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N 000	Initial Comments On 08/20/2025, Surveyor conducted a complaint investigation and standard survey at River Falls CBRF II. Data collection continued thorugh 08/27/2025. The complaint was substantiated. Five deficiencies were identified. Three of 5 deficiencies were repeat deficiencies. See Statement of Deficiencies (SOD) HQFY12, dated 10/05/2023, SOD HQFY11, dated 03/27/2023, SOD DESV12, dated 12/17/2020, and DESV11, dated 11/14/2019. Census: 39	N 000		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment. Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress.	N 247		

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

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N 247	Continued From page 1 Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Dietary Aide (DA) B received dietary training including determining nutritional needs, menu planning, food preparation and food sanitation. DA B prepared and served a meal of corn dogs and french fries that did not follow Resident 1's mechanical soft diet orders, which resulted in a choking incident that led to death. Findings include: On 04/10/2025, the Department received a complaint regarding resident care. On 08/20/2025 at approximately 10:45 AM, Surveyor interviewed Administrator A requested to review DA B's record. Administrator A stated DA B was initially hired as a caregiver and later	N 247		

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transitioned to kitchen duties. Administrator A informed Surveyor DB A was working at the time of a suspected choking incident that resulted in death.

On 08/20/2025 at approximately 12:00 PM, Surveyor received DA B's employee file from Quality Assurance Manager (QAM) E. DA B had a hire date of 04/04/2024 and was terminated on 04/05/2025 for not following diet orders, per the "Employee Separation" form.

DA B had a position description for "Unlicensed Personnel/Caregiver" job duties, signed by DA B and Administrator A on 04/04/2024. The position description read in part, "Assist the resident with personal cares as identified in the resident care plan ...This job description is not intended to be all-inclusive. The employee will perform other reasonable related duties as assigned by the supervisor or other management." DA B's record did not contain evidence of task specific kitchen duties.

On 08/21/2025, Surveyor obtained the police report, dated 04/05/2025 through the Office of Caregiver Quality (OCQ). The police report documented an officer responded to the facility at approximately 5:05 PM, regarding an unconscious and not breathing [gender] resident at the facility. The officer observed the resident sitting at a table with his/her head down, and there was food, specifically mini corn dogs and fries, in his/her mouth and on the table. The report further states there appeared to be chewed up food in Resident 1's mouth and on the ground next to him/her after s/he was moved to the ground. The medical examiner arrived and confirmed the death, noting the time of death as 5:50 PM, and determined the likely cause of

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death was choking or a cardiac event while eating.

The police report further documented the officer requested DA B's training documentation from Administrator A. Administrator A informed the officer s/he could email the documents. The officer left temporarily, but decided to go back and review the records in person. The records did not contain documentation on training for special diets. When the officer asked Administrator A if there was documentation for training in the kitchen, Administrator A said no. Administrator A informed the officer documentation was started approximately one month ago, but it was after DA B started so DA B did not have documented training.

On 08/27/2025 at approximately 12:00 PM, Surveyor interviewed Cook D via phone. Cook D stated new staff are trained in the kitchen for 3 days by shadowing and serving. Cook D stated s/he reviews special diets with staff and shows them where the special diets are listed on the cupboards and the white board. Cook D stated the training could be better when the facility was short staffed, as some staff are pulled from the caregiving floor to help in the kitchen. Cook D confirmed DA B had been working in the kitchen for approximately 6 months and primarily worked evening and weekend shifts in the kitchen. Cook D informed Surveyor the facility did implement a kitchen checklist, but stated it was not detailed and had a box to check off titled, "Special Diets."

On 08/27/2025 at approximately 1:40 PM, Surveyor interviewed Administrator A regarding kitchen training documentation for DA B. Administrator A informed Surveyor they could not locate DA B's caregiving checklist that included a

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N 247	Continued From page 4 box for dietary training. Administrator A stated Cook D developed a kitchen checklist in February, but DA B had already been working and did not have a documented training checklist on file. Administrator A acknowledged the standard orientation checklist was not specific to kitchen duties and did not contain special diet instructions for preparation and serving expectations. Administrator A stated s/he would pass the recommendation on to enhance their training documentation to reflect more specific training instructions. Cross Reference N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 247		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record.	N 302		

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N 302	Continued From page 5 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 3 residents were screened for clinically apparent communicable disease, including tuberculosis within 90 days before or 7 days after admission. This is a repeat deficiency. See Statement of Deficiency (SOD) HQFY11, dated 03/27/2023, SOD HQFY12, dated 10/05/2023, and SOD DESV12, dated 12/17/2020. Findings include: On 08/20/2025, Surveyor requested a sample of resident records to review. Resident 2 had an admission date of 07/18/2025. Surveyor reviewed the communicable disease screen for Resident 2 with 26 questions. The communicable disease screen was signed by Registered Nurse (RN) C on 07/31/2025, 13 days after admission. On 08/20/2025 at approximately 2:00 PM, Quality Assurance Manager (QAM) E stated it appeared RN C opened the screen on the appropriate date, but did not sign the screening until a later date. QAM E informed Surveyor RN C was typically in the building on Mondays, which could have been the reason for the delayed date.	N 302		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative,	N 387		

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N 387	Continued From page 6 as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 3's legal representative was involved in developing the individual service plan (ISP) when Resident 3's ISP was not signed acknowledging their involvement in, understanding of, and agreement with the plan. Findings include: On 08/20/2025, Surveyor reviewed Resident 3's record, including the comprehensive ISP. Resident 3 had an admission date of 02/04/2025. The ISP was not signed. On 08/20/2025 at approximately 2:00 PM, Administrator A and Quality Assurance Manager (QAM) E informed Surveyor the ISP for Resident 3 was mailed to his/her legal guardian to review, but the signature page was never received back.	N 387		

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N 387	Continued From page 7 The provider did not have documented evidence the ISP was mailed to Resident 3's guardian, or when it was mailed.	N 387		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not follow Resident 1's individual service plan (ISP) as written. This is a repeat deficiency. See Statement of Deficiency (SOD) DESV11, dated 11/14/2019. Findings include: On 04/10/2025, the Department received a complaint regarding resident care. On 08/20/2025, at approximately 10:45 AM, Surveyor interviewed Administrator A about special diets and choking incidents. Administrator A acknowledged an incident with Resident 1 had occurred in April 2025, where Resident 1 was served a meal and was found unresponsive at the dining room table, and was pronounced deceased. Administrator A stated s/he had submitted a self-report to the Department. Surveyor reviewed the self-report submitted by Administrator A on 04/09/2025. The report read, in part: "On April 5th, 2025 [sic] at approximately 5 PM [Resident 1] was brought to the dining room	N 388		

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table where corn dogs were served for dinner. [Resident 1] has a minced and moist diet, and the dietary aid accidentally brought the wrong tray. Resident became unresponsive, possible heart attack, aspiration or choked, according to medical examiner. RCA (resident care assistant) called 911, staff did start chest compressions as adviced [sic] while on the phone. EMS arrived with local police as first responders and resident was pronounced dead at the scene." The report further stated, "Dietary staff member was separated from [facility name] for not following the chart. Staff meeting was held on 4/9/25 for additional education on following charts/reviewing diets. Placemats for special diets have been placed at residents seating chart."

Administrator A confirmed Dietary Aide (DA) B was not following the ISP at the time of the incident. Administrator A stated Resident 1 was on a "minced and moist" diet but was served corn dogs and French fries on the date of the incident.

Surveyor requested Resident 1's ISP and documentation related to Resident 1's diet. Administrator A provided Surveyor with a signed ISP, dated 09/24/2024 and an additional copy of Resident 1's ISP which was reported by Administrator A as "the most current copy."

Surveyor reviewed the most current copy of Resident 1's ISP, containing the following information:

-Eating/meals: Resident will be able to maintain independence with eating/meals. Resident will participate in meals. Resident's diet is minced and moist. Only water to drink. Remind resident to go to meals. Report changes in ability to eat or drink to management/RN. Resident eats all meals

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in dining room. Resident needs preparation of all meals. Staff to prepare and serve all meals for resident. Facility staff will encourage resident to eat and drink at all mealtimes. Facility staff will document resident's meal and fluid intake. Facility staff will offer/encourage resident to have snacks. Facility staff will document if resident has a snack."

On 08/20/2025, Surveyor requested the minced and moist diet order from Administrator A. Administrator A stated s/he could not locate a physical order but provided Surveyor a printout of the documentation on their electronic charting system related to communications with Resident 1's primary care provider (PCP). The document read, in part:

"3/04/2025 at 6:54:46 PM: Reviewed speech therapy report and recommendations for diet-water protocol IDDSI Level 5 moist and minced."

On 08/21/2025, Surveyor obtained the police report, dated 04/05/2025 through the Office of Caregiver Quality (OCQ). The police report documented an officer responded to the facility at approximately 5:05 PM, regarding an unconscious and not breathing [gender] resident at the facility. The officer observed the resident sitting at a table with his/her head down, and there was food, specifically mini corn dogs and fries, in his/her mouth and on the table. The report further states there appeared to be chewed up food in Resident 1's mouth and on the ground next to him/her after s/he was moved to the ground. The medical examiner arrived and confirmed the death, noting the time of death as 5:50 PM, and determined the likely cause of death was choking or a cardiac event while eating.

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N 388	Continued From page 10 The ISP documented Resident 1 was on a minced and moist diet. Resident 1's ISP was not followed, as written on 04/09/2025 when Resident 1 was pronounced deceased after receiving a meal that was not prepared in accordance with his/her dietary orders. Cross Reference N0247 DHS 83.22(1)-(4) Task Specific Training N0389 DHS 83.35(3)(d) Service Plans Updated Annually Or On Changes	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not update Resident 1's individual service plan (ISP) to identify him/her as a choking risk, or when Resident 1's diet changed to mechanical soft on 03/10/2025.	N 389		

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N 389	Continued From page 11 This is a repeat deficiency. See Statement of Deficiency (SOD) HQFY11, dated 03/27/2023, SOD DESV12, dated 12/17/2020, and SOD DESV11, dated 11/14/2019. Findings include: On 04/10/2025, the Department received a complaint regarding resident care. On 08/20/2025, at approximately 10:45 AM, Surveyor interviewed Administrator A about special diets and choking incidents. Administrator A acknowledged an incident with Resident 1 had occurred in April 2025, where Resident 1 was served a meal and was found unresponsive at the dining room table, and was pronounced deceased. Administrator A stated s/he had submitted a self-report to the Department. On 08/20/2025, Surveyor requested all diet orders for Resident 1 from Administrator A. On 08/20/2025 at approximately 11:45 AM, Administrator A stated s/he could not locate a physical order for the minced and moist diet but was able to provide a printout of the documentation on their electronic charting system related to communications with Resident 1's primary care provider (PCP). The document read, in part: "3/04/2025 at 6:54:46 PM: Reviewed speech therapy report and recommendations for diet-water protocol IDDSI Level 5 moist and minced." An additional order was provided by Administrator A which read, "Mech (mechanical) soft diet, O.K.	N 389		

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coffee with breakfast ..." The order was signed and dated on 03/10/2025.

On 08/20/2025 at approximately 11:50 AM, Surveyor reviewed Resident 1's ISP with Administrator A.

Administrator A provided Surveyor with a signed ISP, dated 09/24/2024 and an additional copy of Resident 1's ISP which was reported by Administrator A as "the most current copy."

The ISP read, in part, "Eating/meals: Resident will be able to maintain independence with eating/meals. Resident will participate in meals. Resident's diet is minced and moist. Only water to drink. Remind resident to go to meals. Report changes in ability to eat or drink to management/RN. Resident eats all meals in dining room. Resident needs preparation of all meals. Staff to prepare and serve all meals for resident. Facility staff will encourage resident to eat and drink at all mealtimes. Facility staff will document resident's meal and fluid intake. Facility staff will offer/encourage resident to have snacks. Facility staff will document if resident has a snack."

Administrator A confirmed Resident 1's ISP was not updated to reflect the diet order change from minced and moist to mechanical soft on 03/10/2025.

On 08/27/2025, at approximately 1:45 PM, Surveyor interviewed Administrator A and asked if Resident 1 had previous choking incidents. Administrator A reviewed charting and informed Surveyor Resident 1 had a previous choking related incident documented on 02/07/2025 when staff reported s/he was coughing while eating.

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N 389	Continued From page 13 Administrator A further stated Resident 1 had a speech therapy order at that time and the incident prompted the family to conduct a swallow study. Administrator A confirmed the ISP did not identify Resident 1 as a choking risk, with a history of choking on 02/07/2025. Cross Reference N0247 DHS 83.22(1)-(4) Task Specific Training N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan	N 389		