STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225546	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Merrimack Valley	80 Boston Road Billerica, MA 01862

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review, and interviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#14) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluids and waste products from the blood when the kidneys are not able to) out of a total sample of 25 residents. Specifically, for Resident #14 the facility failed to ensure nursing scheduled his/her phosphate binder (medication that is essential for managing elevated phosphate levels in the blood, a condition known as hyperphosphatemia. This condition often occurs in residents with chronic kidney disease because their kidneys are less able to excrete phosphate. High phosphate levels can lead to various health issues, including weakened bones and cardiovascular problems) to be administered with meals and snacks as recommended by the dialysis center. Findings include: Review of the facility policy titled, Hemodialysis Offsite Policy, dated as revised 9/16/25, indicated the facility assures that each resident receives care and services for the provision of offsite hemodialysis dialysis consistent with professional standards of practice. This includes: 3. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. - Procedure3. The facility and dialysis facility dietitians should coordinate the nutritional care including monitoring, documenting, and deciding how and when to address weight changes and nutrition issues.- Communication Between the Dialysis Center 3.The communication process should include how the communication will occur, who is responsible for communicating, and where the communication and responses will be documented in the medical record, including but not limited to: a. Timely medication administration (initiated, administered, held or discontinued) by the nursing home and/or dialysis facility; andb. Physician/treatment orders, laboratory values, and vital signs. Resident #14 was admitted to the facility in April 2025 with diagnosis including diabetes, heart failure, chronic kidney disease and dependence on renal dialysis. Review of the most recent Minimum Data Set (MDS) assessment, dated 10/22/25, indicated that Resident #14 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #14 required dialysis. Review of Resident #14's plan of care related to therapeutic diet needs, dated 10/23/25, indicated:- Registered Dietitian (RD) to evaluate and make diet change recommendations as needed (PRN). Diet education as needed per collaboration of needs with dialysis (renal) RD. - Administer medications as ordered.- Lab/diagnostic work as ordered. Report results to physician and follow-up as indicated.-Receives dialysis. Send to dialysis on Tuesday /Thursday / Saturday bag lunch. Collaborate care with hemodialysis. Review of Resident #14's physician's order, dated 8/5/25, indicated: -Dialysis Resident: Receives dialysis. Send to dialysis on Tues/Thurs/Sat pick up at 10:00 A.M. Review of Resident #14's physicians order, dated 10/28/25, indicated:- GIVE CALCIUM ACETATE 667 milligrams (mg) WITH MEALS OR SNACK, three times a day for kidney health. Scheduled three times daily at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of the facility's meal truck delivery time form, dated as current, indicated the following meal truck delivery times for the C-Unit: -Breakfast: 7:40 A.M., -Lunch: 12:00 P.M., and -Dinner: 5:00 P.M. Review of Resident #14's most recent NUTRITION: Quarterly Nutrition Data Collection. - V 2 assessment, dated 10/23/25, indicated:-phosphorus level is high.Summary: October 2025 monthly dialysis labs indicate corrected calcium 8.3 (Low), phosphorus 7.7 (High), same as September, dietary interventions implemented (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after September level of 7.7 milligrams/deciliter (mg/dL). Communications with hemodialysis dietitian, indicate next step to address phosphorus with a binder - calcium acetate suggested due to his/her low corrected calcium. Review of Resident #14's hemodialysis form titled Nutrition and Blood Test Reports, dated 12/4/25, indicated:Phosphorus: Goal of 3.0 to 5.5 mg/dLDraw Date: 11/4/25 6.4 mg/dLDraw Date: 12/2/25 6.6 mg/dLNotes and comments: Reach the goal for health bones and heart. Take phosphorus binder as prescribed. Review of Resident #14's form titled Pre/Post Dialysis Communication from the Dialysis Dietitian, dated 12/4/25, indicted:- Lab result phosphorus 6.6, remains high, continue to provide phosphorus binders with oral intakes with meals and snacks. During an interview on 12/9/25 at 10:00 A.M., Resident #14 said that he/she was waiting to go dialysis. Resident #14 said that he/she takes a bag lunch with him/her to dialysis and he/she does not take any medications. Resident #14 said that he/she is back at the facility for dinner. During an interview on 12/10/25 at 8:40 A.M., Nurse #3 said that he obtained the recommendation for Resident #14's phosphorus binder, and he said the order should be scheduled with meals and snacks. During an interview on 12/10/25 at 8:43 A.M., Nurse #6 said that Resident #14 receives a phosphorus binder, and she said the medication should be given with meals and with snacks. Nurse #6 said that she was not sure why the order was in the computer to be given at 2:00 P.M, because that is after his/her lunch. Nurse #6 said that she does not work the evening shift and she reviewed the order, and she said that dinner time medications are to be scheduled at 5:00 P.M. During an interview on 12/10/25 at 8:59 A.M., Nurse #1 said Resident #14 is on a phosphorus binder and the medication should be taken with meals and snacks according to pill bottle. The surveyor and Nurse #1 reviewed Resident #14's medication bottle that indicated:- Calcium Acetate 667 mg capsule, take one capsule three times daily and with snacks. Take with meals. During an interview on 12/10/25 at 10:02 A.M., Unit Manager #1 said that phosphorus binders should be scheduled to administered with meals, and she said that Resident #14's were not scheduled correctly. Unit Manager #1 said that the phosphorus binder should be scheduled at 8:00 A.M, 12:00 P.M., and 5:00 P.M. During an interview on 12/10/25 at 10:50 A.M., the Director of Nursing said that nursing should have transcribed the phosphorus binder to be administered during mealtimes as recommended by the dialysis center. The DON said that the phosphorus binder should be scheduled at 8:00 A.M, 12:00 P.M., and 5:00 P.M., and there should be an order as needed for staff to administer the medication with snack. During an interview on 12/10/25 at 11:51 A.M., the Physician said that Resident #14 is prescribed a phosphorus binder for his/her elevated phosphorus levels. The Physician said that the medication is to be given during meals as the medication binds phosphorus from food. The physician said this is important because Resident #14 has kidney disease and he/she has elevated phosphorus levels.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure two Residents (#85 and #113) were free from significant medication errors, out of a total sample of 26 residents. Specifically,1. For Resident #85, the facility failed to ensure Nurse #3 administered the correct dose of furosemide on twelve occasions.2. For Resident #113, the facility failed to ensure nursing transcribed the correct dose of lisinopril from his/her hospital discharge medication list resulting in Resident #113 receiving the incorrect dose of lisinopril on four occasions. Findings include: 1. Review of the facility policy titled, Administration of Medications, dated 9/9/25, indicated the facility will ensure medications are administered safety and appropriately per physician's order to address residents' diagnosis and signs and symptoms.2. Staff who are responsible for medication administration will adhere to the 10 rights of medication administration. c. Right Dose. Check the Medication Administration Record (MAR) and the physician's order before medicating. Resident #85 was admitted to the facility in October 2023 with diagnoses including chronic kidney disease stage three and congestive heart failure (CHF). Review of the most recent Minimum Data Set (MDS) assessment, dated 9/17/25, indicated that Resident #85 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #85 received a diuretic medication. Review of Resident #85's physician's order, dated 11/5/25, indicated: -Lasix Oral Tablet (Furosemide, diuretic medication), give 30 milligrams (mg) by mouth in the morning for CHF. On 12/9/25 at 8:38 A.M., during the medication administration task, the surveyor observed Nurse #3 prepare medications for Resident #85. Nurse #3 obtained a medication card of furosemide 20 milligrams (mg) cut in half to equal 10 mgs. The medication card indicated to give one half tablet (10mg) with one whole tablet (20 mg) for a total dose 30 mg in the morning. Nurse #3 only removed one half tablet from the medication card. On 12/9/25 at 9:01 A.M., Nurse #3 had committed to administering only the one-half tablet of furosemide to Resident #85. Nurse #3 said that he only placed one half tab tablet in the medication cup, and he re-reviewed the order with the surveyor. Nurse #3 showed the surveyor another card of furosemide 20 mg tablets and then Nurse #3 said he had only been administering this one-half tablet since the order changed about a month ago. Nurse #3 administered Resident #85 only 10 mg of furosemide despite the order for 30 mg and he returned to the medication cart with the surveyor. Nurse #3 was unable to comprehend his error. The surveyor immediately reported the medication error to Unit Manager #1. During an interview on 12/9/25 at 9:11 A.M., Unit Manager #1 said that Nurse #3 should administer the correct dose of furosemide. During a follow-up interview on 12/9/25 at 9:35 A.M., Unit Manager #1 said that the order for the furosemide was unclear in the electronic health record, and she clarified the order. Unit Manager #1 said that she reviewed the order with Nurse #3, and she said that he now understood his mistake. During a follow-up interview on 12/9/25 at 9:38 A.M., Nurse #3 said that he did not realize the error he had made with the furosemide and he said that he has been working the medication cart for over a month and he has been administering incorrect dose of furosemide. Review of Resident #85's Medication Administration Record, between 11/17/25 through 12/9/25, indicated Nurse #3 administered the furosemide twelve times. During an interview on 12/10/25 at 10:50 A.M., the Director of Nursing said that nursing should administer the correct dose of furosemide to prevent medication errors. During an interview on 12/10/25 at 11:52 A.M., the Physician said that Resident #85 is prescribed furosemide for heart failure and the medication is used to keep the fluid off the heart. The Physician said that nursing should administer the correct dose of furosemide to prevent errors. 2. Review of the facility policy titled, Medication Reconciliation across the Continuum of Care, dated as revised 9/9/25, indicated medications will be reconciled by the licensed nurse. Clinically significant medication issues identified will be communicated to the physician, acted upon, and documented in the medical record. 3. The home medication listing (if available), the physician admitting orders, and the hospital transfer form (if coming from a hospital) are received by a licensed (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse who reconciles the medication lists, phones the physician if necessary for clarification, obtains physician's orders and then updates the electronic health record. Resident #113 admitted to the facility in December 2025 with diagnoses including osteoarthritis of the hip, hypertension, and spinal stenosis. Review of Resident #113's NRSG: Admission/readmission Collection Tool - V 6 assessment, dated 12/5/25, indicated Resident #113 was alert and oriented to person, place, time, and situation. Review of Resident #113's NRSG: Medication Reconciliation Form assessment, dated 12/6/25, indicated: 1. Type of Reconciliation, coded as Admission. 2. Were there any clinically significant medication issues identified during reconciliation, coded as no. Review of Resident #113's hospital Discharge summary, dated [DATE], indicated:- lisinopril 20 milligrams (mg), take 10 mg by mouth in the morning. Review of Resident #113's, physician's order, dated 12/5/25, indicated:- lisinopril 20 mg, give 1 tablet by mouth one time a day for hypertension. During an interview on 12/9/25 11:11 A.M., Resident #113 said his/her home dose of lisinopril is 10 mg. Resident #113 showed the surveyor his/her home medication list from his/her pharmacy that indicated Resident #113 was prescribed lisinopril 10mg by mouth daily. During an interview on 12/9/25 at 12:10 P.M., Nurse #1 said that she obtained the physician's orders for Resident #113 based on the hospital discharge summary. Nurse #1 said she contacted the on-call and reviewed the hospital discharge summary with the on-call provider. Nurse #1 said that there were no changes made in the medication list, and she transcribed the orders as written from the hospital discharge summary. Nurse #1 said she did not complete the medication reconciliation with the Resident. Nurse #1 reviewed the order for the lisinopril, and she said she should have transcribed the order as lisinopril 10mg by mouth in the morning. During an interview on 12/9/25 at 2:17 P.M., Nurse #4 said that she completed Resident #113's Medication Reconciliation Form and she said that she misread the order for the lisinopril in the hospital discharge summary, and she thought that Nurse #1 had transcribed the order correctly and she should have noticed that the order was for lisinopril 10mg by mouth daily. Nurse #4 said that had she caught the error on the transcribed medication she would have contacted the physician for a new order. Nurse #4 said that administering a higher dose of lisinopril could cause the Resident to bottom out (hypotensive episode, low blood pressure). During an interview on 12/9/25 at 1:32 P.M., Unit Manager #1 said that medications are to be transcribed according to the hospital discharge summary. Unit Manager #1 said that new orders are supposed to be checked by the night nurse and there is also a medication reconciliation form used to catch errors. Unit Manager #1 reviewed Resident #113's hospital discharge summary and she said the order was not transcribed correctly. Unit Manager #1 said that too much lisinopril can result in low blood pressure. During an interview on 12/9/25 at 1:39 P.M., the Director of Nursing (DON) said that new admission orders should be transcribed based on the hospital discharge summary. The DON said that orders placed in the electronic health record and should be reviewed by the overnight nurse and corrections should be made. The DON said that medication reconciliation should be completed accurately on all new admissions. During an interview on 12/10/25 at 11:49 A.M., the Physician said that Resident #113 is prescribed lisinopril for blood pressure and heart failure. The Physician said that nursing should have obtained and transcribed orders based on Resident's hospital discharge summary.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure medications were dated once opened and stored according to manufacturer's guidelines in one of three medication carts observed. Findings include: Review of the facility policy titled, Storage and Expiration Dating of Medications and Biologicals, dated as revised 6/30/25, indicated policy 5.3 sets forth the procedures relating to the storage and expiration dates of medications, biologicals, syringes, and needles. 11. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened or opened.11.1 Facility staff may record the calculated expiration date based on date opened on the primary medication container.11.2 Medications with a manufacturer's expiration date expressed in month and year will expire on the last day of the month.11.3 If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer date for that opened vial.11.4 When an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container.11.4.1 Facility staff should evaluate the continued sterility of the product based on clinical judgment or contamination of the dispenser after contact with eye, eyelid, lashes or finger. On 12/8/25 at 1:12 P.M., the surveyor observed on the C-Wing low side medication cart the following: -two bottles of latanoprost eye drops, opened and undated. Manufacture's guidelines indicate the medication is good for 6 weeks once opened. -two Novolin R pens, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. -two insulin aspart pens, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. -one fluticasone furoate/vilanterol inhaler, opened and undated. Manufacture's guidelines indicate the medication is good for 6 weeks once opened. -one insulin lispro pen, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. -one insulin glargine pen, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. -one vial insulin glargine, opened and undated, Manufacture's recommendations indicate good for 28 days once opened. -one vial insulin glargine, unopened. Manufacture's recommendations indicate to refrigerate until opened. -one bottle of dorzolamide eye drops, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. -one bottle of brimodine eye drops, opened and undated. Manufacture's recommendations indicate good for 28 days once opened. During an interview on 12/8/25 at 1:21 P.M., Nurse #1 said insulins and eye drops should be dated when opened. Nurse #1 said she was going to look to see when the medications were delivered from the pharmacy and she would add opened dates based on one day after the delivery from the pharmacy. Nurse #1 said that insulin should be refrigerated until opened. During an interview on 12/8/25 at 1:31 P.M., the Assistant Director of Nursing (ADON) said that eye drops and insulins should be stored according to manufactures guidelines. The ADON said that insulin should be refrigerated until opened. During an interview on 12/10/25 at 10:55 A.M., the Director of Nursing said that nursing should date and label, and store medications according to manufacturer's recommendations.

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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, record review and interview, the facility failed to provide one Resident (#93) with a therapeutic diet as ordered by the physician out of a total sample of 26 Residents. Specifically, the facility failed to ensure that Resident #93 received an easy to chew textured diet as prescribed by the physician.Findings include:Review of the facility policy titled Therapeutic and Modified Diets, dated and revised 12/5/23, indicated the following:- Therapeutic and modified diets will be provided by the attending physician or per state guidelines. The intent of this is to ensure the residents receive and consume foods in the appropriate consistency as prescribed by a physician.Review of the facility policy titled Nutrition Assessment, dated and revised 12/16/21, indicated the following:- The Registered Dietitian assesses the resident to determine nutritional needs by reviewing the collected data and completing the nutrition assessment. Nutrition Assessment also includes information such as any special food formulation.Resident #93 was admitted to the facility in September 2025 with diagnoses including Achalasia of cardio (a condition when food and liquid does not move through the esophagus to the stomach), dysphagia (difficulty swallowing), Gastroesophageal Reflux Disease and Dementia.Review of Resident #93's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview of Mental Status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident requires supervision or touching assistance with eating.The surveyor made the following observations:- On 12/8/25 at 7:50 A.M., the surveyor entered Resident #93's bedroom, Resident #93 was not in his/her room. On his/her bed was a plastic bag of Cheez its, two bags of Life Savers hard candies and a box of [NAME] Mints.- On 12/9/25 at 8:22 A.M., the surveyor entered Resident #93's bedroom, Resident #93 was not in his/her room. Resident #93's bedside table drawer was open, sticking out was a plastic bag containing Life Savers hard candies along with red and white striped hard mint candies.- On 12/10/25 at 7:28 A.M., Resident #93 was awake, sitting up in his/her bed, the curtain was drawn, his/her door was halfway shut, and the Resident could not be seen from the hallway. Next to Resident #93's was a plastic bag containing Life Savers hard candies along with red and white striped hard mint candies. Resident #93 was eating a Life Savers mint, he/she told the surveyor that he/she eats the mints whenever he/she feels like it.Review of Resident #93's physician's orders indicated the following:- May NOT omit diet restrictions on special occasions - Dated 9/24/25- Regular diet, Easy to Chew Texture, thin consistency - Dated 11/10/25Review of Resident #93's Nutrition care plan dated and revised 10/3/25, indicated the following interventions:- supv (supervise) meals & snacks. - Dated 11/19/25- Observe and report PRN (as needed) any s/sx (signs/symptoms) of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing. - Dated 10/3/25- Provide, serve diet as ordered. - Dated 10/3/25Review of Resident #93's Speech Therapy Evaluation and Plan of Treatment dated 11/11/25, indicated the following:- Reason for Therapy: Resident #93's presenting with baseline esophageal dysphagia and cognitive linguistic deficits. No s/sx (signs/symptoms) of aspiration with east to chew texture/thin liquids. Regular texture not trialed as recommendation from GI (gastroenterologist) is easy to chew texture as this time. Recommend easy to chew/thin liquids.- Malnutrition Risk Factors Identified as part of Assessment = Need for altered diet- Recommendations: What diet is recommended for the patient to swallow solids safely? = Easy to chewReview of Resident #93's Nutrition Assessment conducted by the Registered Dietitian (RD) dated 11/19/25, indicated the following:- Diet Texture: Easy to Chew- Assessment Summary: Resident #93 referred to ST (speech therapy) for swallowing as patient had recent Botox injection for achalasia and diet downgrade was recommended. Prior Medical History: Botox injection for achalasia ETC (easy to chew) diet prescribed after this tx (treatment) & provided a/o (as ordered) & tolerated well.Review of the progress notes written by the RD indicated the following:- Dated (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/10/25: Resident #93's diet was recommended to change to easy to chew r/t (related to) resident recent Botox injection for achalasia. NP (nurse practitioner) agreed.- Dated 11/11/25: Diet texture downgraded to ETC. SLP (speech language pathologist) agrees with ETC.During an interview on 12/10/25 at 9:02 A.M., Certified Nursing Assistant (CNA) #1 said Resident #93 likes to snack a lot and his/her family brings in candy and crackers often for him/her.During an interview on 12/10/25 at 9:17 A.M., CNA #2 said Resident #93 likes to snack a lot and his/her family often brings in snacks for him/her.During a follow-up interview on 12/10/25 at 9:29 A.M., CNA #1 said Resident #93's current diet is easy to chew foods which are soft foods and he/she cannot have anything that is hard or crunchy. When the surveyor asked CNA #1 if the Resident should have hard candies, CNA #1 said probably not and Resident #93 is only monitored when he/she is in the dining room.During an interview on 12/10/25 at 9:29 A.M., Unit Manager #2 said she uses her clinical judgement on what diets mean. Unit Manager #2 said easy to chew means soft, cut-up bites of food with extra sauces and gravies and that hard and crunchy foods are not allowed. Unit Manager #2 said we use the ordered diet for Resident #93. Unit Manager #2 was unaware of the bags of hard candies and crunchy foods in his/her room, she said if staff observed them then they should let nursing or herself know.During an interview on 12/10/25 at 10:09 A.M., the Speech Language Pathologist (SLP) said she assesses residents upon admission and as needed. The SLP said she follows the International Dysphagia Diet Standardization Initiative's (IDDSI) guidelines for modified diets and textured diets. Then SLP said Resident #93 has esophageal dysphagia and has a procedure every few months to help him/her swallow better and the GI doctor recommended an easy to chew diet and Resident #93 does really well on it. The SLP then said no crunchy food is allowed and the food should be able to be cut in half with a fork or spoon. The SLP then said Resident #93 should not have any hard candies or crunchy foods including cheez its.Review of the ISSDI Level 7 Regular Easy to Chew guidelines, last reviewed July 2019 (https://www.iddsi.org/images/Publications-Resources/DetailedDefnTestMethods/English/V2DetailedDefnEngl indicated the following:- Do not use foods that are: hard, tough, chewy.- Foods should be able to be cut or broken apart with the side of a fork or spoon.- Food Characteristics to AVOID: Chewy - lollies/candies/sweetsDuring an interview on 12/10/25 at 2:26 P.M., the Director of Nursing said Resident #93 should not have hard candies or crunchy snacks and the physician's ordered diet should be followed as he/she is at risk of choking.The surveyor attempted to reach the Registered Dietitian by the telephone number provided by the facility on 12/11/25 at 12:06 P.M. and on 12/12/25 at 1:30 P.M. but was unsuccessful with no return phone call.