STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145441	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelbyville Manor	1111 West North 12th Street Shelbyville, IL 62565

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to provide showers, twice a week, to a dependent resident. This failure affected one of three residents (R7) reviewed for showers on the sample list of 14. Findings include:R7's Current Diagnoses List documents R7 has diagnose of Chronic Kidney Disease, Diabetes, Chronic Pain, and Morbid Obesity,R7's Minimum Data Set, dated [DATE] documents the following: Brief Interview of Mental Status score of 14 out of a possible 15, indicating no cognitive impairment.R7's Care Plan dated 2/19/26 documents the following: Approach Start Date: 03/14/2025, Bathing Type: (R7) receives showers twice weekly. (R7) requests we (facility staff) make sure she is dry and pat skin folds dry.R7's February 2026 shower sheets document R7 received a shower on 2/3/26, 2/10/26, 2/18/26, and 2/21/26. There is no documentation that R7 declined a shower between 2/3/26 and 2/10/26 or between 2/10/26 and 2/18/26 which indicates R7 missed two showers.On 2/24/26 at 1:10 pm R7 stated the staff forget to give R7 a shower almost every week. They (staff) just forget, so I remind them. Sometimes they don't have time until later in the day. I still have to ask to get one shower per week sometimes. It is supposed to be routine. I am scheduled for two, on Wednesday and Saturday.On 2/25/26 at 2:00 pm V2, Director of Nursing (DON) stated R7 was scheduled to receive two showers a week and care planned to get two showers each week. V2, DON reviewed shower sheets and confirmed R7 missed two showers in February 2026.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement fall prevention interventions according to residents' care plans for fall risks. This failure affects two residents (R6 and R10) out of three reviewed for falls with injuries on the sample list of fourteen.Findings include:1. R10's Demographic Face Sheet dated 3/3/26 documents R10 was admitted to the facility 4/10/25 with medical diagnoses including Dementia with Behavior Disturbance, Neuralgia, Glaucoma, History of Transient Ischemic Attacks, Chronic Pain, Pseudobulbar Affect, rash, Insomnia, Depression, Migraines, and Vitamin Deficiency.R10's Physician Order Sheet dated 3/3/26 documents R10 receives multiple anti-hypertension, anti-depressant, anti-anxiety, and anti-convulsant medications.R10's Event charting with associated Nursing Progress Notes dated 4/19/25 document R10 slid out of her bed onto the floor.R10's Event charting with associated Nursing Progress Notes dated 6/6/25 documents R10 was self-propelling her wheelchair, got her feet tangled in the wheelchair foot pedals, fell out of the wheelchair and struck her head on the wall. The interdisciplinary team review of this fall documents a revised care plan intervention was implemented to remove the foot pedals from R10's wheelchair to allow R10 to self-propel her wheelchair.R10's Event charting with associated Nursing Progress Notes dated 1/1/26 documents R10 fell out of her wheelchair and landed on the foot pedals, also striking her head on a doorway. The interdisciplinary team review of this fall documents a revised care plan intervention was implemented to remove the foot pedals from R10's wheelchair and to place non-slip material in the seat of R10's wheelchair.R10's Care Plan Resident Care Information section documents R10 requires the use of medical equipment including a high-back reclining wheelchair with anti-tip bars, and bilateral foot pedals dated 9/15/25. R10's Care Plan Fall Risk section documents to remove the foot pedals from R10's wheelchair dated 1/2/26. There was no reference to the non-slip material to be placed in the seat of R10's wheelchair.On 3/3/26 at 11:10 AM, following a staff-assisted transfer utilizing a sit-to-stand mechanical lift, there was no non-slip material in the seat of R10's wheelchair, either directly underneath R10 nor under the padded seat cushion.On 3/3/26 at 11:20 AM, V4, Minimum Data Set/ Care Plan Coordinator, was walking through the facility's central rotunda carrying a piece of non-slip material. V4 stated the material was intended for R10's wheelchair seat. V4 stated she would need to review R10's care plan to see if the non-slip material was listed as an intervention. At 12:55 PM, V4 confirmed R10's Care Plan Resident Care section listed to have R10's foot pedals in place on her wheelchair, and the Fall Risk section listed to remove the foot pedals from R10's wheelchair. V4 stated R10 does self-propel her wheelchair and does need the foot pedals to be removed. V4 stated she was not present at the interdisciplinary team reviews for R10's falls but V4 had revised R10's care plan to include the non-slip material.On 3/4/26 at 10:50 AM, V4 confirmed the intervention for R10's foot pedals to be removed should have been revised in the resident care section of R10's Care Plan. V1, Administrator, stated the care plan interventions recommended by the interdisciplinary team are expected to be implemented into the care plan. V4 stated the care plan changes need to be communicated.2. R6's Demographic Face Sheet dated 2/27/26 documents R6 was admitted to the facility 12/1/25 with medical diagnoses including Encephalopathy, Dementia with Agitation and Psychotic Disturbance, Non-displaced Fracture of Medial Malleolus of Right Tibia (12/25/25), Parkinsonism, Seizures, Pain, Constipation, Anxiety, Disorientation, Rhabdomyolysis, Osteoporosis, Altered Mental Status, Hypertension, Magnesium Deficiency, and Vitamin Deficiency.R6's Physician Order Sheet dated 2/27/26 documents R6 receives anti-Parkinson's, anti-psychotic, and multiple anti-seizure medications.R6's Nursing Progress Notes dated 12/19/25 document R6 experienced a fall in her own room while attempting to ambulate across the hallway to another resident's room looking for a bathroom. This note describes R6 was not wearing non-skid socks as she was bare-footed.R6's Nursing Progress Note dated 12/25/25 documents R6 experienced a fall in her own room and was wearing non-skid slippers at that time.R6's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress Note dated 2/10/26 documents R6 experienced a fall in her own room and was seated on the padded mat beside her bed with an orthopedic boot in place on R6's right foot.R6's Nursing Progress Note dated 2/15/26 documents R6 was found on the floor of her room with a bird seed bag in her hand and bird seed spilled on the floor. There was no documentation of R6's footwear or orthopedic boot for this fall.R6's Nursing Progress Note dated 2/16/26 documents R6 made two attempts to get out of her thickly padded rolling recliner and had to be reminded that she needs assistance to get up.On 2/27/26 at 10:20 AM, R6 was seated in her high-back wheelchair, her left foot dangling between the two-foot pedals, wearing regular dress socks.On 2/27/26 at 10:23 AM, V14, Licensed Practical Nurse, stated R6 does make attempts to stand up without assistance. V14 stated she had been administering anti-seizure and anti-anxiety medications to R6 as R6 appeared to be having mild seizures or was in a post-seizure refractory period. At 10:50 AM, V14 clarified R6 had made an attempt to get out of bed the prior week, and this same morning had attempted to stand up from the wheelchair. V14 stated R6 should be wearing gripper (non-slip) socks and instructed a passing Certified Nursing Assistant to place gripper socks on R6.On 2/27/26 at 1:45 PM, V2, Director of Nursing, stated she would need to find out about gripper socks for R6 but the reason R6 was not wearing gripper socks may be related to R6's use of an orthopedic boot on her right foot for two months, which was just recently discontinued (2/18/26), and R6 had recently began receiving hospice services.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatments, services, non-pharmalogical interventions, and abuse risk assessments to maintain psychosocial well-being for residents diagnosed with dementia and severe cognitive impairment. This failure affects four residents (R2, R3, R4, R5) out of four reviewed for resident-to-resident incidents on the sample list of fourteen.Findings include:R2's Demographic Face Sheet dated 2/27/26 documents R2 was admitted to the facility 6/20/24 with medical diagnoses including Dementia. R2's Minimum Data Set, dated [DATE] documents R2 could not answer any questions during a Brief Interview for Mental Status and was assessed by staff as severely cognitively impaired.R3's Minimum Data Set, dated [DATE] documents R3 completed the Brief Interview for Mental Status with a score of 4 out of a possible 15, rating R3 as severely cognitively impaired.R4's Demographic Face Sheet dated 2/27/26 documents R4 was admitted to the facility 7/3/25 with medical diagnoses including Alzheimer's Disease, Restlessness and Agitation, and Dementia with Behavioral disturbance.R5's Demographic Face Sheet dated 2/27/26 documents R5 was admitted to the facility 6/28/26 with medical diagnoses including Dementia with Agitation.R2's Nursing Progress Note dated 2/6/26 documents another resident (R3) put her hand on the right side of the face of R2.R2's comprehensive medical record did not include a risk assessment to determine if R2 was at risk for abuse, either as a victim or perpetrator. R3's Nursing Progress Note dated 2/6/26 documents R3 put her hand on the right side of another resident's (R2's) face.R3's comprehensive medical record did not include a risk assessment to determine if R2 was at risk for abuse, either as a victim or perpetrator. On 2/25/26 at 1:35 PM, V11, Certified Nursing Assistant, stated she was the sole witness to the incident between R2 and R3. V11 stated R2 and R3 were talking, then R3 seemed to get mad and smacked R2. V11 confirmed observations that she was approximately six feet away from the dining room table where R2 and R3 were seated. V11 stated she did not hear a smack sound but appeared as though R3's finger, or fingernail, contacted R2 on the cheek under the eye.R4's Nursing Progress Note dated 12/19/25 documents R4 grabbed the buttocks of an unidentified Certified Nursing Assistant (CNA) and also was found in an unidentified female resident's leaning over the top of the female resident. This note describes the female resident as very scared, very upset, startled, and in tears. This note documents the facility staff removed R4 from the female resident's room. There was no documented staff intervention for R4 after grabbing the buttocks of the CNA.R4's Nursing Progress Note dated 12/25/25 documents R4 grabbed the buttocks, breasts, and attempted to kiss an unidentified CNA. This note documented the CNA wanted a different staff member to provide care for R4, and that R4 would be monitored for further behaviors. In a separate incident on this same date, R4 grabbed the buttock of an unidentified CNA today. There was no documented intervention for this episode.R4's Nursing Progress Note dated 12/26/25 documents R4 had been placed on an anti-psychotic medication Rexulti 0.5 milligrams daily and describes further and continued grabbing of female staff and exposing his genitals while walking in the public hallway. There were no documented interventions for R4's continued grabbing of staff or exposing his genitals.R4's Nursing Progress Note dated 12/27/25 documents R4 had grabbed the buttocks of an unidentified CNA. There was no documented intervention for this episode.R4's Nursing Progress Note dated 12/29/25 documents R4 was walking in the public hallway with only a shirt and an incontinent undergarment, attempted to grab the breasts of V39, Registered Nurse, who directed R4 to watch a movie in the dining room and have a snack. A second Nursing Progress Note of this same date documents R4 was in the dining room, waited for the staff to leave, then sneaks over to the women's table. The documented intervention for this behavior was to instruct R4 to go sit at another table. A third Nursing Progress Note of this same date documents R4 was in the public hallway following female residents to their rooms and standing in the (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doorways to watch the females. A fourth Nursing Progress Note of this same date documents R4 told an unidentified CNA he would love to see her boobs. The documented intervention for this instance was to tell R4 his behavior was inappropriate and ask R4 not to do that.R4's Nursing Progress Note date 12/31/25 documents R4 making attempts to go into female resident rooms. This same note further describes staff attempting to redirect R4 away from the female resident rooms and R4 hit the staff with his walker.R4's Nursing Progress Note dated 1/1/26 documents R4 in the public hallway without clothes and staff had to make several attempts to direct R4 to put his clothes on.R4's Nursing Progress Note dated 1/3/26 documents facility staff caught R4 coming out of a female resident's room and the female resident was asleep. The intervention for this episode was to monitor R4.R4's Nursing Progress Note dated 1/4/26 documents R4 was peeking out of the doorway of his room looking back and forth down the public hallway, completely naked and urinating into the public hallway. The responding staff noted R4 had also moved his bowels on the floor of his room. The documented intervention for this behavior was to assist R4 with cleaning care and put R4 back to bed. A second Nursing Progress Note of this same date documents R4 was making continued attempts to go into female resident's rooms and despite redirection from staff continued to watch female residents intently. This same second note documents R4 was observed scooting his dining room chair closer to a female resident's chair and attempting to touch her but staff were able to reach R4 prior to contact with the female resident.R4's Nursing Progress Noted dated 1/5/26 documents R4 reached under a blanket covering a female resident and grabbed her hand. This note documented R4, and the unidentified female resident were seated in separate chairs in the dementia unit day room when the observation was made. The documented staff intervention was to tell R4 to keep his hands to himself or he would have to go to his room. This same note documents R4's anti-psychotic medication Rexulti was doubled to 1 milligram daily.On 2/25/25 at 9:55 AM, R5 was noted to be seated in the dementia unit day room in a recliner with a blanket covering her. No other residents were noted to be seated in the day room covered by a blanket throughout the survey on 2/24/26, 2/25/26, 2/27/26, 3/3/26, 3/4/26, and 3/5/26.R4's Nursing Progress Note dated 1/6/26 documents R4 touched the buttocks of an unidentified staff member. The documented staff intervention was to tell R4 that was inappropriate and to not do it again.R4's Nursing Progress Note dated 1/11/26 documents R4 attempted to grab the buttocks of an unidentified CNA which was observed by another unidentified CNA and redirected R4.R4's Nursing Progress Note dated 1/12/26 documents R4 was walking naked in the public hallway towards staff who attempted to redirect R4 but R4 grabbed the buttocks of a CNA. After this incident, staff intervention was to assist R4 to re-dress and return to bed. A second Nursing Progress Note of this same date documents R4 continued to come out of his room naked and urinated on the floor in front of a CNA. The documented intervention was to assist R4 in cleaning and to go back to bed.R4's Nursing Progress Note dated 1/20/26 documents R4 received a visit from the facility Nurse Practitioner (V3) who acknowledged R4 had been prescribed a second anti-psychotic medication Seroquel 25 milligrams every evening. V3 wrote a new prescription to increase R4's second anti-psychotic Seroquel to 75 milligrams every evening. Additionally, this same note documents V3 prescribed an antacid Tagamet 200 milligrams daily. This same note documents V3 ordered for R4 to be referred to a geriatric psychiatric hospital for a possible admission, a referral which was undocumented in R4's medical record despite documentation that V1, Administrator, had been notified of the order for the referral.R4's Nursing Progress Note dated 1/22/26 documents R4 was in the dining room, waited until all staff were out of the dining room, moved close to an unidentified female resident who was resting at a different table, then when staff returned into the dining room R4 was observed rubbing the female resident's leg. The documented staff intervention for this behavior was to separate the residents and monitor R4's behavior.R4's Nursing Progress Note dated 1/24/26 documents R4 touched, and attempted to rub on, the upper thigh of a CNA as she was clearing breakfast dishes from the dining room table. The CNA informed R4 this was inappropriate and moved away from R4. The CNA informed the unidentified Licensed Practical Nurse in charge to monitor and (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document R4's behavior. A second note of this same date documents R4 grabbed the buttock of a CNA and was redirected. This second note documents R4 had another increase in his anti-psychotic medication Seroquel.R4's Nursing Progress Note dated 1/26/26 documents R4 had been making sexual comments to staff. This same note documents facility staff reminded R4 these comments are inappropriate and continue to monitor R4's behavior.R4's Nursing Progress Note dated 2/3/26 documents an allegation that R4 touched a female's breast and was redirected by an agency CNA. This same note documents R4 threw a pillow at the agency CNA.The facility's Resident-to-Resident Incident Investigation Report dated 2/3/26 documents the unidentified female resident allegedly touched on the breast by R4 was R5. On 2/24/26 at 1:25 PM, V17, Dementia Care Unit Director, stated the agency CNA who alleged R4 touched the breast of R5 was V19. V17 stated she had not witnessed any inappropriate behaviors from R4 but did have reports from other staff about R4 grabbing them. Throughout the survey from 2/24/26 through 3/5/26, V19 did not respond to multiple phone calls with messages left requesting an interview and to return the call, including a call directly to the agency managerial staff requesting to facilitate an interview with V19.R4's Nursing Progress Note dated 2/4/26 documents V1, Administrator, requested R4 be sent to the local emergency room for evaluation.R4's Nursing Progress Note dated 2/7/26 documents R4 was observed several times to put his hands down his pants and fondle himself.R4's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 10 out of a possible 15, rating R4 as moderately cognitively impaired. R5's Minimum Data Set, dated [DATE] documents R5 could not answer any of the questions for a brief interview and was assessed by staff as severely cognitively impaired.R4's Care Plan included a section for behavioral problems, physical in nature, directed at others and R4 was not able to differentiate between socially appropriate versus inappropriate behaviors. The care planned staff interventions listed in R4's care plan included to (1/21/26) administer anti-psychotic medication Seroquel 50 milligrams in the morning and 50 milligrams in the evening, another undocumented increase. Further staff interventions were documented as (1/21/26) review medications during behavior committee meeting, (1/21/26) monitor for behavior or mood changes in relation to medication changes, (1/21/26) if (R4) is disrobing redirect him to his room and assist with re-clothing as appropriate, (1/21/26) if (R4) is urinating walk with him to the bathroom or provide a urinal in a private location, (2/5/26) provide one-to-one supervision at all times, (12/19/26) if behavior occurs tell (R4) his comments and touch make you and others uncomfortable and re-focus to an activity of interest, (12/19/26) If observed approaching a female resident while appearing agitated or making any sexual comments, refocus his attention by asking him about being a painter at (industrial equipment company), talking to him about sports, or talking about his kids, (12/19/26) When not in his room, involve R4 in activities of interest and keep him engaged through interests such as talking about sports, spending time outdoors (weather permitting), physical activities like exercise, physical games, and Mindful Moments programming to stimulate his mind such as sorting objects by shape and color, organizing objects by category. There was no documented evidence that staff implemented any of the listed non-pharmacological interventions except for repeated verbal redirection, repeated monitoring, repeated reminding R4 his actions were inappropriate, and verbal direction to go watch a movie and have a snack on one occasion.On 2/24/26 at 11:35 AM, V4, Minimum Data Set/ Care Plan Coordinator, stated she had only witnessed R4's behaviors as yelling, screaming, and hitting at people.On 2/24/26 at 11:45 AM, V6, Registered Nurse, stated she had not witnessed R4's inappropriate behaviors but did have R4's behaviors reported to her from other staff members which she would document in R4's chart and notify the (former) Director of Nursing.On 2/24/26 at 11:50 AM, V7, Licensed Practical Nurse, stated she had not witnessed any of R4's inappropriate behaviors but did have CNAs report to her about R4's behaviors. V7 continued to state one incident that stands out in her memory was R4 waiting for all staff to leave the dining room and touching a female resident who was sitting with her eyes closed asleep. V7 stated she couldn't remember if the touch was on the female's arm or leg.On 2/24/26 at 12:00 PM, V8, V9, and V10, CNAs, all stated they had not (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	witnessed any behaviors exhibited by R4 and had no problems providing R4 care.On 2/24/26 at 12:10 PM, V11, V12, and V13, CNAs, all stated they had not witnessed any inappropriate behaviors by R4.On 2/24/26 at 1:15 PM, V15, CNA, stated she had not witnessed any inappropriate behaviors from R4.On 2/24/26 at 1:20 PM, V16, CNA, stated R4 had made an attempt to reach under her shirt but she had not witnessed any inappropriate behaviors between R4 and other residents.On 2/24/26 at 1:30 pm, V18, Agency Registered Nurse, stated she had not witnessed inappropriate behaviors from any resident.On 2/24/26 at 1:35 PM, V20, CNA, stated he had witnessed R4 in the doorway of a female resident's room but was able to guide R4 away from the door.R4's Nursing Progress Note dated 2/21/26 documents R4 was sent to the local hospital for treatment of an infected chest port. R4's Nursing Progress Note dated 3/2/26 documents R4 had returned from the hospital after treatment for his infected chest port and had experienced a mild stroke during his hospital stay.On 3/3/26 at 9:40 AM, R4 stated he was well taken care of at the facility, received showers according to schedule, had plenty to eat, and had plenty of activities to engage in. R4 stated he did not have a girlfriend but there were many women who fit the bill for women he would like to have as a girlfriend. R4 stated he had to be careful or else he or the women might become attached. R4 denied touching any female residents or staff inappropriately on their buttocks or breasts. R4 concluded by stating he considered the residents and staff to be family and wouldn't want to make trouble for them.On 3/3/26 at 11:15 AM, V14, Licensed Practical Nurse, stated she had not witnessed any inappropriate behaviors from R4 and only had hearsay knowledge of the allegation made by the agency CNA (V19) that R4 had touched the breast of R5.On 3/3/26 at 12:55 PM, V40, Care Plan Coordinator in Training, stated she had worked in the facility as a Licensed Practical Nurse prior to the care plan position but had not witnessed any of R4's inappropriate behaviors nor had any staff reported directly to her about any inappropriate behaviors exhibited by R4.On 3/3/26 at 2:30 PM, V44, Social Services Designee, and V4, Minimum Data Set/ Care Plan Coordinator, stated and confirmed V44 had been in the training process for the documentation required to assess resident's social histories and behavioral risks. V4 stated she was not aware of any specific abuse or neglect risk assessment forms or documents utilized by the facility. V4 and V44 searched in the computer and stated there is a social history assessment completed for all residents which does include any history of abuse or sexual abuse. V4 stated the question was used to evaluate a resident's social history and not directed as a risk assessment. V4 stated the question also included Have you or a loved one ever experienced a car or plane crash, been in a war, been kidnapped, been in a natural disaster, had a life-threatening illness. V4 stated this document was used to determine if a resident had a prior history of a traumatic event and would require special services for trauma-informed care provisions, and not for a resident-to-resident or staff-to-resident abuse situation.The facility's Abuse Prevention policy dated 11/28/19 documents, Special attention will be given to identifying behavior that increases the resident's potential for abusing self or others or being the victim of abuse. These behaviors would include residents with a history of aggressive behaviors, residents who have behaviors such as; entering other residents rooms, residents with self-injurious behaviors, residents with communication disorders, and those who require heavy nursing care and / or are totally dependent on staff. Appropriate interventions to address identified behaviors will be included on resident care plans, and reviewed as / when change occurs. These interactions will be communicated to the direct care staff.On 3/4/26 at 10:21 AM, V1, Administrator, confirmed the Social History Assessment was used to inform any trauma-related care and not for a risk of abuse. V1 stated the electronic record system used by the facility does not provide an actual abuse risk assessment. V1 stated interventions in a resident's care plan are expected to be implemented. V4, present during the interview with V1, stated the care plan changes must be communicated. V1 and V2, Director of Nursing, present during the interview with V1, concluded by stating the facility can not fix what already happened but they can fix it going forward.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a physician ordered high protein supplement and failed to honor a resident's food preference. These failures affect one of three residents (R8) reviewed for dietary intake/meals on the sample list of 14.Findings include:R8's Current Diagnose List includes: Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Vitamin D Deficiency, Unspecified, Vitamin E Deficiency, Unspecified, and Ascorbic Acid Deficiency and Disorder of Teeth and Supporting Structures, Unspecified.R8's Dietary Physician Order dated February 04, 2026, documents R8 is to have a Regular HP (High Protein) supplement TID (three times a day) with meals. 07:30 AM, 12:00 PM, and 05:30 PM.R8's Minimum Data Set, dated [DATE] documents the following: R8's Brief Interview of Mental Status score as 11 out of a possible 15 indicating, moderate cognitive impairment.On 2/24/26 at 12:20 pm R8 was served Chicken Cordon Bleu as the entree for lunch. R8 was not served the High Protein milkshake supplement documented on R8's physician ordered/meal ticket. R8's same physician ordered/meal ticket documents R8 dislikes chicken.On 2/24/26 at 12:58 pm R8 stated he does not like chicken but the ham inside with the chicken made some difference, and he could not taste the chicken, only the ham. R8 stated I really like the milkshakes (High Protein) I get. I am not sure why some days, I get one at every meal and some days, I don't get any at all. It is written on my ticket. My guess is they must run short of them. They taste good so a lot of people probably get them to.On 2/24/26 at 1:03 pm V8, Certified Nursing Assistant (CNA) confirmed R8 did not receive R8's high protein milkshake and received chicken cordon bleu in error. It is on his ticket (physician order/meal ticket). We messed up.On 2/25/26 at 11:15 am (V25) Dietary Manager stated (R8) was not supposed to get chicken yesterday. I am not sure if chicken does not taste good to him, or if it causes gastric discomfort, either way it is noted on his diet order ticket, as a dislike. It should be honored. My (the facility) Dietary Aides are supposed to check the ticket against what goes on the trays. The CNA should be checking the diet order tickets as well. They serve the trays to the residents. As far as (R8's) high protein supplement, we add those supplements in the kitchen. I guess that was our error, we (kitchen staff) missed that. He is supposed to be getting that three times a day.On 2/25/26 at 11:35 am V2, Director of Nursing (DON) reviewed and confirmed R8's Physician order/ dietary ticket and confirmed R8 dislikes chicken and was to receive a high protein milkshake with his meal. V2 stated staff will be reeducated on paying attention to the meal tickets when serving resident meals.