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Future Care Irvington	22 South Athol Avenue Baltimore, MD 21229

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation and facility staff interview, it was determined the facility failed to ensure residents had access to their call bell. This was evident for 7 Residents (#7, #18, #39, #133, #109, #112, #47) of 65 residents included during the surveyor's initial tour of the facility during the recertification survey. The findings include: On 08/28/25 at 8:45 AM the surveyor commenced to interview Resident #7 at the resident's bedside. The surveyor observed that Resident #7's call bell cord and it's activation pad (to operate the call bell) was wrapped around the bedframe at the head of the bed. On 08/28/25 9:02 AM the surveyor and the unit manager, Staff #9 entered Resident #7's room. The surveyor interviewed Resident #7 who said that he/she could not locate his call bell device (a flat pad attached to a cord) to use for when he/she needed help. Staff #9 attempted to locate the call bell device on the resident's person and within their bed sheets, however it was found hooked around the left side of the bedframe (near the head of the bed) which was out of the resident's reach. The surveyor observed Staff #9 untangle the call bell cord and place it under Resident #7's right hand. On 8/38/25 at 9:14 AM the surveyor interviewed Staff #9 who revealed that Resident #7 was given morning hygiene care by a geriatric nursing assistant, and they did not place the resident's call bell within his/her reach afterwards. On 08/28/25 at 8:37 am the surveyor observed Resident #18 in bed with their call bell on the floor on the right side of the bed. Resident #39 call bell was across the overbed light which was not in reach. At 8:48 am during observation rounds the surveyor observed Resident #133 in bed without their adaptive call bell within reach. The resident verbalized being unable to use their left hand and asked the surveyor to place the adaptive call bell near their right hand. At 9:06 am the surveyor observed Resident #109 call bell on the floor. At 9:12 am the surveyor observed Resident #112 call bell on the floor on the left side of the bed. At 9:29 am the surveyor observed Resident #47 call bell hanging on their overbed light. On 08/28/25 at 12:06 pm during an interview with Geriatric Nursing Assistant (GNA) #13 the surveyor asked them to describe how their morning is started. GNA #13 verbalized they go into the residents' room, greet the residents, get them cleaned up, change the sheets, and make sure they have their call bell. Before leaving the room the residents' bed is put into the lowest position. They surveyor (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verbalized observing multiple residents without their call bell during observation rounds. On 08/28/23 at 12:16 pm during an interview with Certified Medication Aide #14 the surveyor asked when they verify the residents have their call bell. CMA #14 verbalized they make sure the residents have their call bell and bed control when they enter the residents' room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews it was determined that the facility staff failed to report and complete maintenance concerns on Unit 1 South in a timely manner. This deficient practice was widespread on Unit 1 South and was discovered during the recertification survey. The findings include:On 08/28/25 at 8:24 AM during observation rounds on Unit 1 South the surveyor observed multiple maintenance concerns. At 8:37 AM the surveyor observed the lights exposed in the bathroom in room [ROOM NUMBER] bathroom; the light cover was on the floor beside the sink in the bathroom. At 8:42 AM the surveyor walked in Room#103 and observed a large hole in the wall behind the resident's bed on the left side. The surveyor walked to the right side of the bed and observed a large hole in the wall behind the bed. There were damaged tiles on the floor under the resident's bed. At 8:53 AM while in room [ROOM NUMBER] the surveyor observed marring on the wall behind the resident's bed, and an outlet had exposed wires. At 8:58 AM the surveyor observed a hole in the wall in the bathroom near the right side of the commode in room [ROOM NUMBER]. In room [ROOM NUMBER] the door to the clothing armoire was loose and hanging. At 9:12 am the surveyor observed the first and second drawers were broken to a resident's bedside table in room [ROOM NUMBER]. At 9:18 AM the surveyor observed a hole in the wall behind the right side of the bed in room [ROOM NUMBER]. At 9:49 AM the surveyor observed an electrical outlet with exposed wires in room [ROOM NUMBER].On 08/28/25 at 12:10 PM the surveyor asked Geriatric Nursing Assistant (GNA) #13 if the observed a maintenance concern on the unit, what would they do. GNA #13 verbalized they would let the nurse know about the problem. If the nurse were not available, they would let someone in the maintenance department know.On 08/28/25 at 12:13 PM the surveyor asked Certified Medication Aide #14 what the process was for reporting maintenance concerns. CMA #14 verbalized there is a maintenance log on the unit to report maintenance concerns. The maintenance log is kept behind the desk on the shelf. They document the location of the concern, the problem, and the date.On 08/28/25 at 12:20 PM during an interview with Maintenance Director #15 he/she verbalized they have a log to enter maintenance concerns, and the logs are checked one - two times a day. They have a preventative maintenance log in TELS. The system lets the maintenance staff know when something is scheduled. They attempted to start checking the residents' rooms monthly. Every Tuesday they do rounds on the units. The surveyor and Maintenance Director #15 walked the unit simultaneously to visualize all the surveyor's maintenance concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility staff interview and review of facility policy it was determined that the facility failed to maintain an effective infection prevention and control program. This was found to be evident for 7 of 7 residents reviewed for infection control practices and was widespread on Unit 1 South.The findings include: 1) During medication administration, the surveyor observed that Employee #20 failed to practice infection control by not washing their hands or using hand sanitizer between providing residents with medication. It was noted that Employee #20 used a glucometer on residents #20, # 25, 153, and #193 without washing their hands or using hand sanitizer and did not clean the glucometer between residents. 2) On September 2, 2025 at 9:30 PM spoke with the Director of Nursing (DON), The Regional Clinical Services Manager (#3) and the Administrator and asked them what their expectations for infection control during medication administration. The DON stated that they expected the nurse to wash and/or sanitize their hands between medication administration to residents and that all equipment used in resident care to be cleaned between usages. 3) On 08/27/2025 at 9:56 AM Resident #170's nasal cannula tubing, including the part that goes in the resident's nose, was observed on the floor. Resident #170's nebulizer mask was not covered but was lying on the bedside table next to open peri-care wipes, skin care cream, peri-spray, and an open container of Boost. On 08/27/2025 at 10:04 Staff #12, Licensed Practical Nurse (LPN) was interviewed and asked if Resident #170's nasal cannula should be on the floor. Staff #12 replied no, stating it should be in the resident's nose, and said he/she would get new oxygen tubing to replace the tubing on the floor. Staff #12 was then asked if the nebulizer mask on the bedside table was used daily for Resident #170's ordered nebulizer treatments, to which he/she replied yes. When asked if the nebulizer mask should be lying uncovered next to open peri-care products and an open container of Boost, Staff #12 replied no and stated he/she would remove and replace the mask and cover it. 4) During observation rounds on 08/28/25 at 8:28 AM the surveyor observed several infection control problems on Unit 1 South. In the shared bathroom in room [ROOM NUMBER] the surveyor observed an unlabeled basin on top of the paper towel dispenser, a bedpan on the floor beside the commode, and an unlabeled fracture bed pan on the metal bar beside the commode. At 8:33 AM the surveyor observed a yellow kidney basin inside of a bedpan on Resident #176 wheelchair cushion. The surveyor also observed grey slippers on top of the refrigerator. At 8:37 am the surveyor observed two unlabeled basins on the floor in room [ROOM NUMBER]. Certified Nursing Assistant #4 confirmed the surveyor's findings. At 8:53 AM while in room [ROOM NUMBER] the surveyor observed a bed pan on the floor near the left side of the commode in the bathroom. At 9:09 AM the surveyor observed a kidney basin on the floor under the sink in room [ROOM NUMBER]. At 9:18 AM the surveyor observed two unlabeled bedpans on the bathroom floor in room [ROOM NUMBER]. At 9:23 AM the surveyor observed two unlabeled urinals, a basin on the floor, and three unlabeled basins in room [ROOM NUMBER]. At 9:26 AM the surveyor observed Resident #49 oxygen tubing on the floor on the right side of the bed. On 08/28/25 at 12:36 PM the surveyor informed Infection Preventionist #5 the infection control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concerns observed on the unit. Also, the surveyor shared pictures to verify the concerns were valid. Infection Preventionist #5 verbalized the nursing staff was instructed to write the room and bed number on the residents' personal care equipment. The staff were provided permanent markers to label the residents' personal care equipment. They are not sure why the equipment was on the floor. They will evaluate the staff and agency personnel because that was not the standard of practice. Rounds will continue to be done, and they will follow up with the Nurse Manager.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Number of residents sampled: Number of residents cited: Based on observation and an interview with facility staff, it was determined that the facility failed to maintain a resident's privacy by having their foley catheter bag uncovered. This was evident for 1 (Resident # 170) of 3 residents reviewed during the annual recertification survey.The findings include:GUIDANCE S483.10(h)Each resident has the right to privacy and confidentiality for all aspects of care and services. A nursing home resident has the right to personal privacy not only his or her own physical body, but of his or her personal space, including accommodation and personal care.On 08/27/2025 at 9:52 AM, during an observation of Resident #170, the foley catheter bag was seen hanging in the center of the bed upon entering the room. Amber-colored urine was visible in the foley catheter bag from the doorway.Staff # 12, Licensed Practical Nurse (LPN) was interviewed and asked about the policy/practice for covering foley catheter bags with a privacy bag. Staff #12 confirmed their policy was to keep foley bags covered with a privacy bag. Staff #12 acknowledged that Resident #170's catheter bag was not covered with a privacy bag and stated they would cover it.

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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. Based on interviews and record review it was determined that the facility failed to develop and implement a comprehensive care plan to meet the need of a Resident. This was found evident of 1 (Resident #8) out of 65 residents reviewed during the survey. The findings include: On 9/2/25 at 7:56 AM, the surveyor reviewed Resident #8's medical record. The review revealed that Resident #8 had a past psychological history that included schizophrenia and depression. On 9/2/25 at 8:24 AM, the surveyor reviewed Resident #8's care plan. The review revealed a care plan created on 1/13/23 that stated Resident #8 had a mood disturbance related to changing in health status, depression and bipolar disorder. The surveyor was unable to find any documentation in the medical record that indicated Resident #8 had bipolar. On 9/2/25 at 10:54 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that the care plan was created in error and that Resident #8 did not have bipolar disorder. She further stated that the Unit Manager that created the care plan no longer works at the facility and was unable to find out why the care plan was created.

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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, record review and interview, it was determined that the facility failed to 1) reassess the effectiveness of the interventions and review/revise them (Resident #25) and 2) failed to invite a resident to attend and participate in their care plan meeting (Resident #186). This was found on review of 65 resident's care plans. The findings include: 1) Observation, on 08/28/2025 at 9:17 AM, Resident #25 with their feet ace-wrapped from toe to knee level and the resident was sitting in the chair with their feet down to the floor. During a record review on 08/29/2025, at 10:42 AM, it was noted that Resident #25 was admitted to this facility from the hospital on [DATE], due to hospitalization of septic leg wounds. The admission medical diagnoses included: non-pressure ulcers of the lower legs, ongoing hemodialysis, Type II diabetes mellitus, leg pain, and peripheral vascular disease. Peripheral Vascular Disease (PVD) is a systemic disorder that involves the narrowing of peripheral blood vessels (vessels situated away from the heart or the brain). This happens because of narrowing body arteries as arteriosclerosis, or a buildup of plaque, and can happen with veins or arteries. When plaque accumulates, it may result in blood clots and dangerously limit the amount of oxygen that circulates to the legs. Observation, on 08/29/2025 at 12:50 PM, Resident #25 remained in the same position and there was no staff available to assist with changing position or helping into bed. On the same day, at 01:05 PM the Unit Manager Staff #6 stated that wound care plans were initiated on 07/14/2025. However, it was noted that Resident #25 was not consistently adhering to the most interventions, specifically keeping feet elevated at all times or turning/repositioning at least every two hours. A record review conducted on August 29, 2025, at 2:01 PM, from the wound assessment documentation, revealed that Resident #25 had a total of 12 lower leg wounds (wound areas per staff- right heel; right dorsal foot; left shin; left heel; right shin; right lateral calf; right lateral foot) on admission. Only one wound was healed from wound documentation. Also found that all wound care plans were initiated on 07/14/25, to address Resident #25's impaired skin integrity related to vascular insufficiency, with the goal of decreasing wound areas. Staff documentation often indicated that the resident had been unable to keep his feet elevated or remained in bed all day, and had not been repositioned at least every two hours. It appears that interventions had not been revised since 07/14/2025, to reflect these challenges or to include this resident's input. Interview, on 09/02/2025 at 10:05 AM, reviewing above findings with the Administrators that revising of care plans' interventions was an on-going process, however, the facility staff failed to revise them as a deficiency concern. 2) On 8/29/25 at 9:28 AM, the surveyor conducted an interview with Resident #186. During the interview Resident #186 stated that he/she had not been involved in the care planning process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/2/25 at 12:07 PM, the surveyor reviewed Resident #186's medical record. The review revealed that Resident #186 had been in and out of the facility multiple times in 2025. On 6/20/25 Resident #186 was admitted to the facility and on 6/27/25 Resident #186 had a Minimum Data Set (MDS) admission assessment completed. Next the surveyor requested care conference notes and attendance documentation for the care plan meeting following the 6/27/25 MDS admission assessment. On 9/2/25 at 1:37 PM, the surveyor reviewed the documentation with the Regional Clinical Services Manager Staff #3. Resident #186 was not on the attendance log, and the care plan meeting note written by Registered Nurses (RN) #29 for the meeting date of 7/8/25 only referenced that the care plan was reviewed by the interdisciplinary team. There was no mention of the Resident. Staff #3 stated she would follow-up with the Social Worker for clarification if the Resident was in attendance. On 9/2/25 at 1:54 PM, the surveyor conducted an interview with Social Service Assistant, SW #28. During the interview SW #28 stated that Residents are invited to their care plan meeting with a written invitation and if they attend then their name should be added to the attendance log. The surveyor reviewed the attendance log and care plan note with the Social Worker and asked if Resident #186 was in attendance and part of the care plan meeting on 7/8/25. SW#28 stated she believed the care plan meeting was done at the bedside but could not remember for certain. The surveyor asked if there was documentation that Resident #186 was invited to the meeting. SW #29 confirmed there was no documentation to show that Resident #186 was invited to the meeting or that he/she attended the care plan meeting.

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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. Number of residents sampled: Number of residents cited: Based on observations and interviews it was determined that the facility staff failed to practice according to professional nursing standards as evidenced by a nurse removing a pain patch from a resident and placing it on the windowsill. This deficient practice was evidenced in 1 (#18) in 1 resident observed with a pain patch that was not properly discarded. This deficient practice occurred during the recertification survey. The findings include:On 08/28/25 at 8:37 AM while speaking with Resident #18 the survey observed a pain patch dated 08/26, 7:00 AM - 3:00 PM shift was on the windowsill. Geriatric Nursing Assistant (GNA) #4 confirmed the surveyor's findings.On 08/29/25 at 1:02 PM during an interview with the Director of Nursing (DON) the surveyor asked what the expectation of the nursing staff when removing a resident's pain patch. The DON verbalized the expectation was for the nurse to discard the pain patch.On 08/29/25 at 2:03 PM during an interview with Registered Nurse (RN) #17 the surveyor asked to explain the process of removing a resident's pain patch. RN#17 verbalized they would first check the resident's order before the patch was removed. They would wash their hands and apply gloves, then remove the patch. A clean washcloth would be used to clean the area where the patch was located. The patch would be discarded in the wastebasket. The nurse would document on the medication administration record that the patch was removed.

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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 record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was found evident in 1(Resident #77) out of 3 Residents reviewed for Activity of Daily Living (ADL) cares. The findings include:On 9/2/25 at 9:25 AM, the surveyor reviewed Resident #77's medical record. The review revealed Resident #77 had a Minimum Data Set (MDS) assessment dated [DATE] that assessed Resident #77 as Dependent (helper does all the effort) for shower/bathe self category. Also dependent for upper and lower body dressing and toileting. Next the surveyor reviewed Resident #77's Task documentation for bathing/showering for the month of August 2025. The review revealed that on 8/5/25, 8/11/25 8/28/25 and 8/31/25 Resident #77 was documented as set up or clean up (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) by two different staff members. One of the staff two members additionally documented that Resident #77 was dependent for bathing 15 other days in August 2025. On 9/2/25 at 10:32 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the documentation with the DON and asked, if Resident #77 was dependent on staff for bathing, then how was a bath completed on the 4 days in August when it was documented that he/she was set up. The DON confirmed that the Resident was dependent on staff and that if a bath were completed it would have been completed completely by staff and not a set up. At the time of exit no additional information was given to indicate appropriate Activities of Daily Living (ADL)'s care were provided on 8/5/25, 8/11/25 8/28/25 and 8/31/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Number of residents sampled: Number of residents cited: Based on observations, record reviews, and staff interviews, it was determined that the facility failed to ensure oxygen therapy was set up in accordance with professional standards of practice. This was evident for 1 (Resident #122) out of 3 residents reviewed for respiratory care during the annual survey.The findings include:On 08/27/2025 at 9:51 AM, the surveyor observed that the oxygen tubing was not connected to the humidifier bottle, and the end of tubing was lying on the floor. There was no date label observed on the tubing or the humidifier bottle. LPN #1 was notified that the oxygen was disconnected and laying on the floor. Licensed Practical Nurse (LPN) #1 verified that she did not see labeling and stated she would provide Resident #122 with new tubing.On 08/27/2025 10:27 AM Assistant Director of Nursing was notified of the missing oxygen label and administration tubing lying on the floor disconnected. She stated she would investigate the concern.The Director of Nursing confirmed that she was aware of the oxygen tubing and labeling concern identified on 09/03/2025 at 01:20 PM.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Number of residents sampled: Number of residents cited: Based on review of narcotic counts, it was determined that the facility failed to ensure that narcotic medications were consistently accurate. This was evident for 2 of 6 medication carts reviewed for accuracy and completeness of controlled medication storage and documentation. The findings include: Controlled substance medications, due to their potential for abuse and addiction, are required to be thoroughly tracked and accounted for by the facility. This includes but is not limited to an accounting of controlled substance in storage whenever they are administered to a resident occurs. Any discrepancy in the count from what is expected to be found must be addressed immediately. 1. While performing the medication storage facility task, the surveyor while inspecting 6 medication carts discovered discrepancies in the controlled substance log. The following controlled substance were found to be in discrepancy: Resident #160's Oxycodone; Resident #27's Oxycodone and Lyrica; Resident #129's Diazepam and Resident#195's Tramadol. 2. On September 2. 2025 at 9:30 PM the surveyor spoke with the DON, the Administrator and the Regional Clinical Service Manager (#3) and requested their expectations for maintaining an accurate control substance count. They confirmed that they expected the nurse to sign out any control substance that they are administering.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215219	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Irvington	22 South Athol Avenue Baltimore, MD 21229

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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 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. Number of residents sampled: Number of residents cited: Based on observation and facility staff interview, it was determined that the facility failed to properly label bulk medications with the date that included month, day and year and to properly date multi-dose insulin injectable pens when they are opened. This was evident for 3 of 6 medication carts that were reviewed.The findings include:1. While conducting the Medication Storage and Labelling facility task, it was observed that in 3 of the 6 medication carts that the bulk medication had either an incomplete date indicating when the medication was opened or no date at all. It was also noted that an open insulin pen was not labelled with the date the medication was opened.2. On September 2, 2025, at 9:30 PM spoke with the Director of Nursing (DON), The Regional Clinical Services Manager (#3) and the Administrator and asked them what their expectations for the labelling of bulk medication and other medications when they are opened. The DON stated that they expected the nurse to date any medication with the date it was opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215219	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Irvington	22 South Athol Avenue Baltimore, MD 21229

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, it was determined that the facility failed to provide sugar substitute as specified by the ordered diet. This was found to be evident for 1 (#86) out of 3 residents investigated for food preferences. The findings include:The primary purpose of a Consistent Carbohydrate diet is to manage blood sugar levels in individuals with diabetes or prediabetes. By maintaining a steady intake of carbohydrates, the body can better regulate insulin production and prevent blood sugar spikes or crashes.On 08/29/2025 at 12:29 PM, the surveyor observed Resident #86's lunch tray. Resident #86 stated that the facility served regular sugar instead of sugar substitute on the tray. He/She further stated, I am a diabetic and should not be served regular sugar. The surveyor observed the tray card provided with the meal. It read CCHO (Consistent Carbohydrate), Dysphagia 3, Thin 1350 fluid restriction/day and specified sugar substitute under condiments. At 12:37 PM on 8/29/2025, LPN #18 confirmed that the tray contained sugar, while the menu specified sugar substitute. LPN #18 offered to provide sugar substitute to Resident #86. During an interview on 09/02/2025 at 1:18 PM, Registered Dietician (RD) #25 stated that a typical CCHO diet would have sugar substitute. RD #25 provided the Dining Service Menu Guide titled CCHO Diet (LCS) (Consistent Carbohydrate Limited Concentrated Sweets) which stated, the CCHO diet utilized sugar substitute. On 09/03/2025 at 1:20 PM, the Director of Nursing confirmed that RD #25 informed her of the concern.