STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035260	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain Hills Post Acute	16300 East Keith McMahan Drive Fountain Hills, AZ 85268

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, hospital records, facility documentation, policies and procedures, the facility failed to ensure physician-ordered diets were followed and implemented for 2 of 10 sampled residents (#9 and #12). This deficient practice resulted in resident #9 choking and requiring hospitalization.Findings include:Regarding Resident #9-Resident #9 was admitted on [DATE], with a diagnosis of heart failure, chronic atrial fibrillation, hypertensive heart and chronic kidney disease, with heart failure and chronic kidney disease, and moderate vascular dementia with anxiety. The Order Summary Report revealed an active physician order dated December 23, 2024, which prescribed a regular diet, regular texture, thin liquids consistency, cut into bite-sized pieces/large protein portions. No food allergies/no isolation. Further review of the Order Summary Report revealed no active order for speech therapy evaluation or treatment. A nutrition care plan, which was initiated on December 30, 2024, revealed that the resident was at risk for malnutrition. Interventions indicated to provide and serve the diet as ordered and specified, a regular diet with large protein portions. However, the care plan did not reflect that the resident required his food to be cut up into bite-sized pieces per the physician's order. A SLP (Speech-Language Pathologist) Evaluation and Plan of Treatment note dated January 9, 2025, documented that treatment approaches may include speech/hearing therapy, evaluation of speech sound production, and language assessment. Per the note, the resident would benefit from skilled speech therapy services to enhance cognitive abilities and develop compensatory strategies for executive functions. A cognition care plan revised on January 11, 2026, revealed that the resident was at risk for impaired cognitive function or impaired thought processes related to diagnoses of dementia. Interventions indicated to communicate with family/caregivers regarding the resident's capabilities and needs. Review of a NP/PA (nurse practitioner/physician assistant) Progress Note dated March 26, 2026, documented a plan for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) evaluation and treatment. However, review of the resident's Order Summary Report revealed no orders for PT/OT/ST evaluation or treatment. A care plan revised on March 31, 2026, revealed that the client has an ADL (activities of daily living) self-care deficit performance related to congestive heart failure. The goal identified was for the resident to safely perform ADLs such as eating through the review date of April 2, 2026. Review of the nutritional quarterly evaluation dated March 31, 2026, indicated a regular diet order and specified cut into bite-sized pieces/large protein portions. Fluid consistency was marked as thin. The assessment identified the resident's dining ability as able to feeds self with a tray set-up. A quarterly MDS (minimum data set) assessment dated [DATE], revealed a brief interview for mental status (BIMS) score of 10, indicating the resident had moderate cognitive impairment with no indicators for mood or behaviors. Further review of the MDS revealed the resident had upper extremity impairment on both sides and required set-up or clean-up assistance with eating. The assessment indicated no identified concerns with swallowing. Per the MDS, the resident had no broken or loosely fitting full or partial dentures, mouth or facial pain, discomfort or difficulty when chewing. Although the MDS indicated no swallowing concerns, the resident had risk factors, including cognitive impairment and physical limitations. The Order Summary Report indicated orders dated April 8, 2026, for the (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 0684 Level of Harm - Actual harm Residents Affected - Few	following:- Change of condition for abnormal labs. The order directed to check the resident every shift for 3-days.- Sodium Chloride Solution 0.9%. The order prescribed 125 ml/hr (milliliters per hour) intravenously every shift for dehydration for 2 days x 2 liters. A Nursing note dated April 8, 2026, documented that lab results were reported to the NP and new orders for NS (normal saline) 125cc/hr x 2 liters and BMP (basic metabolic panel) in the morning. Per the note LFA (left femoral artery), PIV (Peripheral Intravenous) was placed, and IVF (intravenous fluids) was administered.A Nursing progress note dated April 11, 2026, documented that at approximately 10:03, the LPN (Licensed Practical Nurse/staff #60) was notified by a CNA (Certified Nursing Assistant) that the resident had possibly aspirated and that the floor nurse was in the room with the resident. Per the note, the resident was observed sitting up in bed with very labored, turbulent rhonchi respirations. The note indicated that the resident was suctioned, and O2 (oxygen) was applied with a non-rebreather. According to the note, the resident was able to open his eyes but was unable to respond or cough when instructed. Per the note, 911 was called. The resident's vitals were 151/92 with an oxygen saturation rate of 90-93% on non-rebreather and 36% when off the rebreather for suctioning, with a pulse of 105, and a respiration rate of 24. The note documented that EMS (emergency medical services) arrived and took residents to the hospital. Another Nursing progress note dated April 11, 2026, documented that when staff #4/LPN went to administer the resident's medication at approximately 9:58 a.m., the LPN found the resident with mooshy food like coming out of his mouth. Per the note, the resident appeared to be sleeping with his food tray in front of him. The note indicated that the LPN called out the resident's name with no response, and help was called. According to the note, food was manually removed from the resident's mouth, and the resident was suctioned. The note indicated that 911 was called. The resident's vitals were 151/92 with a respiration and oxygen saturation rate of 33%. A non-rebreather mask was applied with 25 liters of supplemental oxygen. The resident's oxygen saturation rate increased to 94%, and the resident was sent to the hospital. The Order Summary Report revealed an order dated April 11, 2026, which prescribed an immediate transfer to a higher level of care as required by the resident's urgent medical needs. Emergency Department hospital notes dated April 11, 2026, documented the resident's chief complaint as altered mental status and indicated that the resident was brought in by ambulance. Per the note, the resident was eating eggs with the nurse, the nurse stepped away and came back, and the resident was choking and unresponsive. The resident's Glasgow Coma Scale (GCS) score was 3, indicating deep coma or death. Physical exam revealed temperature 96 degrees Fahrenheit, heart rate 94 beats per minute, blood pressure 119/72, SpO2 (Peripheral Oxygen Saturation) rate of 100% with oxygen device-non-rebreather mask. Physical Exam further revealed GCS 7, indicating severe brain injury or a comatose state. Per the note, during the examination, the resident's eyes were closed; he gave a very weak, mumbled response when his name was called and withdrew in both upper extremities to painful stimulus. The note indicated that eggs were observed on the shirt. Additionally, the resident had shallow and labored respirations, diminished breath sounds at the bases. The note documented that the resident presented as DNR DNI (Do not Resuscitate, Do Not Intubate) status. Per the note, the physician had several follow-up conversations with the resident's daughter about rescinding the DNI, but the daughter decided to keep the DNR/DNI. Diagnosis was documented as aspiration into the airway, respiratory failure with hypoxia and hypercapnia. The note indicated the resident's disposition as deceased . An interview was conducted on April 21, 2026, at 12:44 p.m. with Certified Nursing Assistant (CNA/Staff#24). Staff #24 stated she has been a CNA for more than 20 years. Staff #24 stated she did not provide care to resident #9 on April 11, 2026, and that the resident was under the care of CNA (#6) and CNA (Staff #80). Staff #24 stated that the breakfast meal is served between 8:00 a.m. and 9:00 a.m. Staff #24 stated that when residents are served their meals in bed, they should be positioned at a 90-degree angle. Per the CNA, she checks in on all her assigned residents to ensure they are eating, encourages them to eat their food, ask if they want anything more to drink. Staff #24 said she ensured that the resident had the right food, pureed or not, by reviewing (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	their meal ticket. Staff #24 stated she would inform the nurse of any concerns with chewing their food or any other concerns because she has to chart if her resident ate their food. Staff #24 stated she was aware that resident #9 had choked on his food, but did not observe anything on the date the resident aspirated. An interview was conducted on April 21, 2026, at 1:07 p.m. with sister facility (LPN/staff #4). Staff #4 stated she just picked up a shift on April 11, 2026, for 8:30 a.m.-10:00 p.m. and was assigned to resident #9. Staff #4 stated resident #9 was not on oxygen that day, or had concerns with eating on his own. She stated that the resident was apparently able to eat by himself, he was upright in his bed, tray in front of him, and his food was gone. Staff #4 said she went to give the resident his morning medications at approximately 9:30 a.m. and noticed him in distress. Staff #4 stated that when she arrived at 8:30 a.m., resident #9's breakfast tray was not there, and breakfast came sometime after that. Staff #4 stated that the resident was upright in bed, with a room tray in front of him, and it appeared he had eaten all his food. Staff #4 stated he looked like he was asleep, food was around his chin, and a good amount of food was around his mouth. Staff #4 said the food around his mouth and chin looked like it had been chewed; mushy, but not like he had vomited. Staff #4 stated she called his name, with no response, and that it looked like he was sleeping. She stated she lifted the tray food cover and noticed all his food was gone; his eyes were closed, never opened, and he was grunting and moaning, he was breathing, not labored breathing, and it sounded like he was snoring. Staff #4 stated she went to the dining area right outside of the resident's room and called for his assigned CNA (Staff #6) to ask if this was the resident's baseline or normal. She stated CNA #6 confirmed that it was not how he usually was. Staff #4 stated she was not familiar with the resident and had not worked with him for approximately two years. Staff #4 stated she grabbed the crash cart from the dining room with the suctioning machine and asked CNA #6 to go get the charge nurse (Staff/#60). Staff #4 stated she began to suction the resident's mouth, stating that she was aware the resident was a Do Not Resuscitate (DNR), but needed to suction the food from his mouth. She stated she was able to take as much food as she could as she suctioned him. She stated that not too much food was in his throat and that the food was mostly located in his mouth. She stated that after suctioning, it appeared the resident was breathing a little better. She stated the charge nurse (Staff/#60) arrived to assist and had brought a plunger with her to see if anything else would come out of the resident's chest or throat. She stated Staff #60 called 911 when she entered the resident's room and began to suction and use the plunger apparatus she had brought with her. She stated no more food came out, and when EMS arrived, they continued to suction and could not dislodge any further remnants of food from the resident. She stated EMS placed the resident on oxygen and that his vitals still showed the resident was alive, but his eyes were still closed and not responsive. She stated the resident was transported to the hospital. Staff #4 stated she received a call from the hospital, notifying her that the resident had passed and they could not intubate due to the resident's DNR/DNI wishes. An Interview was conducted on April 21, 2026, at 1:30 pm with (CNA/Staff #6). Staff #6 stated she has been employed with the facility for approximately one year. She stated she was working on April 11, 2026, and was assigned to resident #9. She stated he appeared to be within baseline but had noticed a decline in the last month in terms of energy. The CNA did not indicate whether the decline had been reported to the nurse and stated she was taking back her statement because she is not in the medical field. She stated the resident required assistance to sit in an upright position and required tray set-up assistance. She stated she served him his breakfast that day and provided a tray set-up. She does not remember all the items for breakfast that day, but that he had oatmeal, cranberry juice, and a cut-in-half egg burrito. She stated that she does not know what his diet is, but stated that his meals did not need to be cut up. Per the CNA, she did not cut the burrito for him, and further stated he was not required to have his meal cut up. Staff #6 stated she became aware there was an issue with resident #9 because Staff #4 had asked her what his normal was, then went into the resident's room with the nurse and saw him aspirating. She stated there was food around and, in the resident's mouth, and it looked like the eggs from his burrito, and that the food on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the tray was gone, it looked like he had eaten all his food. She stated that staff #4 immediately started to suction the resident and told her it was to help with his aspiration and remove any food stuck in his mouth, and observed food particles come out from the suctioning. Staff #6 stated she went to go get (LPN/Staff #60). She stated that both nurses assisted the resident with suctioning and oxygen needs until EMS arrived. Staff #6 stated she could not recall what time she served the resident his breakfast, but it was around 8:00 a.m. and 9:00 a.m. She stated it was approximately 15-18 minutes between the time she served the resident his meal to the time staff #4 asked about the resident's condition. According to the CNA, she does not review the meal ticket or do anything else to the resident's breakfast. Per the CNA dietary knows the resident's dietary needs, and that the eggs were inside the burrito and the burrito was cut in half for his breakfast. She stated that any changes in a resident's condition, activities of daily living (ADLs), eating, or diet are communicated by the nurse, director of nursing (DON), or care plan. An interview was conducted on April 21, 2026, at 1:56 p.m. with (LPN/Staff #60). Staff #60 stated she has been the charge nurse since 2022. Staff #60 stated she knew resident #9 from being familiar with all the residents' care. She stated resident #9 required quite a bit of assistance recently. Per the LPN, the resident used to get up out of bed on his own, but has had a slow decline since his admission. She was aware of his recent diagnoses, but was unfamiliar with specific recent lab results. She stated his decline did not affect his ability to eat and was able to feed himself with tray set-up assistance. She stated she did not recall any special diets or special instructions. Per the LPN, he would have cut up food, finger foods, and food cut up into small pieces. She stated this was what they did for him, but was not sure that it was recommended. She stated his diet would be in his orders or care plan or under special Instructions on his electronic health record homepage, and in reports from nursing staff regarding the resident's needs. Staff # 60 stated that CNA/staff #6 informed her that she thought resident #9 had aspirated, and LPN/Staff #4 was in the room with the resident. She went to the room and observed Staff #4 actively suctioning the resident. Per Staff #60, she observed some egg on his chest and started oxygenating him. The resident had turbulent breathing with accessory muscles, he would open his eyes to look at her, but could not cough or clear his throat. Per the nurse, this indicated he had aspirated or was choking, but believed it was a partial blockage because he was moving air in and out. Staff suctioned and put him on a non-rebreather, then 911 was called within 2 to 3 minutes. She made the 911 call for possible aspiration. She stated EMS took about 5-10 minutes for them to arrive on scene. She stated both she and the other LPN/Staff#4 used the suction machine and a secondary device (LifeVac) to help remove items in the throat. She stated she had no formal training using the LifeVac Device and had previously used it one other time. She stated she used the device to aid in dislodging more eggs, but that suctioning took most of the egg out. She stated she only noticed egg and mucous secretions coming out. She stated that resident #9 needed his food to be cut up, but that he was eating scrambled eggs. She stated the menu said egg burrito, but either it was cut up or the burrito was taken off because she only saw eggs coming out of the resident's mouth.An interview was conducted on April 21, 2026, at 2:39 p.m. with the Dietary Manager (Staff #34). Staff #34 stated he has been in his role since 2022. Staff #34 stated the process for dietary orders, that he receives dietary notes in the electronic record from nursing, and nursing will provide a slip about a resident's change in nutrition. He stated he is responsible for updating the information, and the new meal ticket will automatically print. Staff #34 stated he was unable to retrieve previous diet slips once a resident was discharged from the facility. Staff #34 stated that any modifications to a resident's diet is relayed to him from nursing, and he will make the changes to the ticket in the system. Staff #34 stated that dietary is responsible for cutting food for the residents, not CNAs. He stated there is a three-part system to ensure the diet order is followed, with the cook who would have the first look, then the cook line member would check the meal for accuracy, then the CNA or nurse. Staff #34 stated finger foods do not need to be cut up, but that bite-sized pieces would also include burritos, and that a resident's food should go to the floor already cut up. The resident Manager stated that the risks of not (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	following the orders on the meal tickets are that the residents will not have what they need or the diet they are supposed to have.An interview was conducted on April 22, 2026, at 9:41 am with a family member of resident #9. Family member stated she has had numerous concerns regarding the facility's care of her father, primarily concerns regarding his food not being cut up. The family member stated that when she visited, she would find his meals were not cut up. The family member stated her father required his food to be cut up due to weakness with his upper body extremities and a decline in his motor skills. The family member stated she hires a companion who would report to her that her father's food was not cut up when served. The family member stated she had filed complaints with the facility and had spoken to Dietary Manager (Staff #34), Charge Nurse (Staff #60), (DON/#46 on multiple occasions regarding his food not being cut up. Review of the grievance logs for February through March 2026 revealed no formal grievances filed by the family member. The family member stated she also voiced her concerns to CNAs (#80) and (#6). The family member stated (Staff #34) informed her that the weekend staff would sometimes miss the order to have his food cut up. The family member further stated that the concern with not having her father's food cut up into bite-sized pieces was also addressed during care plan meetings. She stated that her father preferred to eat in the dining room, but weekends are always the worst, and his wishes were not met by taking him to the dining room as he preferred. The family member stated she was informed telephonically by Charge Nurse (Staff #60) that her father kept putting eggs in his mouth, forgot to swallow, and that the nurse tried to suction, but the food kept breaking apart and going further down his throat, so they sent him out to the emergency room. She stated that when she arrived at the hospital, her father's mouth was filled with tears and blood, most likely from the suctioning. The family member stated that his diet slip and care plan should have indicated that the food be cut up. The family member stated that during visits, she observed him in bed with his tray in front of figuring out how to feed himself. Per the family member, the resident should have been monitored due to his decline. She stated that he was care planned to encourage fluid intake. However, on numerous occasions, she observes his cups empty. She believed that if he had been in the dining room, the staff would have monitored him more closely and prevented this event. An interview was conducted on April 22, 2026, at 10:11 a.m. with Certified Nursing Assistant (CNA/Staff #80). Staff #80 stated he has been a CNA for about one year and has been with the facility for three years. He stated he worked on the weekends and worked on April 11, 2026, with (CNA/Staff #6). He stated breakfast meal trays usually arrive between 8:00 and 8:30 a.m., but sometimes they run a little late. He stated he passed meal trays and started with the 200 rooms, and helped with the 100 rooms that he was assigned to. He stated he was not assigned to resident #9 and did not serve him his tray that morning. He stated that resident #9 did not need aid in eating. Per the CNA, he has helped resident #9 before, and he was pretty good at eating up until the event. He stated he had no food restrictions and was on a regular food diet. He said that some CNAs would cut up the resident's food now and then. He stated that no one informed him of special instructions to cut up food into bite-sized pieces. He stated he only set up the resident's tray. He is aware of a resident diet orders from the meal tray ticket that annotated food intakes and water intakes for a resident. The meal tickets indicated mechanical food or puree for swallowing issues. However, resident #9 had no special instructions that he could recall. Staff #80 stated he has served resident #9 enough to know that his diet was regular and had no special instructions. If there were any changes to a resident's diet, information would be relayed by the speech therapist, dietary manager, and nurses. Staff #80 stated he was informed resident #9 had aspirated on eggs and that they had served egg burritos that day. He said that (CNA/Staff#6) was assigned to the resident. He denied altering resident #9's meal that day and was unaware that any changes needed to be made to his diet. He stated that the resident was found by the nurse, called over CNA#6 with the crash cart, and began suctioning. He stated it was just the nurse and the CNA until the charge nurse (staff #60) was notified. It took about a minute for the charge nurse to arrive and assist the other nurse, who also used a mask to suction the resident. Staff #80 stated he has received training on choking, (continued on next page)

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She was unaware of any special instructions for the resident's food to be cut into bite-sized pieces. She stated she has had CPR training. A follow-up interview was conducted on April 22, 2026, at 1:19 p.m. with (LPN/Staff#60). She verified that she had not received training on the LifeVac, has only used it twice, once on her child and once on resident #9. She stated that the LifeVac is located in the dining room for just-in-case scenarios, and any staff member can use it. If staff are not comfortable, they can use the Heimlich if there is a complete blockage. She stated that resident #9 did not have a complete blockage, was decompressing on oxygen saturation stats, and they would suction and hold the mask over his mouth. She confirmed having conversations with the resident's daughter regarding his food not being cut up. She does not recall if it was an order, but that family prefers his meals cut up. Per the LPN, it is a preference for the resident to have finger foods. She stated that if it were an order, the expectation is that it would be care planned and put under special instructions on his banner in the electronic health record. She stated dietary slips would be changed if orders changed and the changes are relayed to the dietary team. She stated the process for relaying diet order or changes, if it is an actual order, is put into special instructions, and the dietary manager is notified by whoever is making the care plan. Other team members, nurses, and CNAs would be made aware in the report and electronic health record under special instructions, and updated in the care plan. She failed to answer the question about risks for not following the physician's orders, in terms of the resident's food not being cut up into bite-sized pieces. She stated that staff always cut up resident #9's food because it was a preference, and the nurses always check to see if the food is cut up. She further stated she knew the resident, the daughter, and their special requests to have his food cut up. She stated that new staff are made aware of the residents' diets or any changes in diet through report, under special instructions in the electronic health record, and in the resident's care plan. She stated this information should not be missed if the report is done correctly, and there is no reason for this to be missed. Staff #60 stated that if dietary missed the cut-up instructions, then staff would verify, and dietary would cut it up themselves, or the CNAs would cut up the food. She further stated that dietary did not always cut up his meals, so nursing would have to. An interview was conducted on April 22, 2026, at 1:30 p.m. with a senior menu specialist. The specialist stated that the facility utilized the Menu Wizard Program to build menus, tray cart and tray ticket program, budget management tool, shopping lists, menu templates built on customer needs, facility needs based on policy menus, and special dietary menus. The specialist stated the facility uses the tray card for resident information and diet information, and uses electronic records that interface with Menu Wizard for resident management data. Per the specialist, the facility is responsible for entries on orders on the electronic health record, and Menu Wizard data communicates with the electronic health record. The specialist stated that the interface with the electronic health record only pulls over certain critical items, not everything. The program has a list that automatically pulls over from the electronic health record to Menu Wizard. Anything like a preference such as cutting up into small pieces, any additional notes, has to be added in the notes section of the electronic health record to cross over to Menu Wizard and the dietary department is responsible for putting those specialized notes (like cut-up foods) within the notes section in electronic health record and that information like resident name, date of birth , room number, basic information and order for their food goes on automatically. The specialist stated that (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 0684 Level of Harm - Actual harm Residents Affected - Few	any special needs, like cutting foods and adaptive equipment to be used by residents, would have to be added manually by the dietary team for it to cross over into Menu Wizard. The specialist stated she was contacted by the dietary manager for help on April 22, 2026, regarding inputting data and using the system that he was unfamiliar with. The specialist was able to review the previous tray card for resident #9. She stated from her records the resident had a diet order for Regular, Regular, Thin Liquid, under Notes; cut into bite-sized pieces and large protein portions. She further stated from her review that this was the only diet order history for the resident from December 23, 2024, at 2:39 p.m. The info remained the same instructions since that date, and the system will automatically state when the note was updated or put in its original. The specialist noted that the tray card she indicated for the resident's food is to be cut into bite-sized pieces. An interview was conducted on April 22, 2026, at 2:59 p.m. with the Director of Nursing (DON/Staff# 46). According to the DON, nurses are responsible for passing on any new information during the report, just like a medication change. The DON stated the family member for resident #9 was involved up until a year ago, and would have meetings with the Ombudsman and whole care plan team; the family member was concerned with the resident's dignity in front of visiting girlfriend and finger food was recommended by the family member, but it was not assessed during ST, OT, this was due to family member wanting the resident to not be embarrassed in front of his girlfriend. The DON stated resident #9 was assessed in April and showed no indication for a speech assessment. The DON stated no assessment was done by OT or ST for the resident's swallowing or eating, maybe just screened. This would not show on the electronic health record, as it was just a screen; this information would be within the records of the therapy team. The DON stated her expectations were that the Nurse and CNA would look at the resident's meal tickets, verify the resident and food matched the ticket, and then deliver the food. The DON stated that the family member asked for finger foods, so that meant the resident could just eat without utensils, cut into small pieces. The DON stated that it was a preference, not an actual physician order. The resident's diet order was reviewed with the DON. The DON stated that the portion of the order about cutting food into bite-sized pieces is not part of the the actual order but rather an additional information indicating the resident's preference. The order states Regular-Regular, Thin Liquid, but the additional information on the order regarding bite-sized pieces is just a preference. The DON stated that the order summary just summarizes the whole order and preferences, but when looking at the specific order for regular texture, regular thin liquids, it does not contain to cut food into bite-sized pieces, which is a preference. The DON reviewed the provider orders in the resident's electronic health record and verified that the only thing that gets transferred to the kitchen and meal ticket would be the actual order; anything under the additional information does not cross over, because it's a preference and not a part of the ordered diet. An interview was conducted on April 22, 2026, at 3:32 p.m. with Medical Doctor (MD/provider/staff #84). The provider stated he was familiar with resident #9, as he had some difficulty with chewing and needed his food cut up. He further stated he was no longer the resident's physician since the resident is now seen by a different group of doctors. A review of the current active diet order was conducted with the provider. The provider confirmed he had prescribed a diet order for regular food, thin liquids, cut into bite-sized pieces, and large protein portions for the resident. The provider stated that when he wrote the order to cut into bite-sized pieces, the expectation was to follow that order and that the whole order is followed by staff; cut into bite-sized pieces, large protein portions are part of the whole order, and that is to be followed. The provider further stated the order is read as written, and it includes the whole order, including being cut into bite-sized pieces, not just the texture and consistency. Regarding Resident # 12 -Resident #12 was admitted on [DATE], and re-admitted on De[TRUN