STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135103	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard View Post Acute	1014 Burrell Avenue Lewiston, ID 83501

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to protect the residents right to be free from physical abuse by other residents for two out of nine residents (Resident (R) 32, and R61) reviewed for abuse of 25 sample residents. These failures had the potential to cause physical harm or psychosocial distress.Findings include:Review of the facility's policy titled, Abuse screening, training, identification, investigation, reporting and protection - Idaho, dated February 2019, revealed It is the policy of this center to. Protect our residents from abuse.Abuse is defined as.the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Instances of abuse of all residents, irrespective of any mental, physical condition, cause physical harm, pain or mental anguish. 1. a. Review of R23's EMR under the Profile tab revealed he was admitted to the facility on [DATE] and had diagnoses of anxiety, personality and behavioral disorder, schizoaffective disorder, mood disorder, and restlessness/agitation.Review of R23's annual MDS with an ARD of 06/04/25 and located under the MDS tab of the EMR, revealed a BIMS score of two out of 15 which indicated R23 was severely cognitively impaired. He exhibited minor mood symptoms and no behavioral symptoms.b. Review of R32's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] and had diagnoses including intracerebral hemorrhage and depression.Review of R32's quarterly MDS with an ARD of 05/15/25 and located under the MDS tab of the EMR, revealed a BIMS score of nine out of 15 which indicated R32 was moderately cognitively impaired. He exhibited moderate mood symptoms but did not exhibit behavioral symptoms.Review of R23's Behavior Note, dated 03/09/25 and located under the Progress Notes tab of the EMR, revealed Resident walk [sic] up to the nurse station, no word said other than breathing heavily then LN saw both arms up and reaching for LN neck, LN backed up as this resident was grabbing holding on and hands were around LN neck, this LN had to put foot up against this resident's abdomen to stop this resident though this resident was too strong. Another resident [R32] was in the hallway that saw and witnessed the entire as this resident continue [sic] to grab, hit, push, and attempt to cause serious bodily harm. Other resident in the hallway observed the incident and help [sic] intervene. The other resident help [sic] pull this resident off LN. Then this resident [R23] went after the other resident [R32] and grabbed his arm attempting to cause bodily harm to this resident. On-call nurse notified, and administrative staff notified. Review of the facility's investigation packet for the above incident, dated 03/14/25 and provided on paper, revealed the incident occurred on 03/09/25 at 1:30 PM. R23 began choking RN2 and R32 tried to intervene, at which time R23 grabbed R32's arm and twisted it. Interviews with staff revealed RN2 was directly involved in the incident and witnessed R23 grab and twist R32's arm. Interview with R32 revealed he stated R23 grabbed his arm, and assessment revealed a bruise to R32's right arm. The facility's investigation substantiated resident-to-resident abuse occurred, as it was witnessed by staff and residents. R32 only received minor bruising and did not exhibit signs or symptoms of psychosocial distress.During an interview on 08/13/25 at 2:17 PM, the Director of Nursing (DON) stated on 03/09/25, R23 began choking RN2 without any warning. She stated R32 attempted to intervene when R23 turned his attention to R32 and grabbed his arm. The DON stated this incident of resident-to-resident abuse was substantiated because the incident was witnessed and R23 assaulted R32. The DON stated the police department was contacted in this situation, but no citations were made and R23 was sent to the emergency room for psychiatric evaluation.2. a. Review of R61's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] and had diagnoses including weakness and limitation of activities due to disability, subdural hemorrhage, and depression.Review of R61's quarterly MDS with an ARD of 05/18/25 and located under the MDS tab of the EMR, revealed a BIMS score of 12 out of 15 which indicated R61 was moderately cognitively impaired. He exhibited minor mood symptoms and no behavioral symptoms. b. Review of R32's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] and had diagnoses including intracerebral hemorrhage and depression.Review of R32's quarterly MDS with an ARD of 05/15/25 and located under the MDS tab of the EMR, revealed a BIMS score of nine out of 15 which indicated R32 was moderately cognitively impaired. He exhibited moderate mood symptoms but did not exhibit behavioral symptoms.Review of R61's Alert Charting, dated 05/09/25 and located under the Progress Notes tab of the EMR, revealed At 1020 this LN heard yelling coming from down the hallway, I went into room and observed [R32] standing up over roommate [R61] who was sitting on his bed. [R32] was yelling at

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure an alleged violation involving abuse was reported immediately to the Director of Nursing (DON) and to other officials in accordance with state law through established procedures for two of nine residents (Resident (R) 6 and R69) reviewed for abuse of 25 sample residents. This failure decreased the facility's potential to protect the residents from a possible allegation of abuse and ensure a safe environment during the investigation.Findings include:Review of the facility's policy titled, Abuse screening, training, identification, investigation, reporting and protection-Idaho, dated 02/19, indicated that all employees were mandatory reporters and any suspicion of a crime including assault must be reported if there was an injury or within 24 hours if there was no bodily injury.Review of the facility's policy titled, Grievance, dated 03/19, indicated that alleged violations involving abuse should be reported immediately as required by state law and facility policy. 1. Review of R6's Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnosis that include heart failure, respiratory failure, type II diabetes, kidney failure, and hypertension.Review of R6's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R6 was cognitively intact.During an interview on [DATE] at 11:35 AM, R6 stated that on [DATE] of this year, somebody came into her room while she was sleeping and cut her hair off. R6 stated that she told the nurse, but nobody had done anything about it.During an interview on [DATE] at 12:42 PM, the Administrator stated that R6 did report the incident and filed a grievance report. The Administrator stated that R6 reported that two residents had entered her room while she was asleep and cut her hair. The Administrator stated that the Director of Nursing (DON) had conducted the investigation and had determined during the investigation that R6's hairclip which she never removed from her hair had somehow broken her hair off and no residents were involved. A review of the grievance report, provided by the facility, revealed that the report was filed on [DATE] indicating that the incident happened on [DATE] and reported as two residents came into R6's room and cut her hair off while she was asleep.During an interview on [DATE] at 2:44 PM the DON stated that the grievance was given to her by the Social Worker and she immediately investigated it. The DON stated that the incident was not reported because when she talked with R6 she told her that nobody came into her room and cut her hair. The DON stated that upon inspection of R6's hair they did not find any cutting marks and the hair looked broken and R6 could not find the hairclip she always wore.During an interview on [DATE] at 2:05 PM the Social Service Director (SSD) stated as soon as she received the grievance, she alerted the DON and went and talked with R6. The SSW stated R6 told her no one was in her room, so she felt there was no need to report the incident to the state agency. The SSW agreed that the way the incident was reported, it should have been reported before they determined there was no abuse or an assault did not happen. The SSW stated staff should know how to report these allegations and should not have filed a grievance but reported it as an allegation of an assault.During an interview on [DATE] at 4:06 PM, Licensed Practical Nurse (LPN) 1 stated R6 reported to her that two residents came into her room and cut her hair off, but she didn't notice it for two days. LPN1 stated she looked for signs of her hair being cut but couldn't find any hair. LPN1 stated she noted R6 had a pair of scissors on her nightstand but could not determine if her hair was cut. LPN1 stated that they did not have any residents who wandered and no reported residents going into other resident rooms. LPN1 state she helped R6 fill out a grievance form because she was told that was what needed to be done. LPN1 could not recall who told her that a grievance form should be filled out instead of an abuse report. 2. Review of R69's Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnosis that include type II diabetes, overactive bladder, schizophrenia disorder, anxiety, bi-polar disorder, and cognitive communication deficit. R69 expired in the facility on [DATE].Review of R69's quarterly MDS with an ARD of [DATE] and located in the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated R69 was cognitively intact.A review of a Facility Reported Incident (FRI), dated [DATE] and provided by the facility, revealed R69 reported an allegation of sexual abuse when she awoke to a Certified Nursing Assistant (CNA) checking her brief. R69 became upset and asked the CNA to get the supervisor on duty. R69 reported she felt she was being sexually assaulted when the CNA was checking her brief. The supervisor reassured R69 that the CNA was checking her brief and calmed her down. The report indicated that the incident occurred at 1:05 AM and was not reported to the DON until 8:05

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, facility staff failed to protect one of nine residents (Resident (R) 69) reviewed for abuse from further abuse by not immediately removing a staff from the facility who was accused of sexual abuse of 25 sample residents. This failure decreased the facility's potential to protect the residents and ensure a safe environment during the investigation.Findings include:Review of the facility's policy titled, Abuse screening, training, identification, investigation, reporting, and protection-Idaho, dated 02/19, indicated that any staff member involved will be removed from their duties and sent home while a thorough investigation was conducted. Review of R69's Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnosis that include type II diabetes, overactive bladder, schizophrenia disorder, anxiety, bipolar disorder, and cognitive communication deficit. R69 expired in the facility on [DATE].Review of R69's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R69 was cognitively intact.A review of a Facility Reported Incident (FRI), dated [DATE] and provided by the facility, revealed R69 reported an allegation of sexual abuse when she awoke to a Certified Nursing Assistant (CNA) checking her brief. R69 became upset and asked the CNA to get the supervisor on duty. R69 reported she felt she was being sexually assaulted when the CNA was checking her brief. The supervisor reassured R69 that the CNA was checking her brief and calmed her down. The report indicated that the incident occurred at 1:05 AM and was not reported to the Director of Nursing (DON) until 8:05 AM. A full investigation was then initiated by the DON.During an interview on [DATE] at 1:37 PM, the DON stated that she was not notified of the incident until she arrived at work by the nurse on duty. The DON stated she did a full investigation. The DON stated that the CNA was not suspended until she received the report at 8:00 AM but was re-instated when the allegation was unsubstantiated and did not work with the resident again. During an interview on [DATE] at 9:27 PM, Registered Nurse (RN) 3 stated she was called into the R69's room by CNA5. RN3 stated R69 was visibly upset and told her CNA5 had sexually molested her. RN3 stated she explained to R69 that the CNA5 was checking her brief as she assigned to do. RN3 stated that R69 stated she was not fully awake and was startled by the incident. RN3 stated she assured R69 that CNA5 would not come into the room and that she would be the only staff to assist her the rest of the night. RN3 stated that R69 calmed down and went back to sleep. RN3 stated she did not send CNA5 home at the time of the incident and did not immediately report the incident to DON because she told CNA5 not to go back in the room and took over the care of R69.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the medication usage of three (Resident (R) 4, R61, and R34) of 25 residents reviewed in the sample. These failures created potential for an incomplete or ineffective plan of care related to medication use and side effect monitoring.Findings include:1. Review of R4's admission Record located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including type two diabetes with hyperglycemia.Review of R4's quarterly MDS with an Assessment Reference Date (ARD) of 06/20/25 and located under the MDS tab of the EMR, revealed she used hypoglycemic medication and used insulin one day of the previous seven days.Review of R4's Medication Administration Record (MAR), dated June 2025 and located under the Reports tab of the EMR, revealed an order, which originated on 05/27/25, for Ozempic (a hypoglycemic medication that is not an insulin), one time a week for diabetes management. There were no orders for insulin on the MAR.During an interview on 08/14/25 at 1:25 PM, the MDS Coordinator (MDSC) stated R4 was using Ozempic, which she mistakenly believed was an insulin. After further research, the MDSC agreed R4 was receiving hypoglycemic medication but was not receiving insulin, and this was incorrect on the MDS. 2. Review of R61's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including type two diabetes.Review of R61's quarterly MDS with an ARD of 05/18/25 and located under the MDS tab of the EMR, revealed he used hypoglycemic medication and used insulin one day of the previous seven days.Review of R61's MAR, dated May 2025 and located under the Reports tab of the EMR, revealed an order, which originated on 04/04/25, for Ozempic one time a week for diabetes management. There were no orders for insulin on the MAR.During an interview on 08/14/25 at 1:25 PM, the MDSC stated R61 was using Ozempic, which she mistakenly believed was an insulin. After further research, the MDSC agreed R61 was receiving hypoglycemic medication but was not receiving insulin, and this was incorrect on the MDS.3. Review of R34's admission Record located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including history of stroke.Review of R34's quarterly MDS with an ARD of 06/26/25 and located under the MDS tab of the EMR, revealed he used anticoagulant medication.Review of R34's MAR, dated June 2025 and located under the Reports tab of the EMR, revealed an order, which originated on 03/20/25, for clopidogrel bisulfate (an antiplatelet medication that is not anticoagulant) for stroke prevention. There were no orders for an anticoagulant on the MAR.During an interview on 08/14/25 at 1:25 PM, the MDSC stated R34 was using an antiplatelet medication and not an anticoagulant; this was a data entry error on the MDS.During an interview on 08/14/2025 at 1:47 PM, the Administrator stated the facility did not have a policy addressing MDS accuracy and followed the guidance in the RAI [Resident Assessment Instrument] Manual.Review of the Centers for Medicare & Medicaid Services (CMS) RAI Manual, dated October 2024 and located at https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf, revealed, Insulin.Steps for Assessment 1. Review the resident's medication administration records for the 7-day look-back period.2. Determine if the resident received insulin injections during the look-back period.4. Count the number of days insulin injections were received.Coding Instructions.Enter.the number of days during the 7-day look-back period.that insulin injections were received.Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period.Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as.Anticoagulant.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interview, record review, and policy review, the facility failed to ensure a newly admitted resident had a baseline care plan documented within 48 hours of admission for one of four residents (Resident (R) 70) reviewed for baseline care plan of 10 newly admitted residents. As a result of this deficient practice the residents had the potential for care needed not being provided during the initial days of admission to the facility.Findings included:Review of the facility's policy titled, Care Plans-Baseline, revised 05/24, revealed A baseline plan of care should be developed for each resident within forty-eight (48) hours of admission. The baseline care plan should include instructions needed to provide effective, person-centered care of the resident, which may include the following: a. Initial goals based on admission orders and discussion with the resident/representative. b. Physician orders. c. Dietary orders. d. Therapy services. e. Social services. Review of R70's admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 08/06/25 with medical diagnoses that included encephalopathy and aftercare provided after total joint replacement.Review of R70's EMR revealed the document for a baseline care plan had not been initiated or completed.During an interview on 08/12/25 at 1:15 PM, the Resident Care Manager (RCM) 1 reviewed the EMR for R70 and confirmed the EMR lacked completion of the baseline care plan by the admitting nurse, and it should have been completed.During an interview on 08/12/25 at 2:39 PM, the Director of Nursing (DON) confirmed there should be a baseline care plan for all new admission residents within 48 hours of admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to develop a comprehensive Care Plan for one of 25 sample residents (Resident (R) 4) that addressed psychiatric diagnoses and needs. This placed R4 at risk for unmet psychosocial and behavioral care needs and the inability to meet their maximum practicable level of functioning.Findings include:Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, revealed The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including.any specialized services to be provided as a result of PASARR [preadmission screen and resident review] recommendations.Review of R4's admission Record located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] and had diagnoses including bipolar disorder, major depression, insomnia, suicidal ideation, and post-traumatic stress disorder (PTSD). Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/25 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS)score of 14 out of 15 indicating intact cognition. She exhibited only minor mood symptoms and no behavioral symptoms. R4 received antianxiety and antidepressant medications. Review of R4's Pre-admission Screen and Resident Review (PASARR) Level II Evaluation, dated 04/26/23 and located under the Documents tab of the EMR, revealed, Supporting documents identify diagnoses of bipolar disorder, major depressive disorder, anxiety disorder, posttraumatic stress disorder, and borderline personality disorder. Remote history of suicidal ideation with inpatient hospitalization 6/2022. Provider note of 3/29/2023 references restarting counseling. [R4] may benefit from an evaluation for specialized services. Review of R4's Care Plan, dated 01/13/25 and located under the Care Plan tab of the EMR, revealed it did not address her diagnoses of post-traumatic stress disorder, depression, or bipolar disorder. During an interview on 08/14/25 at 1:45 PM, the Social Services Director (SSD) stated R4 was receiving medication for depression and anxiety, received daily visits by the SSD, and received counseling services. The SSD also stated R4 was followed by a psychiatrist and had a diagnosis of PTSD. The SSD stated the only trigger she was aware of for R4's PTSD/anxiety was using the telephone. The SSD stated her diagnoses, and potential PTSD should have been included in the Care Plan in order to develop appropriate interventions.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure the indwelling urinary catheter tubing and collection bag were not in contact with the floor for one of three residents (Resident (R) 54) reviewed for catheters and urinary tract infection of 25 sample residents. This failure placed the residents at risk for transmission of infection to the urinary tract.Findings include:Review of the facility's policy titled, Catheter Care, Urinary, dated 08/22, indicated that to prevent urinary catheter-associated complications, staff should be sure to keep the catheter tubing and collection bag off the ground. Review of the Profile tab in R54's electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including depression, heart failure, neurogenic bladder, adult failure to thrive, overactive bladder, and history of urinary tract infections.Review of R54's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R54 was cognitively intact. She used an indwelling urinary catheter.During an observation on 08/11/25 from 2:06 PM to 3:12 PM, R54 was sitting in her wheelchair in the activity area. R54's catheter tubing was observed dragging on the floor as several staff passed by. During an interview on 08/11/25 at 3:12 PM, Certified Nursing Assistant (CNA) 6 stated that R54's catheter tubing was usually checked several times a day. CNA6 stated she did not notice the tubing was on floor and it did not belong there. CNA6 stated that the catheter privacy bag seemed small, and the tubing tended to come out of the bag. During an interview on 08/13/25 at 2:34 PM, the Director of Nursing (DON) stated that catheter tubing and placement was checked every shift and would expect staff to check often during the day to ensure the tubing was not dragging on the ground.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review, the facility failed to maintain sanitation in one of one dining room area by allowing a dog to wander the dining area and into two of eight residents' rooms during a meal. This failure had the potential to expose the residents to harmful pathogens and infections.Findings include:Review of the 2022 Food Code by the U.S. Food and Drug Administration, located at https://www.fda.gov/food/fda-food-code/food-code-2022, Chapter 6-501.115, indicated that pets in nursing homes were allowed in the common areas except during mealtimes.Review of the facility's undated policy titled, Pets in the Building indicated that staff must keep pets out of the dining area during mealtimes.During a meal observation on 08/12/25 at 12:43 PM, a dog was observed wandering in and out of the dining area during the lunch meal service. The dog was observed to go up to several different residents and sit by them begging for food. Residents were observed to tell the dog no, and the dog would go to a different resident. The dog was observed to wander in and out of room [ROOM NUMBER] and 314 several times while the residents in those rooms were eating their meals.During an interview on 08/13/25 at 11:43 AM, the Dietary Manager (DM) stated that dogs did not belong in the dining room, and their owner should be monitoring them.During an interview on 08/13/25 at 2:41 PM, the Director of Nursing (DON) stated that dogs did not belong in the dining room, and the owners have been educated to keep better track of them and keep them out of the dining area.