STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525681	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Nazareth LLC	814 Jackson St. Stoughton, WI 53589

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure comprehensive care plans were revised in accordance with the resident's current status and care needs for 1 of 3 residents (R4) reviewed for care planning timing and revision.The facility did not update R4's care plan to prevent future occurrences after he had a resident to resident incident where he grabbed the wrist of another resident (R3).Evidenced by:Facility policy, titled Comprehensive Care Plans, dated 2023, includes: . It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The care planning process will include an assessment of the resident's strengths and needs. Trigger specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. Alternative interventions will be documented as needed.R3 admitted to the facility on [DATE] with the following diagnoses: Anxiety disorder and depression.R4 admitted to the facility on [DATE] with the following diagnoses: Unspecified dementia with psychotic disturbances, irritability and anger, cognitive communication deficit.R4's Comprehensive Care Plan, includes: Initiated 8/12/24, Focus-R4 has delusional thoughts at times. Goal- no harm to self or others due to delusional thoughts. Will be free of signs and symptoms of delirium. Interventions- Redirect and provide gentle reality orientation as required. Initiated 10/28/25, The resident has a mood problem related to admission. Goal- The resident will have improved mood state, happier, calmer appearance, no signs and symptoms of depression, anxiety, or sadness. Interventions- The resident needs time to talk. Encourage the resident to express feelings.Facility Self Report, dated 4/4/26, includes, in part: Investigative Summary- On Saturday, 4/4/26, an altercation transpired between R3 and R4. The event occurred at approximately 6:10 PM in the. dining room. According to staff, R3 was seated at the dining table with other residents awaiting their dinner meal when he began extending his middle finger in the air. At this time, R4 was walking around the dining room, and it appeared that this was perceived as a derogatory gesture towards him. In response, he grabbed R3's wrist, which was later understood to be an effort to get R3 to stop. Staff present immediately intervened and it was reported the entire event lasted 5 seconds. The two individuals were separated and R4 elected to return to his room. Nursing assessed both individuals and there was no evidence of injury. The evening continued with no further interactions between the two individuals. Staff remained present in the dining room and continued to monitor. CNA XXX witness statement- At dinner time around 5:40 PM R3 and R4 was in the dining room with the others. Residents were getting agitated as dinner has not arrived yet. R3 flicked off. as R4 was walking past and saw it. R4 went at R3 grabbing his wrist trying to punch him.On 5/27/26 at 10:30 AM, DON B (Director of Nursing) indicated staff are aware of R4's and R3's resident to resident interaction and staff make sure R4's proximity to others is not near. DON B indicated R4 is a higher risk for a resident to resident since he has already been involved in one incident with R3. DON B indicated the facility (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uses agency staff who may not be aware of R4's and R3's history and would not be able to identify that R4 is high risk of having a resident-to-resident incident. DON B indicated the facility should have updated R4's care plan with focus, goals, and interventions related to preventing another resident-to-resident interaction, but they focused too much on R3's care plan. DON B indicated the facility could include R4's triggers for aggressive behaviors include perceived insults and obscene gestures.On 5/27/26 at 12:06 PM, Surveyor observed R4 to be walking in the dining room approaching other residents. R4 handed another resident a packaged cinnamon roll but then took it back. R4 took an empty cup away from one resident and tossed it in the garbage. Surveyor also observed R4 to be standing and fixing the radio antenna in the dining room that was near R3 who was at this was raising his fist and shaking it in the air. Staff were present during the interaction, but had their backs turned away from R3 and R4.(It is important to note R4 is independent with ambulating and is entering into other residents' spaces. It is also important to note staff were not visualizing R4 at all times while in dining room amongst other residents, including R3.)On 5/27/26 at 3:23 PM, NHA A (Nursing Home Administrator) indicated the IDT (Interdisciplinary Team) reviewed R4's care plan and thought it was appropriate at the time. NHA A indicated R4 is at a higher risk for a resident-to-resident incident due to the fact that he has already been involved in one. NHA A indicated the facility uses agency staff who may not be aware R4 had a resident to resident in his history and would not be able to identify R4 as being at a higher risk for this. NHA A indicated there were no changes made to R4's care plan after the incident to prevent future occurrences and so unfamiliar staff are able to identify R4 is at a higher risk for resident-to-resident interactions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure professional standards were in place to describe the characteristics of food and drink. This has the potential to affect the 65 Residents of the facility.The facility is not following current standards of practice for nutrition by not following IDDSI (International Dysphagia Diet Standardisation Initiative).Evidenced by:Per the SOM Professional standards of quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature. Possible reference sources for standards of practice include: Current manuals or textbooks on nursing, social work, physical therapy, etc. Standards published by professional organizations such as the American Dietetic Association, American Medical Association, American Medical Directors Association, American Nurses Association, National Association of Activity Professionals, National Association of Social Work, etc. Current professional journal articles. Per the IDDSI website : The IDDSI Framework (the Standard) The IDDSI framework consists of a continuum of 8 levels (0 - 7), where drinks are measured from Levels 0 - 4, while foods are measured from Levels 3 - 7. The IDDSI Framework provides a common terminology to describe food textures and drink thickness. IDDSI Testing Methods are intended to confirm the flow or textural characteristics of a particular product at the time of testing. Testing should be done on foods and drinks under the intended serving conditions (especially temperature). The clinician has the responsibility to make recommendations for foods or drinks for a particular patient based on their comprehensive clinical assessment. (https://www.iddsi.org/standards/framework)Per the National foundation of Swallowing Disorders, IDDSI is the global framework designed to standardize the terminology and descriptors for texture-modified foods and thickened liquids for individuals with swallowing difficulties, known as dysphagia. I was created to improve safety, reduce confusion and ensure consistent care across healthcare settings worldwide.) On 5/27/26 at 1: 54 PM, Surveyor interviewed SLP F (Speech Language Pathologist) who stated we don't follow IDDSI. On 5/28/26 at 8:01 AM, Surveyor interviewed CD G (Clinical Dietician) who stated this facility doesn't use IDDSI at all. On 5/28/26 at 1:01 PM, Surveyor interviewed DM H (District Manager) who stated we go off whatever the client (the facility) has in place and what they want to do. IDDSI is used by a sister facility, but it is not used here. Surveyor asked if the standard of practice should be followed. DM H stated based off the situation of the last few weeks, yes. This would be more specific and help everyone in the process. On 5/28/26 at 1:08 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked about the facility not following IDDSI. NHA A stated I didn't know that it needed to be followed. I am not aware of CMS (Centers for Medicare and Medicaid Services) regulation saying that it has to be followed. Surveyor asked if the Standard of Practice should be followed. NHA A stated yes.Additional information was provided by NHA A on 5/28/26 which indicated the facility follows the 12th edition of simplified diet manual, However this resource is not the current edition. The 13th edition indicates revisions and additions to the twelfth edition of the simplified diet manual include: .Revision of the modified texture diets and addition of the International Dysphagia Diet Standardization Initiative . Cross Reference F689.

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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 interview and record review, the facility did not ensure that each resident received adequate supervision to prevent accidents for 2 of 3 residents (R2 and R1) reviewed.On 5/12/26, the facility substituted Brussels sprouts for carrots at the evening meal, without the approval of CD G (Clinical Dietician.) Brussels sprouts were served whole to resident R2 and R1, despite having mechanical soft diets.R2 had a choking episode and was sent to the emergency room (ER) for evaluation.R1 had a choking episode and was sent to the ER for evaluation. R1 expired at the hospital.The facility's failure to ensure appropriate meal substitution, prepare food to the proper consistency for ordered diet, and recognize that inappropriate consistency was served created a finding of immediate jeopardy that began on 5/12/26. NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the immediate jeopardy on 5/28/26 at 12:48 PM. The immediacy was removed and corrected on 5/13/26; the deficient practice is being cited as past noncompliance. Evidenced by:The facility's Menu Substitution policy, undated, states in part: .If therapeutic or mechanically altered diets are offered, appropriate substitutions will be approved by the Registered Dietician based on the therapeutic diet policies or the diet manual used by the community.The facility's Therapeutic Diet Orders policy, dated 5/26, states in part: The facility provides 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. Definitions: Mechanically Altered Diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Food must be soft, moist, and easily mashed with a fork. Maximum size: 1/2 inch pieces.5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.The International Dysphagia Diet Standardization Initiative (IDDSI) website's (https://www.iddsi.org/) IDDSI Framework and Detailed Level Definitions, dated July 2019, states, in part: 6 Soft and Bite-Sized Examples of Level 6 Soft and Bite Sized Food for Adults .Vegetables steamed or boiled with final cooked size no bigger than 1.5 cm (centimeters) by 1.5 cm. 5 Minced and Moist Examples of Level 5 Minced and Moist Food for Adults .Vegetables cooked, finely mashed or use a blender to finely chop it into a 4 mm (millimeter) lump size pieces.On 5/28/26 at 8:37 AM, Surveyor interviewed [NAME] I and asked about the evening meal on 5/12/26. [NAME] I stated we didn't have carrots. I put the Brussels sprouts in the steamer. I did puree some for those with pureed diet. For the mechanical soft, I served them whole. 1.) R2 was admitted to the facility on [DATE] and has diagnoses that include in part: vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain); and dysphagia (difficulty swallowing.)R2's Physician orders include: Regular Diet, mechanical soft texture, Regular (thin) consistency, no bread, soft fruits only for diet. Order date 5/15/25R2's care plan includes: R2 is at risk for malnutrition related to history of .dysphagia requiring mechanically altered textures. Diet: regular diet, mechanical soft, thin liquids. No bread, soft fruits only. R2's Progress notes include, in part:*5/12/26 5:32 PM CNA (Certified Nursing Assistant) observed resident choking in dining room and pushed resident to nursing station. Writer started the Heimlich maneuver and proceeded to give the resident the Heimlich and dialed 911, proceeded to give the Heimlich until EMS (Emergency Medical Services) arrived; resident sent out to ER via EMS.*5/12/26 7:43 PM Resident returned to facility via EMS transport, VSS (vital signs stable.) Chest x-ray negative. Resident was able to clear secretions on resident's own prior to arriving at hospital.R2's Emergency/Urgent Care note, dated 5/12/26 at 6:28 PM, states, in part: Chief Complaint patient presents with *Aspiration Pt (patient) arrives via EMS.Staff reported resident was choking. EMS state pt was blue when they arrived. Pt placed on 3 liters (oxygen) via nasal (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cannula. Pt was able to clear food secretions. XR (x-ray) chest.findings: .No pleural effusion (excess buildup of fluid in the space between the lungs and the chest wall) or pneumothorax (collapsed lung). Lungs are clear.R2's Speech Therapy Evaluation dated 5/13/26, states in part: Pt was on a mech (mechanical) soft diet prior to her choking incident, .R2's meal ticket, dated 5/12/26, evening meal, states in part: *Diet: Regular-mechanical soft*Dislikes: .SOFT FRUIT ONLY!!! MINCED AND MOIST FOODS ONLY*Scalloped potatoes and grd (ground) ham, soft topping*Parslied Carrots .On 5/28/26 at 12:59 PM, Surveyor interviewed CNA J and asked about R2's meal on 5/12/26. CNA J stated R2 had a bowl of whole Brussels sprouts. As soon as R2 started coughing, I felt something wasn't right. I ran R2 straight to the nurse station, since I wasn't 100% confident so I got her to someone who would do it right (the Heimlich.)On 5/27/26 at 3:29 PM, Surveyor interviewed LPN E and asked about the choking episode for R2. LPN E stated R2 was in the dining room and food was placed in front of R2. LPN E stated I stepped away to give a resident a medication. I was training a MT (Medication Technician) by the nurses' station. CNA J ran R2 down the hall to me saying R2 was choking. I started the Heimlich and asked the MT to call 911. The MT helped me to set R2 up in the chair. I was doing the Heimlich, R2 was sort of breathing a bit, then she started turning blue. We were on the phone with 911. I asked the CNA to get another nurse to help with paperwork. LPN C came up and started listening to lungs, then took over on the phone. R2 was breathing but it was distressed. The Heimlich wasn't doing much. R2 was spitting up; some of it was not discernible. CNA J said R2 hadn't been fed yet, but R2 picks up food from her tray, so she may have gotten one of the Brussels sprouts. Then another CNA came up from 1st floor and said that another resident was choking on the 1st floor. At that point R2 was breathing and LPN C was there, so I ran to the 1st floor. On 5/27/26 at 2:15 PM, Surveyor interviewed LPN C (Licensed Practical Nurse) and asked about the choking episode for R2. LPN C stated that a CNA came to the 1st floor from the 2nd floor and said that a resident was choking on the 2nd floor and the nurse needed assist. When I got to the 2nd floor, LPN E was on the phone with 911 and I went straight to the patient and asked LPN E about what assessments had been done. I did a complete assessment; oxygen level was in the 70s. R2 was wearing oxygen, I turned it up a little bit. R2 wasn't moving hardly any air due to how her lungs sounded. She was gasping for breath and anxious, so I started talking to her and encouraging her to cough. As R2 coughed, her oxygen level was going up and she started calming down as I talked with her. EMS arrived quickly; they applied oxygen, put R2 on the gurney and left with her. On 5/27/26 at 1:54 PM, Surveyor interviewed SLP F (Speech Language Pathologist) and asked about mechanical soft diets. SLP F stated It should have ground meat, things should be cut in small pieces. Vegetables should be able to mash. Surveyor asked if there is a difference between mechanical soft and minced and moist. SLP F stated that minced and moist, to my understanding, everything is chopped pretty fine and has a gravy or moisture to it. We don't follow IDDSI (International Dysphagia Diet Standardization Initiative). Mechanical soft means different things to different food services and to different speech therapists. Surveyor asked what level of IDDSI mechanical soft would be. SLP F stated between level 5 and 6. Surveyor asked if Brussels sprouts are an equivalent to carrots? SLP F stated no, though R2 did have mashed Brussels sprouts during one of our assessments and ate 100%. With a true mechanical soft diet, Brussels sprouts would not be offered. Dietary said that if they are quartered, they are ok. But I feel they are really hard to break down. Surveyor asked if Brussels sprouts are part of a mechanical soft/minced and moist diet. SLP F stated no, I would say not. Surveyor asked about R2. SLP F stated R2 was no longer on speech due to hospice, though I'd have preferred to continue with her treatment. R2 was on mechanical soft diet. Surveyor asked if Brussels sprouts would be safe on R2's diet. SLP F stated no. While mashed Brussels sprouts were served in a therapy session, I would not have chosen/recommended this for her meals. 2.) R1 was admitted to the facility on [DATE] and had diagnoses including: vascular dementia and dysphagia;R1's Physician Orders include in part: Heart healthy diet Mechanical soft texture, regular (thin) consistency. Resident to remain on a mechanical soft diet with Supervision for small bites and slower eating pace.Order date 2/24/26R1's Care plan (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	includes:*R1 has a swallowing problem r/t (related to) dysphagia, aspiration risk.diet mechanical soft minced/moistR1's Speech Therapy Discharge summary, dated [DATE], states in part: *What diet is recommended for the patient to swallow solids safely? = Minced and moist*Solids=Mechanical soft/ground texturesR1's meal ticket, dated 5/12/26 evening meal, states in part:*Diet: Heart healthy-mechanical soft*Ground pork steak Soft/chopped CarrotsR1's Progress Notes, dated 5/12/26 at 5:50 PM, state: Resident in dining room eating with staff present at table with staff member sitting at table supervising. Several other nursing staff present when client started coughing and sneezing. CNA immediately went to resident saw that resident was in distress and turning cyanotic, and started the Heimlich maneuver, resident coughed up food objects and started breathing on own, resident took to her room put her on 2 lt (liters) of O2 (oxygen) Resident still in distress ore (sic) objects coughed up nurse assessed resident still having complications.On 5/27/26 at 2:50 PM, Surveyor interviewed MT D (Medication Technician) who stated, I was in the dining room making coffee for another resident. A CNA called out saying R1 needed help. I asked R1 if she was ok and R1 put her hands to her throat (universal sign of choking.) I asked a CNA to help me raise R1 into a better sitting position and I started to do thrusts. A piece of food came out of R1's mouth. I told someone to get the nurse. Surveyor asked what came out of R1's mouth. MT D stated, It was a Brussels sprout; it appeared to be a whole Brussels sprout. Surveyor asked what happened next. MT D stated while the CNA went to get the nurse, I took R1 to her room. R1 said there was more in there. I did a couple more thrusts and more came out; it appeared to be meat, it was brown. I put R1 on oxygen, and then LPN E came. LPN E told us to come along and take R1 to the other nurse. On 5/27/26 at 3:29 PM, Surveyors interviewed LPN E who stated, a CNA came to the unit while I was working with LPN C and R2. The CNA said there was a resident choking on level 1. LPN C stayed with R2, and I went to R1. When I got there, the CNAs were doing the Heimlich. I started the Heimlich, R1 was blue when I arrived. With the Heimlich, R1 started to breathe, but it sounded like there was phlegm in her throat. I told the CNAs to get oxygen and get R1 upstairs by LPN C. R1 was breathing and talking at that point. LPN E stated, during the Heimlich a piece of Brussels sprout came out; when we got upstairs, more came out. EMS was there and taking R2. Someone asked if EMS could take both residents, but someone said they wanted us to call hospice.not sure if it was LPN C or EMS that wanted hospice called. R1 was breathing and talking, but the breathing was scary. On 5/27/26 at 2:15 PM, Surveyor interviewed LPN C and asked about R1. LPN C stated I was on the 2nd floor assisting with R2. Someone said that I had a resident choking on 1st floor. LPN E went to help R1 while I finished with R2. The CNAs and MT had done the Heimlich, then brought R1 up to the 2nd floor by me. R1 was breathing and talking but was still having respiratory noises and I knew that something was still in there. I gave R1 a thrust, and a Brussels sprout came out and rolled across the floor. It was a whole Brussels sprout. I took R1 back to the 1st floor. I checked R1's vital signs, she was talking to me. R1's oxygen level was low, I put oxygen on her; I think 3 Liters, she was still making a noise, like you could hear that there was something in there. I called the POA, I called hospice and was on hold. I called the on-call physician and got orders to send R1 out. R1's Emergency/Urgent Care hospital note, dated 5/12/26, states in part: Chief Complaint Patient presents with Aspiration. Aspirated and choked on brussels sprouts and chicken. Lab Interpretation: XR (x-ray) chest. Findings: .low lung volumes (decreased lung capacity) with multifocal interstitial and airspace opacities suggesting aspiration (accidentally breathing food or liquid into the airway and lungs) and atelectasis (partial or complete collapse of a lung or a specific section of the lung) and possible superimposed pulmonary edema (acute development of fluid in the lungs). Superimposed infection would be difficult to exclude.R1 passed away while at the hospital.R1's Hospital Notes Report, dated 5/12/26, states: .per coroner office, medical examiner will go to funeral home to sign death certificate due to death being documented by coroner office as accident. Clinical impressions: choking, initial encounter.cardiopulmonary arrest. Disposition: expired. On 5/27/26 at 1:54 PM, Surveyor interviewed SLP F regarding R1. SLP F stated R1 was on a mechanical soft diet. Surveyor asked if Brussels sprouts would be safe on R1's diet. SLP F stated no. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/28/26 at 8:01 AM, Surveyor interviewed CD G (Clinical Dietician) and asked about a mechanical soft diet. CD G stated it varies based on different sources, it is not necessarily approved by the Dysphagia Association as they use IDDSI. CD G stated it is ground meat, finely chopped meat. No fibrous vegetables. If Brussels sprouts are served, they would need to be tender. Gravy on meats. Everything is moist and soft. Surveyor asked about minced and moist. CD G stated that is IDDSI and is modified a bit different. Things need to be certain sizes, need to stay moist, pass a fork test. This facility doesn't use IDDSI at all. Surveyor asked if there is a difference between mechanical soft and minced/moist. CD G stated yes; there are different ways to distinguish. Mechanical soft is more of an umbrella that combines minced and moist and soft and bite size; the level 5 and 6 of IDDSI. Surveyor asked if Brussels sprouts are part of a mechanical soft/minced and moist diet. CD G stated it depends on the resource. Generally it is not recommended as it is more fibrous. It could be if it is cooked very soft and fork tender and cut small. You'd need to cut out the stem and remove the more fibrous parts. Surveyor asked about meal substitutions. CD G stated the kitchen will let me know if we need to substitute an item due to being out of stock. In this instance, I was not contacted in advance. Surveyor asked if Brussels sprouts are an equivalent substitute for carrots. CD G stated it wouldn't have been my preferred. I would've made sure to remind to cook very soft, remove the fibrous part and cut it into very small pieces. Surveyor asked if a resident on mechanical soft/minced and moist diet should receive whole Brussels sprouts. CD G stated no. On 5/28/26 at 9:26 AM, Surveyor interviewed DON B and asked if whole Brussels sprouts are part of a mechanical soft/minced and moist diet. DON B stated no. Surveyor asked if R2 and R1 were served whole Brussels sprouts. DON B stated yes, that is my understanding. DON B stated that following the choking incidents the facility confirmed that a meal substitution had been done without proper approval, food had been served without modification to the appropriate consistency, and staff had failed to recognize that inappropriate food items were served to residents. The failure to get approval for an appropriate meal substitution, prepare food to the appropriate consistency, and recognize that inappropriate food items were served created a hazard which led to serious harm for R1 and R2, which created a finding of immediate jeopardy. The facility removed the jeopardy on 5/13/26 when it completed the following:Same Day - Immediate Corrective ActionsRN assessments initiated for all residents on mechanically altered diets, including vitals and respiratory checks, completed within 3 hoursOutcome: no other residents affected, all assessments were within normal limits and residents at their baselineImmediate staff education drafted and initiated by 930pm on the following:Identifying mechanically altered diet items andEmergency response to chokingAll staff were educated PRIOR to the start of their next working shift100% compliance achievedWithin 24 HoursSelf˜report to DQA submitted.Thorough investigation initiated by Nursing and Regional Management, including staff interviews.Sentinel Event call held with Executive Leadership, including Director of Risk Management, CEO, Medical Director, etc.Following Days (Ongoing Corrective Actions)Daily tray audits by dietary management and DON to ensure diet texture compliance.Outcome: all trays were in compliance with altered diet requirements, continuation of audits still in place and show 100% complianceDaily rounding by nursing and dietary management to reinforce education and ensure supervision per care plans.Outcome: continuation of rounding still in place and show 100% knowledge of mechanically soft diet items and compliance with following care plansAll dietary staff reeducated on:Mechanically altered diet preparationMeal substitution processAll dietary staff were educated PRIOR to the start of their next working shift100% compliance achievedPolicies updated to strengthen therapeutic diet order language.Post˜Return of Resident from HospitalResident monitored with vitals and respiratory assessments every shift for 72 hours.Outcome: no adverse effects identified, all assessments were within normal limits and resident at her baselineSpeech Therapy evaluation ordered and completed before next meal.Care plan updated according to new Speech therapy recommendations