STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056222	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to ensure federal regulations related to the education qualification requirements of the dietarymanager were followed as outlined in the California Code, Health and Safety Code (HSC1265.4). This failure had the potential to result in inadequate oversight of the food and nutrition services department associated with meal distribution accuracy, safe food handling and sanitation guidelines.Cross references to F812 examples #1, #2, #3 and #4 . Findings:On 03/02/2026 at 11:07 PM, an interview was conducted with the Dietary Manager (DM). The DM stated he was responsible for managing the kitchen. DM stated that the Certified Dietary Manager credential expired 8/31/22. On 03/03/2026 at 12:50 PM, an interview was conducted with Registered Dietitian Nutritionist (RDN). The RDN stated that her responsibilities included nutrition assessments, nutrition interventions, monitoring of weights, participation in weight committee meeting, monitoring of pressure injuries, and monthly kitchen audits and tray line observations. The RDN stated that she spends 4-6 hours a week overseeing the kitchen. The RDN acknowledged that the DM's Certified Dietary Manager credentials had expired. A review of the Dietary Manager job description dated 9/5/23 and signed by the DM, stated that the education requirement of the position is Certified Dietary Manager. During the recertification survey from 3/2/26 to 3/5/26, multiple issues were found in the kitchen, including floors and equipment that were not cleaned and dried properly. According to the California Code, Health, and Safety Code - HSC S 1265.4, a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations.According to the California Code, Health, and Safety Code - HSC 1265.4, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. Review of the facility's documents for qualifications of the DM failed to show evidence that he met the qualifications under the California Code, Health and Safety Code - HSC S 1265.4.

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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(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 - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview and facility document review, the facility failed to ensure the menus were followed when:1.The regular zucchini recipe was not followed.2.The puree zucchini recipe was not followed.3.The BBQ chicken recipe for regular diets was not followed.4.The puree BBQ chicken recipe was not followed.These failures had the potential to not meet the residents' nutritional needs for the 8 (Residents 8, 9, 35, 128, 22, 72, 91, 119) of 124 residents who received a pureed diet and 82 of 124 who received a regular diet. Findings:1. On 3/3/26 at 10:30 AM, a concurrent kitchen observation and interview was conducted during preparation of lunch meal with [NAME] 1 (CK 1). Steamed zucchini was in a hotel pan on the counter. It appeared without seasoning. CK 1 stated he does not add seasoning. CK 1 stated he did not refer to a recipe during the cooking process.A review of the facility policy titled, Cooking Food, revised April 2019, showed that Recipes will be followed for the menu items.A review of the facility document titled, Roasted Zucchini Method, dated 2002-2025, showed that 100 servings, in a large mixing bowl, toss the vegetables with the oil (canola oil 1 1/2 cups) and seasoning (granul garlic, sliced 37 1/2 each, Italian seasoning 2 tbs (tablespoons) plus 1/4 tsp (teaspoons), salt 2 Tbs plus 1/4 tsp, black pepper 1 Tbs plus 1/8 tsp.During an interview with Registered Dietitian Nutritionist (RDN) on 3/3/26 at 12:50 PM, RDN confirmed recipes should be followed.2.On 3/3/26 at 10:35 AM, a concurrent kitchen observation and interview during the pureed preparation was conducted with CK 1. CK 1 stated he was preparing pureed (a smooth, thick paste made by crushing or blending cooked or raw food) zucchini. Using a spoon, CK 1 measured 2 large scoops of cooked zucchini into a blender and added a cup of water. CK 1 was unable to state the measurement of the scoops of zucchini. CK 1 blended the zucchini in the blender. CK 1 added 1/2 cup of food thickener (a substance added to a liquid or semi- liquid food to increase its thickness or viscosity without significantly changing its flavor), blended and added another 1/4 cup of thickener. CK 1 poured zucchini out of the blender into a hotel pan (a metal container for use on a steam table to keep food warm in commercial kitchens), and placed in a hot box for holding until lunch tray line. CK 1 did not refer to a recipe during the pureed process. CK 1 stated that he does not measure and instead relies on sight.A review of the facility policy titled, Cooking Food, revised April 2019, showed Recipes will be followed for the menu items.A review of the facility document titled, Roasted Zucchini Method, dated 2002-2025, showed that pureed: remove portions needed from regular recipe; drain. Place portions needed into a food processor (electric kitchen appliance used to chop, slice, grind, mix or puree food quickly). Process until fine. For every 5 portions needed, add 1/4 cup thickener. Process until smooth. Scrape down sides of processor bowl.During an interview with RDN on 3/3/26 at 12:50 PM, RDN confirmed recipes should be followed.3. On 3/3/26 at 10:45 AM, a concurrent kitchen observation and interview was conducted during preparation of the lunch meal with CK 1. Boneless chicken was cooked and cooled on a sheet pan with barbeque seasoning sprinkled on top. CK 1 put 12 pieces of chicken in a blender and add one cup water and blended. CK 1 added 1/2 cup thickener and blended. [NAME] 1 did not refer to a recipe during the puree process.On 03/03/2026 11:50 AM, during lunch tray line observation, it was observed that the puree meal was runny. The puree BBQ chicken, puree roasted zucchini and puree cheese biscuit were running together on the plate. The puree BBQ chicken had a scoop of BBQ sauce on top.A review of the facility policy titled, Cooking Food, revised April 2019, showed Recipes will be followed for the menu items.A review of the facility document titled, BBQ Chicken Method, dated 2002-2025, showed Pureed: Place deboned cooked meat (2 oz - ounces, each) into a food processor. Progress to a fine texture. For every 5 portions needed, prepare a slurry with 1/4 cup thickener and 1 cup of hot liquid; mix well with a wire whip. Add 1/2 of the slurry to the meat; process for one minute. If too dry, add more slurry (a mixture of starch and a cold liquid, usually water to thicken foods) until meat is pudding consistency (thickness, texture, or firmness of a substance, especially food or liquid). With a rubber spatula, scrape down sides of the (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bowl; reprocess 30 seconds.A review of the facility document titled, Therapeutic (used in medical treatment for special diets) Spreadsheet (a document used to organize data in rows and columns) Week 2 Tuesday, undated showed for BBQ chicken under puree diet, P #8 scoop size for portion. It did not include a scoop of BBQ sauce on top.During an interview with RDN on 3/3/26 at 12:50 PM, RDN confirmed recipes should be followed.4. On 3/3/26 at 11:00 AM, a concurrent kitchen observation and interview was conducted during preparation of the lunch meal with CK 1. CK 1 pulled a pan of cooked plain deboned chicken out of the oven. [NAME] 1 poured BBQ sauce on top of the chicken and placed in the hot box to keep warm for service. When asked why he waited until the end to add the BBQ sauce instead of 1/2 hour before the end of cooking time, CK 1 stated he didn't know.A review of the facility policy titled, Cooking Food, revised April 2019, showed Recipes will be followed for the menu items.A review of the facility document titled BBQ Chicken Method, dated 2002-2025 showed;Preheat oven to 325 degrees F (Fahrenheit, a unit of temperature measurement)Place chicken in steamtable pans.Cover and bake chicken for 1 hour.Pour BBQ sauce over chicken. Continue baking for an additional 1/2 hour.Serve 1 piece of chicken per portion (2 oz edible meat).During an interview with RDN on 3/3/26 at 12:50 PM, RDN confirmed recipes should be followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food safety and sanitation requirements were followed when:1. The kitchen environment was not cleaned adequately around stoves, ranges, and some refrigerators.2. Kitchen utensils and equipment were stored wet.3. Plastic cutting boards were found to be excessively scored & cut.4. Dry storage floors were found to be dirty. These failures posed the risk of foodborne illnesses in a highly susceptible resident population of 124 facility residents who received food prepared in the kitchen. Findings:1.During an observation of the kitchen on 3/2/26 at 11:07 am, grease and grime were observed on multiple surfaces of the main cooking area. Dark brown grease, food particles, and grime were observed on the sides and doors of stoves, on top of the cooking range, and on sidewalls and surfaces of hot oil fryer. During an interview with Dietary Manager (DM) on 3/4/26 at 10:03 am, DM stated, I clean the [oil] fryer every Friday. The cooks are supposed to clean the stoves, ovens, and ranges.On 3/4/26 at 11:50 am, a concurrent kitchen observation and interview was conducted with DM. At dietary aide food preparation station, exterior fridge walls were seen to be visible coated in grease and dust, along upper sidewalls, directly above the food preparation surface. DM acknowledged this and stated, Yes, that's dirty.A review of facility policy titled, Refrigerators and Freezers, dated 4/2018, showed that Refrigerators shelves, ceilings, and walls should be washed with warm water and a detergent. This policy also showed that Refrigerators and freezers should be cleaned per cleaning schedule.According to the USDA Food Code 2022, Section 4-601.11, Non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirty, food residue, and other debris.2. On 3/2/26 at 2:55 pm, a concurrent kitchen observation and interview was conducted with Dietary Aide B (DA B). Two of two stainless steel blenders were found to be stored wet at the main food preparation area. Two of 10 metal food scoops were found to be stored wet inside a metal drawer at the main food preparation area. DA B acknowledged that the blenders and scoopers were being stored wet, and stated, Those should not be stored wet.On 3/2/26 at 2:55 pm, a concurrent kitchen observation and interview was conducted with DM. Two of five clean plastic food storage tubs were found to be stored wet on clean shelving, with visible water drops on them. DM acknowledged, Yes, those should not be stored wet. Should be dry. A review of facility policy titled, General Dish Room Sanitation, dated 3/27/20, showed that All items are to be air-dried. No moisture can be found on any items.According to the USDA Food Code 2022, Section 4-901.11 Equipment and Utensils items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.3.On 3/2/26 at 2:55 pm, a concurrent kitchen observation and interview was conducted with DM. Two of four plastic cutting boards were found to be deeply cut and scored (deep slices on the surface), creating potentially un-cleanable and compromised surfaces of food preparation equipment. DM stated that those excessively scored cutting boards should not be used, and should be replaced.According to the USDA Food Code 2022, Section 4-501.12, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.4.During an observation of the kitchen on 3/2/26 at 11:07 am, the floors of the dry storage pantry were found to be soiled with dark grime, especially around the edges of the room, with food particles and dust visible on the floor. On 3/4/26 at 11:50 am, a concurrent kitchen observation and interview was conducted with DM. In the dry storage pantry room, the floors of the dry storage pantry were found to be soiled with dark grime, especially around the edges of the room, with food particles and dust visible on the floor. DM acknowledged the dirty floors, and stated, Yes that's dirty along the edges of the floor. It could use some scrubbing. This floor should be swept nightly, and mopped.A (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	review of facility policy titled, Storeroom, dated 4/2018, showed that in the dry storage pantry room, kitchen staff should sweep and mop storeroom every day.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate discharges for two of five sampled residents when the facility transferred (when a resident goes to the hospital for an evaluation and is expected to return to the facility), the residents the hospital then refused to allow them to return to the facility and discharged (formal and final release of the resident without intention of them returning) them. Resident 3 and 137's medical records contained no documented reasons by their physicians for not allowing them to return to the facility, the residents were not prepared or notified in advance that they were being discharged from the facility, and the residents and their family members (FM) were not provided with a notice that they had the right to appeal the facility's decision to discharge them.This failure had the potential to cause unnecessary prolonged hospitalizations with increased health care issues and compounded mental health, emotional distress and psychosocial decline.During a review of the facility's policy titled, [Facility Name] Facility Assessment, dated 12/3/25, the Facility Assessment indicated that the facility has the capability of managing residents with psychiatric/mood disorders including impaired cognition, mental disorder. (and) behavior that needs intervention.(and) Medication Administration including intravenous (peripheral or central lines).During a review of the facility's policy and procedure titled, Bed Hold Policy, undated, indicated, Facility admission Agreement contains the facility's policy and procedure for Bed Hold Notices.During a review of the facility's copy from the State of California - Health and Human Services Agency, California Department of Public Health (CDPH) document 327 titled, California Standard admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, CDPH 327 Attachment F, dated 12/2012, indicated, Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge.unless - (i) Necessary for the resident's welfare and the resident's needs cannot be met in the facility; (ii) Resident's health has improved sufficiently; (iii) Safety of individuals (residents) in the facility is endangered; (iv) Health of individuals (residents) in the facility is endangered; (v) Nonpayment to facility; and/or (vi) facility ceases to operate. When the facility transfers or discharges a resident under any of the circumstances specified.it must be documented in the resident's clinical record.Notice may be made as soon as practicable to the resident and/ or representative before transfer or discharge.the notice should include, the reason for discharge, the effective date of discharge.and a statement that the resident has the right to appeal the action to the state .Notice of bed-hold policy and readmission.the nursing facility must provide written information to the resident and a family member or legal representative that specifies.the duration of the bed-hold permitting the resident to return to the facility.During a concurrent interview and policy review on 3/2/26 at 11:30 am, with Administrator (ADMN), in the ADMN office, ADMN states there are no other facility policies regarding readmittance of residents after hospitalization, and the Discharge policies provided use the word transfer and discharge interchangeably. A review of Resident 3's medical record indicated that Resident 3 was admitted on [DATE] with diagnoses that included, Metabolic Encephalopathy (Brain dysfunction due to systemic illnesses that affect chemical and electrolyte imbalances), Acute Kidney Failure (loss of kidney function), and Adult Failure to thrive (rapid decline in health and functional abilities).A review of Resident 3's medical record indicated the most recent Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment of a resident's cognitive and physical capabilities and needs) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 1/20/26 indicated a score of 99 (not enough to score on a scale of 1-15) which equated to severe cognitive impairment. The MDS section D for Mood, indicated that no mood problems and Section E for Behavior, indicated that no behaviors were demonstrated. Patient 3 was not their own representative (RP), does not make their own medical decisions, but can verbalize (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	simple wants and needs.During a concurrent interview and medical record review on 3/2/26 at 10:00 am, with ADMN and Social Services Director (SSD) in the ADMN office, Resident 3's Notice of Proposed Transfer and Discharge form was reviewed. Both ADMN and SSD confirmed resident 3 was sent to the hospital on 2/12/26 for higher level of care needs of Intravenous Catheter (IV) placement and for beating up staff behaviors. On 2/13/26 there was a meeting with the Admissions Director (ADD) and the facility decided they would not be taking Resident 3 back from the hospital. The facility faxed the Notice of Proposed Transfer and discharge, that was prepared and signed by staff on 2/13/26, to the Ombudsman (independent, neutral official who investigates complaints and issues and advocates for fairness). Resident 3's family member (FM 1) was not notified of the proposed discharge. There was no documentation in Resident 3's medical record that Resident 3 had been displaying aggressive, harmful, or dangerous behaviors towards other residents. ADMN and SSD confirmed Resident 3 did not demonstrate that he was a danger to other residents. There was no documentation from Resident 3's physician regarding physical behaviors that endangered other residents, or that Resident 3's needs could not be met by the facility. There was no evidence that a discharge plan or preparation or notice of their right to appeal the facility's decision not to allow Resident 3 to return had been provided to Resident 3 and FM.During a concurrent interview and facility policy and documentation review on 3/2/26 at 11:30 am, with ADMN in the ADMN office, Facility policies on discharge were reviewed. ADMN provided discharge policies that interchangeably used the word transfer and discharge, and stated there were no other facility policies addressing readmittance to the facility after hospitalization. Additionally, there was no documentation by the physician specifying what needs the facility could not meet for Resident 3. According to the ADMIN, the facility discharged Resident 3's due to his combativeness toward staff while attempting to place an IV, and that the family was difficult.During a concurrent interview and record review on 3/3/26 at 9:00 am, with ADMN and ADD, in ADMN office, a text message from the facility to the hospital case management (those who plan discharges for patients in the hospital) was reviewed. ADD confirmed the facility's ADD department sent the text message on the work phone on 2/17/26 to the hospital case management and informed them the facility had decided to discharge Resident 3 while he was in the hospital and would not be allowing Resident 3 to come back to the facility for the following reasons:Behavioral issues that can't be handled by facility staffAggression towards staff creating a dangerous environmentDoes not comply with treatment recommendations/plansHis caregiver interferes with careThe facility could not administer Seroquel (an antipsychotic medication to correct mood and behavior problems), that was ordered while in the hospital, could not be given by the facility.ADD and ADMN confirmed one day after Resident 3 was transferred to the hospital the facility decided not to allow him to return and confirmed there was no supporting documentation in Resident 3's medical record to justify this decision. ADD and ADMIN confirmed there was no documented harmful behaviors or that Resident 3 was a danger to others.During an interview on 3/4/26 at 1:18 pm, with FM 1 on the telephone, FM 1 confirmed they were informed of the transfer to the hospital by the facility but was not informed Resident 3 was discharged and would not be readmitted to the facility following the hospitalization. FM 1 confirmed they were first notified by the hospital case management that Resident 3 had not been accepted back to the facility. FM 1 stated that Resident 3 never had behavior problems but at the time of the hospital transfer, had a bladder infection which contributed to his confusion mood changes.A review of Resident 137's medical record indicated that Resident 137 was admitted on [DATE] with diagnoses that included, Dementia with Behavioral Disturbance (progressive brain syndrome resulting in memory loss, confusion, and personality changes and presents with agitation, aggression, and psychosis), Conduct Disorder (behavioral/emotional disorder such as aggression, bullying, property destruction), and Alzheimer's Disease (progressive incurable neurodegenerative disease causing brain cell shrinkage and death resulting in memory loss, cognitive decline and behavioral changes).A review of Resident 137's MDS BIMS, dated 2/19/2026, indicated Resident 137 had Moderately impaired (cognition)-decisions poor; (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cues/supervision required. Section E Behaviors, reflected Resident 137 demonstrated physical and verbal symptoms such as hitting, scratching, threatening and cursing at others. Resident 137 was not their own RP, does not make their own medical decisions, but can verbalize wants and needs.During an interview on 3/5/26 at 11:14 am, with ADMN and ADD, in the ADMN office, both confirmed they informed the hospital case management that the facility would not accept Resident 137 back to the facility and that Resident 137 was considered discharged . The reasons provided by the ADMIN and ADD were; staff and other residents were endangered by his presence. ADMIN and ADD stated that Resident 137 was aggressive verbally and physically, and attacked staff with fists, a butter knife, and a fork. No residents were attacked nor threatened. ADMIN and ADD confirmed Resident 137's family member (FM 2) was not notified of the discharge, nor could they locate the Notice of proposed Transfer and Discharge form, nor was Resident 137 and FM 2 notified that they had the right to appeal the facility's decision to discharge Resident 137. There was no evidence that Resident 137 or FM 2 were prepared in advance or given notice that they were going to be discharged from the facility while in the hospital.During a phone interview on 3/5/26 at 1:28 pm, with FM 2, FM 2 stated they were never informed by the facility that they decided not to allow Resident 137 to return to the facility after his hospitalization. FM 2 stated she was not informed that they had the right to appeal the decision to be discharged .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food served was palatable, appetizing, or at an appealing temperature for eleven of 124 Residents' (Resident 7, 13, 53, 68, 82, 131, as well as five confidentially interviewed residents) whose meals were cold and or unappetizing.These failures had the potential for decreased meal intake which could result in weight loss, decreased nutritive value and negatively impact the residents' quality of life. (Cross references to F803)Findings During an interview on 3/2/28 at 1:54 pm, Resident 53 stated, Food is horrible. Once in a while it is ok.Once in a while they have a good food. I do not like the watered-down milk. I didn't know I could ask for something else. During an interview on 3/2/26 2:00 pm, Resident 82 stated, Food not good. Does not taste good. Chicken is tough, not good. During an interview on 3/3/26 at 7:40 am, Resident 131 stated [Breakfast] was warm when it arrived, but not hot. I don't like the egg whites, it was cold.Food is cold a lot.They serve a lot of pasta, which is cold often, and cold pasta is not appetizing. During an interview on 3/3/26 at 8:00 am, Resident 13 stated, Food is same thing over again and over again. Choices limited.I would eat if there was decent food. Meat dry, pasta not cooked. During an interview on 3/3/26 at 8:03 am, Resident 7 stated, The food is cold, mostly cold every meal, usually all of them. Now today the sausage is warm.That's the main complaint I have; is the food is always cold. During an interview on 3/3/26 at 8:05 am, Resident 68 stated, The food is not good. A lot of it is tough and bland, and tasteless. During an observation of a lunch test tray on 3/3/26 at 1:26 pm, temperatures were taken of prepared hot and cold foods. A Regular diet tray had chicken that showed 125 Degrees Fahrenheit (F), cooked zucchini that showed 125 degrees F, and a cold dish of potato salad that showed 48 degrees F. A Pureed diet tray had chicken that showed 148 degrees F, pureed zucchini that showed 135 degrees F, and a cold pureed potato salad that showed 52 degrees F. On 3/4/26 at 10:03 am, a concurrent record review and interview was conducted with the Dietary Manager (DM). During a review of facility records titled, Test Tray Evaluation, dated 10/9/25, it showed that hot food items were expected to be served between 135 F and 160F. It also showed that hot food was tested at 122F, 103 F, cold food was tested at 58 F. DM acknowledged that temperatures on test trays were noted to be cooler than expected, and had known about this potential problem since October 2025. During confidential interviews on 3/4/26 at 10:00 am, five out of six confidentially interviewed residents stated facility staff does not turn in their filled out menus to the kitchen. The CNA's take their menu and for some reason the menu does not make it back to the kitchen. The only alternatives they are offered are sandwiches. They would like different choices for alternatives. The food oftentimes is cold. If you eat in your room, they do not heat it back up. The food often does not taste good. During a review of facility policy titled, Food Temperature, dated 2/2025, it showed the temperature of potentially hazardous cold foods will be no greater than 41 degrees F or served according to state regulation.

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Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure glucose testing (blood sugar level check for diabetics) was performed in accordance with the facility's infection control policies and procedures for three of three sampled residents when hand hygiene was not performed before and after wearing gloves and alcohol wipes used to sanitize residents fingers was not allowed to air dry. (Residents 14, 94, and130) This failure put the residents at risk for infections and negatively impact their physical well-being by exposing them to germs.Findings: A review of facility's policy titled, Standard Precautions revised 5/2010 indicated, Standard precautions include the following practices: Change gloves as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one). Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hand immediately to avoid transfer of microorganisms to other residents or environments.A review of the facility's policy titled, Obtaining a Fingerstick Glucose Level -Level III revised 8/2016, indicated, Steps in the Procedure, Perform hand hygiene before placing the glucose testing equipment on the bedside stand or over-bed table upon a clean/protective surface. Wear clean gloves. If alcohol is used to clean the fingertip, allow it to dry completely because the alcohol may alter the reading. Obtain a blood sample by using a sterile lancet (a sterile spring-loaded needle used to puncture skin). Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results. Perform hand hygiene after removing gloves and discarding them into a designated container.During an observation on 3/3/26 at 11:48 am, with Licensed Nurse (LN) LN F, LN F put on gloves without washing her hands. LN F wiped Resident 94's fingertip with an alcohol wipe and immediately punctured Resident 94's fingertip with a lancet, before the alcohol was dry. During an observation on 3/3/26 at 11:55 am, LN F put on gloves without washing her hands. LN F wiped Resident 130's fingertip with an alcohol wipe and immediately punctured Resident 130's fingertip with a lancet, before the alcohol was dry. During an observation on 3/3/26 at 12:12 pm, LN B put on gloves without washing her hands. LN B wiped Resident 14's fingertip with an alcohol wipe then LN B waved her hand back and forth over the fingertip to dry the alcohol. LN B then walked through the hallway with the same gloves on and went to the medication cart approximately 50 feet away where she disposed of the bloody test strip (a measuring device), bloody cotton ball, and bloody alcohol wipe. LN B disinfected the glucometer and entered data into Resident 14's electronic health record, without removing her contaminated gloves. LN B then removed the dirty gloves without washing her hands and prepared Resident 14's insulin pen (a device used to administer insulin to lower blood sugar). LN B touched the medication cart, medication cart drawers, Resident 14's insulin pen and the outside of a packaged alcohol wipe and cotton ball. LN B then applied gloves without washing her hands, and went to Resident 14's room and administered the insulin to Resident 14, without washing her hands or putting on clean gloves. LN B then walked back to the medication cart (approximately 50 feet away) and put Resident 14's insulin pen back in the medication drawer, touching the medication cart and medication drawer, and computer keys before removing her dirty gloves. During an interview on 3/3/26 at 12:30 pm, with LN F, LN F stated she was unaware that the alcohol needed to dry before puncturing the fingertip. LN F stated she thought she had washed her hands before putting on gloves to perform glucose testing on Resident's 94 and 130. During an interview on 3/3/26 at 1:01 pm, with LN B , LN B stated, I thought I washed my hands when she managed Resident 14's glucose testing and insulin administration. During a concurrent interview and record review on 3/4/26 at 10:10 am, with facility Director of Nursing (DON), DON stated it is the expectation that nurses wash their hands before putting on and after taking off gloves, before doing a glucose test, and that the nurse should allow the alcohol to air dry before using the lancet to prick the finger. DON stated all LNs receive skill competency assessments for using lancets and glucose testing, which included infection control procedures.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure two out of two sampled residents (Residents 11 and 130) were free from chemical restraints (behavioral management medication that could cause excessive sleepiness) when:The facility failed to appropriately monitor the specific symptoms for which psychoactive medications (altered the brain) were prescribed to Resident 11; andThe facility failed to appropriately monitor the specific symptoms for which psychoactive medications were prescribed to Resident 130.This failure caused the inability to know if the medication was working for its intended use. Findings:1.A review of the facility's policy and procedure titled, Psychoactive Medication Management and Chemical Restraint Prevention, dated 4/25/25, indicated, residents would be monitored when the physician prescribed psychoactive medications.A review of Resident 11's admission Record, dated, 8/4/24, indicated admission to the facility on 8/4/24 with the diagnoses of bipolar disorder, current mixed episode, severe, with psychotic features (a mental health illness that included severe mood swings with difficulty distinguishing reality from imagination) and major depressive disorder (feelings of sadness and hopelessness that were constant). Resident 11 was not their own responsible party (RP, decision maker).A review of Resident 11's Order Details, dated 5/28/25, indicated the Physician prescribed olanzapine (an antipsychotic medication that altered the brain) 5 milligrams (mg) by mouth every night at bedtime for bipolar disorder as evidenced by (targeted behaviors the medication treated) severe mood swings.A review of Resident 11's Order Details, dated 8/26/25, indicated the Physician prescribed Rexulti (an antipsychotic medication) 1 mg by mouth daily for bipolar disorder as evidenced by severe mood fluctuations (ups and downs) and mania (intense over the top energy).A review of Resident 11's Order Details, dated 11/17/25, indicated the Physician prescribed Seroquel (an antipsychotic medication) 25 mg by mouth for bipolar disorder as evidenced by delusions (not based in reality), hallucinations (seeing things not there), and manic thoughts (uncontrollable, speeding thoughts).A review of Resident 11's Order Details, dated 2/11/26, indicated the Physician prescribed sertraline (an antidepressant that altered the brain) 150 mg by mouth daily for major depressive disorder as evidenced by statements of sadness and tearfulness.During a concurrent interview and record review on 3/5/26 at 9:40 am, with Resident Case Manager (RCM), Resident 11's CA Behavior Notes (behavior notes) dated 3/5/25 was reviewed. RCM indicated the behavior notes reflected generalized behaviors that were assessed by facility staff. RCM confirmed there were no specific monitors in place that tracked Resident 11's targeted behavior for use of olanzapine, Rexulti, Seroquel, and sertraline.During an interview on 3/5/26 at 10:11 am, the Director of Nursing confirmed that the behavior notes were generalized and there was no specific monitor in place for Resident 11's targeted behaviors for use of olanzapine, Rexulti, Seroquel, and sertraline.2.A review of Resident 130's admission Record, dated 2/15/23, indicated, Resident 130 was admitted to the facility on [DATE] with the diagnosis of major depressive disorder, severe, with psychotic features (a sad mood that included difficulty distinguishing reality from imagination).A review of Resident 130's Order Details, dated 10/31/25, indicated the physician prescribed bupropion (an antidepressant medication) 150 mg by mouth, two times a day for major depressive disorder with psychotic symptoms as evidenced by self-isolation (staying away from people), refusal of care, and sadness.A review of Resident 130's Order Details, dated 2/2/26, indicated the physician prescribed quetiapine (an antipsychotic medication) 25 mg, give half a tablet by mouth every night at bedtime for major depressive disorder with psychotic symptoms as evidenced by hallucinations, paranoia (extreme distrust and suspicion of others), and delusions that caused fear.During an interview on 3/5/26 at 9:25 am, RCM was asked how the facility staff monitored targeted behaviors regarding use of psychotropic medication. PCM stated, when there is a change in the medication I do Alert Charting [progress note] for behaviors for medication and after four-to-six (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks they chart by exception [charting what was not normal]. RCM confirmed there were no monitors in place that tracked Resident 130's targeted behavior for use of bupropion and quetiapine.During a concurrent interview and record review on 3/5/26 at 10:32 am, with Administrator (ADM), a blank behavior notes, dated 3/5/26 were reviewed. ADM confirmed, the behavior note was generalized and was where facility staff documented witnessed behaviors. ADM confirmed there was no monitor in place that tracked Resident 11 and 130's specific targeted behavior for use of psychotropic medications.

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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 observation, interview, and record review, the facility failed to review and revise a comprehensive care plan for two of eight sampled residents (Resident 81 and Resident 131) when: 1.Resident 81 did not have activity interventions for specific needs and preferences. 2.Resident 131 did not have specific nursing interventions for shaving himself and getting out of bed. These failures had the potential to result in the residents' needs not being identified, feeling depressed with poor self-esteem, and had the potential to contribute to skin breakdown, infection, and negatively impact their ability to attain or maintain their highest practicable level of well-being. Findings: 1. During a review of the facility's policy and procedure (P&P), titled, Care Planning-Interdisciplinary Team (IDT, a group of experts from different fields working together to provide comprehensive care), revised 11/2017, the P&P indicated, Care planning begins the day of admission for all residents. The care plan is recognized as an interdisciplinary dynamic process that includes at the minimum, nursing, social services, activities and dietary. While the care planning process begins on the day of admission by nursing, the IDT is responsible for the development of an individualized comprehensive care plan for each resident on an ongoing basis. The resident, the resident's family, and/or the family's representative/guardian/or surrogate are encouraged to participate in the development of and revisions to the resident's care plans. During a review of Resident 81's clinical record titled, admission Record, indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of first lumbar vertebrae (common spinal injury described as crushed front corner of one of the lower back bones), cardiac pace maker (surgically placed device to regulate a slow heart rate), dysphagia (difficulty swallowing), high blood pressure, unspecified dementia (loss of mental functioning such as thinking, memory, mood and behavior), anxiety (an intense ongoing feeling of fear, dread, worry and uneasiness), and depression (persistent feelings of sadness and loss of interests). During a review of the most recent Minimum Data Set, (MDS, a resident assessment), dated 12/3/25, indicated that Resident 81 had a slight cognitive (process of thinking, knowing, and processing information) impairment, with a brief interview for mental status (BIMS, a screening tool for thinking, reasoning, and memory) score of 12 out of 15. During a review of Resident 81's clinical record, a record titled, Care Plan Report, dated 9/8/25, indicated Resident 81 did not have specific activity preferences for watching channel 44 for her favorite programs or updating her board in her room for the date due to memory loss. During an interview on 3/4/26 at 9:20 am, Resident 81 stated, I don't have any specific complaints, but I feel sort of overlooked, like I don't matter. Everything is more important than me. I like to watch [name of favorite TV show], but I can't remember what channel it comes on. My mind is bad, I forget things. During an interview on 3/4/26 at 9:50 am, Resident 91 stated, [Resident 81] is the best roommate. She was a missionary in Brazil. She loves to watch channel 44, but she cannot remember it so I remind her so she can watch her Christian programs she enjoys. During an interview on 3/4/26 at 10:40 am, the Resident Care Manager (RCM) confirmed Resident 81's care plan should be more resident specific. RCM stated, They need to update [Resident 81]'s board daily with the date. We have plenty of supplies such as puzzles, and pictures to color to take [Resident 81] for her preferences. During an interview on 3/4/26 at 1:05 pm, the Activities Director (AD) confirmed Resident 81 does have dementia and is forgetful. AD stated, I agree, [Resident 81] cannot remember television channels, I will add a sign for a reminder, and I will update her care plan. I will also take her more religious pictures and puzzles and update her board daily with the dates. 2. During a review of Resident 131's clinical record, a record titled, admission Record, indicated Resident 131 was admitted to the facility on [DATE] with diagnoses that included depression, benign neoplasm of the kidney (non-cancer tumor or growth on the kidney), obstructive and reflux uropathy (a blockage causing urine to not flow properly), mononeuropathy of both legs (one (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	single nerve of each leg has damage causing pain, numbness and tingling), pneumonia (infection of one or both lungs that cause inflammation of the air sacs causing them to fill with fluid), chronic obstructive pulmonary disease (COPD, a progressive lung disease that causes shortness of breath), diabetes (too much sugar in the blood), sepsis (the body's reaction to a severe infection), muscle weakness and high blood pressure. During a review of the most recent record titled, MDS, dated 11/24/25, indicated Resident 131 had a slight cognitive impairment, with a BIMS score of 13 out of 15. During a review of Resident 131's clinical record, a record titled Care Plan Report, dated 11/5/25, indicated Resident 131 did not have specific interventions to promote independence for shaving with set up using his electric razor. This record did not have any new nursing interventions to implement for refusals to get out of bed daily. During an interview on 3/3/26 at 8:45 am, Resident 131 stated, I can shave myself, but they do it. If I had a mirror in here I would do it myself. I have an electric razor over there, pointing to the night stand beside the bed. I like to shave every other day, but they do it two times a week. I would get out of bed if they would use the Apex (mechanical device to safely lift or transfer for patients who cannot support their own weight) lift, therapy used to help me. I don't like the Hoyer (mechanical wheeled device to safely lift and transfer patients with limited mobility) lift; I hurt for a week after I use it. During an interview on 3/4/26 at 8:45 am with Certified Nursing Assistant (CNA) E confirmed she shaved Resident 131 two times weekly. CNA E stated, I did not know [Resident 131] had an electric razor. [Resident 131] does refuse to get up; he does not like the Hoyer lift. I update the nurse sometimes; I don't every day. During an interview on 3/4/26 at 10:45 am, RCM confirmed Resident 131 needed multiple care plan revisions. RCM stated, I totally agree the staff needs to update the nurse daily when Resident 131 does not want to get out of bed, and the nurses need to document all the refusals and try to encourage him to get out of bed. Resident 131's last day of physical therapy was 2/11/26. I obtained a lot of new orders for his medication regimen hoping this would help Resident 131. I am working on Resident 131's care plan revisions right now for more interventions needed. I did not know he can shave himself, but I will make sure he gets a mirror in his room so they can provide set up for Resident 131 to use his electric razor to promote his independence. During an interview on 3/5/26 at 7:50 am, the Administrator confirmed the comprehensive care plan needed revisions for Resident 81 and Resident 131.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a telephone order (when the doctor calls the nurse to give an order for a resident) for a medication was correctly transcribed for one of eleven sampled residents when an order to give a medication in the eye was mistakenly written to be given in the ear. (Resident 58)This error has the potential for residents to receive medication via the incorrect route. Not receiving the medication via the correct route, the medication would be ineffective to treat what it was prescribed for.Findings A record review of facility policy titled, Physicians Medication Orders revised 1/16 indicated on line 6, Orders for medication must include d. Route of administration if other than oral. Line 11 stated, Physicians orders are reviewed and sent to the primary care provider monthly for ongoing order reviewing.A record review of facility policy and procedures titled, Identifying and Managing Medication Errors and Adverse Consequences revised 4/15/21 indicated, under Policy Statement The staff and practitioners shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur. Under Policy Interpretation and Implementation line 1. The staff and practitioner shall strive to minimize adverse consequences by 1. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication.A record review of facility policy titled, Administering Medications revised 12/25 indicated, on line 7 the individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right times, and right method of administration (also known as the 5 rights of medication administration) before giving the medication. A record review of Resident 58's Transfer/Discharge Report indicated Resident 58 was admitted on [DATE] with diagnoses of dementia (memory loss), bladder and intestine infections, and dry, irritated eyes.During an observation on 3/4/26 at 8:31 am, Licensed Nurse (LN) G administered Artificial Tears (lubricant eye drops) Solution 0.4% (percent the strength), 2 drops into each eye to Resident 58. Resident 58 had redness and swelling to both lower eye lids. A record review of Resident 58's Medication Administration Record (MAR), dated 3/1/26-3/31/26, indicated orders for, Artificial Tears Solution 0.4% to be instilled 2 drops in both ears, [instead of both eyes], every day for Dry eye, and every 6 hours as needed for dry, irritated eyes. During a concurrent interview and record review on 3/4/26 at 9:25 am, with LN G, LN G reviewed Residents 58's MARs with surveyor and confirmed the MAR order stated to give Artificial Tears in both ears instead of eyes. LN G stated, There must have been a transcription error for the medication. LN G reviewed and confirmed Resident 58's physician's orders with surveyor and determined that on 7/8/25 she entered the wrong medication route when she transcribed the telephone order for this medication.A record review of Resident 58's, Order Audit Report dated 3/4/26 indicated on 7/8/25 at 2:09 pm, LN G transcribed a telephone order for Artificial Tears, instill 2 drops in both ears every 6 hours as needed AND one time a day. Physician (MD) electronically signed order on 7/8/25 at 8:00 pm and reviewed this order on 8/21/25, 10/8/25, 11/14/25, 1/1/26, and 2/11/26, without recognizing the order entered was for the ears and not the eyes.During a concurrent interview and record review on 3/5/26 at 8:19 am, with Resident Care Manager (RCM 2), RCM 2 stated during the process of monthly order reviews (reviewing each residents MARs and physician's orders for accuracy) nursing, the MD, and their Pharmacy Consultant (PC) had not discovered the error in Resident 58's eye drop directions to be given into her ear, instead of her eye. During a telephone interview on 3/5/26 at 9:31 am, PC stated he does monthly pharmacy inspections at the facility to look at resident's medications (medication labels), orders, and MARS to ensure medication accuracy, effectiveness, and that they are prescribed appropriately for diagnosis. PC stated his last review of Resident 58's medications was on 2/11/26 at 5:00 pm.A record review of the PC's Pharmacy Inspection Dates undated for the facility indicated that on 2/11/26 at 5:00 pm, PC reviewed Resident 58's orders and MARS, there were no recommendations made for the directions on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 58's Artificial Tears order.During a concurrent telephone interview and record review on 3/5/26 at 10:20 am, with PC, PC reviewed Resident 58's electronic health record (EHR) for the order for Artificial Tears dated 7/8/25. PC stated, This is a pretty obvious mistake, they [Artificial Tears] directions should be instilled in eyes not ears.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to remove expired medications from one of four treatment carts and were available for resident use.This had the potential for residents to receive expired medications which would not be effective or safe for use.Findings:A record review of facility policy titled, Storage of Medications revised 5/10, indicated under Policy Interpretation and Implementation Line 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner.A record review of facility pharmacy policy and procedures titled, Medication Storage in the Facility revised 1/1/23, indicated under Procedures, line J stated, Medication storage conditions are monitored on a periodic basis by the consultant pharmacist or consultant nurse and corrective action taken if problems are identified. Line G stated, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.An observation and concurrent interview with the Treatment Nurse (TXN) on 3/4/26 at 3:30 pm, of the Transitional Care Unit treatment cart (holds supplies for treatments), was conducted. The following expired treatment supplies and medications were identified:One tube of Coloplast Hydrophilic wound dressing gel (a zinc-oxide based paste used to treat wounds) with expiration date of 7/31/25.One tube of Benadryl cream (anti-itch cream for skin) that expired in 6/2025.Five Hemorrhoid (treats swollen veins in the lower rectum) suppositories (medication inserted in the rectum) that had expired in 9/2025.Fifteen (15) Bisacodyl (treats constipation) 10 milligram (mg, a unit of measure) suppositories that had expired in 6/2025. TXN confirmed the above treatment supplies and medications were expired and should not have been available for the residents to use. TXN stated he was not aware of who was responsible to check and remove expired treatment supplies and medications from the treatment cart.During an interview on 3/4/26 at 4:00 pm, with Director of Nursing (DON), DON stated the Infection Control Nurse and Resident Care Managers are responsible for checking for expired treatment supplies and medications on the carts, monthly. DON stated the nursing staff was responsible to check for expired treatment supplies and medications, daily. DON stated she was unaware of the expired medications on the TCU treatment cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056222	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquis Care at Shasta	3550 Churn Creek Rd. Redding, CA 96002

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and facility document review, the facility failed to ensure:1.One of three sampled resident's minced and moist (MM5) therapeutic diets (special needs diet plans), was prepared according to the recipe. (Resident 143)2. Nursing staff had a current and complete diet manual reference.These failures had the potential to result in residents receiving diets that do not match physicians' orders and incorrect preparation of special therapeutic diets and for nursing staff not to have reference material to recognize when a diet is served incorrectly. Findings:1.On 03/03/2026 at 10:30 AM, during a kitchen observation, [NAME] 1 (CK 1) was preparing minced and moist diet (MM5, foods are finely chopped and kept moist so they are easier to chew and swallow) minced (foods that have been cut or chopped into very small, fine pieces), chicken without referring to the recipe.On 03/03/2026 at 11:50 AM, during a kitchen observation during lunch trayline, a MM5 diet tray for Resident 143 included minced chicken with BBQ sauce on top.A review of the facility document titled BBQ Chicken Method, dated 2002-2026, showed MM5: Debone chicken. Mince regular cooked portions.Serve 2 oz (ounces) meat mixed with thick gravy.A review of the facility policy titled, Cooking Food, dated April 2019, showed Recipes will be followed for the menu items. Check the spreadsheets for alternate items needed for diet and texture modification.A review of the International Dysphagia Diet Standardization Initiative (IDDSI) website titled IDDSI, dated 1/2019, the IDSSI guideline indicated, Level 5 Minced and Moist Can be scooped and shaped (e.g. into a ball shape) on a plate and Meat Serve in mildly, moderately or extremely thick, smooth, sauce or gravy, draining excessA review of the facility document titled, Resident CF Order Summary Report, dated 3/4/26, showed Resident 143 had an order for Regular Diet Minced and Moist texture, thin consistencyDuring an interview with Dietary Manager (DM) on 03/04/2026 at 10:03 AM, DM stated when shown the picture of the Minced and Moist tray that it doesn't meet the IDDSI guidelines for texture and is not therefore following the diet order for MM5.2.On 03/03/2026 at 10:15 AM a concurrent interview and observation was conducted with Licensed Vocational Nurse (LVN H) at the nursing station. LVN H could not locate the diet manual. LVN H stated she had never heard of a diet manual and didn't know what it was used for. LVN H called the Registered Dietitian Nutritionist (RDN) to find out more information. RDN delivered diet manual from another nursing station.A review of the facility, [Facility Name]/ HPSI Diet Manual (guide or reference that provides instructions, plans, and information about different diets and nutrition), dated 1/30/26, the manual did not include information on the soft and bite sized diet (SB6) (foods are soft in texture and cut into small, manageable pieces that are easy to chew and swallow) and MM5.A review of the facility, Diet Spreadsheet (a sheet containing the kind and amount of food each diet would receive), dated Tuesday Week 2, indicated SB6 and MM5.During an interview with Dietary Manager (DM) on 03/04/2026 at 10:03 AM, DM stated that he approved of the diet manual 1/30/2026 and acknowledged that the diet manual does not include information regarding the puree, SB6 and MM5. DM stated the mechanically altered diet information for IDDSI should be included so that the nurses have a reference. DM stated that the diet information that is currently in the manual is obsolete and no longer used in the facility.