/26 at 12:41 p.m., NA-E stated if she questioned a resident's prescribed diet order, she would look it up on the Kardex. NA-E reviewed R1's Kardex. NA-E stated R1's Kardex identified to provide supervision, small bites, used a small spoon, R1 pocketed food, and to report to nurse if something changed. NA-E stated she assumed R1's meal ticket should say small, easy to chew bites. After the meal, R1 should rinse his mouth or brush his teeth. He's not thickened liquids so not worried but if he was I would look to make sure he doesn't have thin liquids. NA-E reviewed and verified R1's Kardex did not identify he was on thickened liquids which was inconsistent with the diet order dated 4/1/26.During an interview on 4/9/26 at 12:46 p.m., trained medication aide (TMA)-A stated if she was unsure of a resident's diet she would ask staff that were more familiar with the resident and verify the diet with the dietary meal ticket. TMA-A would notify the nurse manager if the Kardex and dietary ticket did not match. TMA-A stated if a resident had a change to the care plan, staff would be notified on a paper sheet that NAs would typically sign to verify they were updated.During an observation on 4/9/26 at 12:55 p.m., NA-E asked RN-B which residents were on thickened liquids. NA-E stated only R1 was on thickened liquids but then corrected himself and stated that R1 and R6 were the only two residents on thickened liquids.During an interview on 4/9/26 at 12:56 p.m., RN-B stated the meal trays come with a ticket and each resident has one printed. The ticket identified what the resident requested to eat and their diet type. RN-B told NA-E who had thickened liquids because she was temporary agency staff and not facility staff, RN-B reported she did not know the residents very well.R6's face sheet dated 4/10/26, identified diagnoses of unspecified dementia, and dysphagia of the oral (voluntary control of chewing, bolus formation, and moving food to back of mouth) and oropharyngeal (difficulty swallowing) phases.R6's comprehensive MDS dated [DATE], identified R6 had moderate cognitive impairment. R6 required setup or clean-up assistance with eating. R6 had a mechanically altered diet and no natural teeth.R6's care plan dated 10/21/25, identified risk of inadequate oral intake due to hospice status. R6 would not exhibit chewing or swallowing problems with current diet texture as evidenced by no signs or symptoms of aspiration, choking, or complaints of difficulty eating. Interventions included on 1/8/26, pureed diet and nectar thick daughter request (speech order).R6's physician order dated 2/27/26, identified regular diet, pureed texture and nectar thick liquids.R6's Visual/Bedside Kardex Report (abbreviated care plan) dated 4/10/26, identified a section titled Eating/Meals that included: provide diet as ordered. 1/8/26, pureed diet and NECTAR thick daughter request (speech order).During an observation and interview on 4/9/26 at 1:06 p.m., R1 and R6 were in the dining room, sitting at their respective tables, waiting for lunch to be served. R6's diet slip directed staff to serve nectar thick liquids and pureed food. R6 was drinking a white, thin liquid substance from a coffee cup. At 1:09 p.m., R6 began repeatedly coughing and spitting the liquid out. Surveyor intervened reported the concern to TMA-A who went to R6, looked in the cup and stated she would have to review the Kardex and diet ticket to know what consistency liquids R6 required. RN-B also went to R6's table and looked in her coffee cup. RN-B stated R6 had regular, thin consistency hot milk in her coffee cup. RN-B removed R6's coffee cup and took it to the kitchenette to thicken it. R6 continued to cough and have a runny nose. R6 was coughing up thick, white phlegm onto her shirt and napkin. At 1:14 p.m., (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN-B returned R6's thickened milk to her, did not perform a respiratory assessment and walked away. NA-E and TMA-A handed out trays to residents at their tables while R6 continued to cough. At 1:17 p.m., TMA-A delivered R1's food to him in the dining room. R1's tray ticket identified ground chicken and pureed everything else. All the words were crossed off and handwritten all mechanical soft according to orders. R1's plate had pureed consistency food. Surveyor intervened -reported the concern to TMA-A who stated R1's liquid was more of a honey consistency than nectar consistency, and R1 had the wrong diet consistency on his plate. TMA-A questioned if the handwritten order on the diet slip was the most up to date. TMA-A questioned RN-B on which consistency of food R1 should have. RN-B reviewed R1's chart and confirmed R1 should have nectar thick liquid and mechanical soft diet. RN-B stated R1 does aspirate pretty easily so the pureed diet was not a bad thing but not what was ordered. At 1:21 p.m., RN-B called the kitchen to verify the pureed food was what R1 was supposed to have. Dietary aide (DA)-B verified R1 received the wrong meal and liquids and walked away without providing R1's correct diet type. At 1:27 p.m., R1 continued to eat the pureed with a teaspoon and coughed after taking a bite. At 1:42 p.m., DA-A came to the dining room with a new plate of food. DA-A removed the lid on the tray and the food was the same pureed food consistency that R1 was already eating. DA-A stated dietary manager (DM)-A gave her the meal. NA-E and RN-B verified the meal was still incorrect according to the ticket. At 1:46 p.m., DM-A came to the dining room and examined R1's meal and orange juice and stated it was the wrong consistency according to his diet and liquid orders. DM-A stated prepackaged nectar thick orange juice was in the refrigerator and staff must not have been aware.During an interview on 4/10/26 at 11:24 a.m., hospice case manager (HCM)-A stated hospice would want to know if there were concerns of R6 aspirating. HCM-A reviewed R6's chart and stated hospice had not been contacted about R6's aspirating/coughing incident with her liquids. This was news to us.During an interview on 4/9/26 at 1:24 p.m., registered nurse (RN)-C stated residents received their meals according to the meal ticket placed on their meal trays. Staff referred to the care plan to know the most up to date diet for residents. When residents received the incorrect diet type, staff would replace the meal then education was provided to nursing and kitchen staff. RN-C stated staff could downgrade a resident's diet but not upgrade a diet. Residents with aspiration risk ate where staff could supervise them or staff were to stay in residents' rooms for supervision with meals. When residents at risk for aspiration refused to get out of bed or go to dining room area to eat, staff would attempt to reapproach/redirect. RN-C stated residents with aspiration risk worked with speech therapy, and therapy communicated recommended interventions to staff verbally or with a paper communication log kept at the nursing station.During an interview on 4/9/26 at 5:16 p.m., the director of nursing (DON) stated all residents needed some supervision to eat related to age and body reflexes not as strong. A stroke placed a resident at high risk and needed supervision. Residents were encouraged to come out of their rooms to eat but ate with their head of bed up if they chose to eat in bed. The facility did not have enough manpower to sit in residents' rooms every meal when the residents chose not to come out to the dining area. Speech therapy communicated recommendations through one-to-one conversation and a document placed in a binder at the nursing station. Recommendations were communicated to the DON and nurse managers and care planned. The DON expected staff to follow diet orders and intervene immediately if given an incorrect diet.During a follow-up interview on 4/10/26 at 8:16 a.m., NM-A stated R1 ate in bed a lot. NM-A stated it would not be a good idea to have R1 eat in bed as he had a recent stroke and dysphagia. NM-A stated without direct supervision while eating and drinking staff would not know if R1 was following safe strategies with eating and drinking. NM-A stated the facility could not provide enough aides to supervise R1 when he ate in his room. NM-A stated the facility would complete Risk versus Benefits for residents that eat in their rooms but residents with dysphagia need to eat in the dining room.During an interview on 4/10/25 at 8:21 a.m., NA-D stated speech therapy recommendations were found under their kiosk with the care plan. NA-D stated resident meal tickets reflected what residents needed for meals. NA-D reviewed a report sheet and stated the report should (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	501 Eighth Avenue Southeast Rochester, MN 55904

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 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tell them what kind of assistance the residents needed with meals and who was at risk for choking but did not. LPN-D entered the interview and showed NA-D to look on the banner in the computer for any special instructions on diets and meals. LPN-D stated staff checked resident care plans and Kardex. LPN-D and NA-D reviewed R1's banner which identified R1 required nectar thickened liquids and dys mech (dysphagia mechanical) soft textures and did not include any other special instructions.During a follow-up interview on 4/10/26 at 11:22 a.m., the DON expected staff to attend to resident coughing or choking as soon as possible. The DON expected nursing assistants to stay with coughing or choking residents until a nurse was present. The nurse was to assess if the resident was coughing or choking to ensure their airway was clear and see if resident was able to clear airway on own, sit resident up if not already, and instruct resident to tuck their chin. If the resident did not clear airway on own, then nurses performed the [NAME] maneuver and progressed to CPR (cardiopulmonary resuscitation) and called 911 if needed. The nurse was to enter a progress note to communicate what occurred. Staff referred residents to speech therapy to determine if they required any diet changes and were to notify the provider. Nurses were able to downgrade resident diets if needed before further evaluated. The DON stated it was important to ensure residents received nutrition in the safest way possible.During an interview on 4/9/26 at 3:20 p.m., the medical director (MD) expected staff and residents to follow resident orders. The MD stated residents have the right to refuse orders and expected the facility to notify the provider group of refusals. The MD expected the facility to notify the provider if residents' family members did not follow provider orders. The MD expected the facility to follow their policies and procedures for speech therapy recommendations and stated the providers normally wrote an order for agreed upon speech therapy recommendations. The MD stated the level of risk for not following orders of a resident at risk for aspiration depended on the specific resident and orders.The facility policy Foreign Body Airway Obstruction Management (Choking) dated 2024, identified residents with impaired swallowing, neurological disorders or dental issues were at an increased risk for foreign body airway obstruction and timely intervention to relieve obstruction was imperative to offset complications. The policy directed the facility to determine which residents were at a higher risk for foreign body obstruction/choking episodes and care plan accordingly. Consult a speech language pathologist as needed. The facility was to ensure residents with impaired swallowing issues and were on an altered diet received the appropriate diet.The facility policy Therapeutic Diet Orders undated, identified the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. The policy identified dietary and nursing staff were responsible for providing diets in the appropriate form and/or the appropriate nutritive content as prescribed.The IJ that began on 3/26/26 was removed when it was determined and verified through observation, interview and document review the facility implemented the following on 4/11/26:Help ticket placed by dietary manager to resolve the issue of tray tracker inconsistencies with tray tickets.Audit completed of tray tickets to ensure the match dietary orders completed 4/10/26.Progress notes from the past 30 days reviewed to ensure no other choking incidents documented on 4/6/26.Residents that receive mechanically altered diets received education on importance of being out of bed and in dining room for meals.Audit completed by therapy department on all residents with recommended supervision.Care plans/Kardex updated to indicate supervision required.Education with clinical staff on mechanically altered diet policy, diet consistency, verifying correct diet accuracy prior to serving meals, supervision during meals, change of condition assessment on 4/10/26-4/13/26.Speech communication will include verification of what specific supervision is needed for those with altered diets and will be given verbally to nursing staff, written on Therapy Communication to Nursing form, and uploaded into residents medical record, care plan, and staff tasks to complete.Nurse will be present in dining room for meals to ensure appropriate diets are served and monitor residents for choking.Residents on mechanically altered diet will