STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Deficiency Text Not Available

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Deficiency Text Not Available

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure all residents maintained acceptable parameters of nutritional status with the facility failed to follow-up and implement Registered Dietitian (RD) recommendations for two residents (Resident #1 and #4) with wounds and for three residents (Resident #2, #3, and #4) who were identified as under body weight. The facility census was 37. Review of the facility's House Supplement Guidelines, dated May 2015, showed supplements are indicated when resident's intake at meals is not adequate to maintain weight, weight gain is needed, or weight loss is too rapid. Review of the facility's Supplement Guidelines, dated May 2015, showed the following: -Physician ordered supplements should be prepared and delivered by the dietary department; -Supplementation should be regular food and beverage items when possible before fortified liquid products are tried; -All individual supplements to be documented on the supplement list by the Dietary Manager (DM) or designee; -When the physician ordered a supplement, the order would be discussed with the resident with likes and dislikes taken into account; -Supplements were not to be served with meals unless prescribed by the physician. 1. Review of Resident #1's face sheet showed: -admission date of 02/04/25; -Diagnoses included sacral (lower base of spine) pressure ulcer, paraplegia (paralysis of bilateral lower limbs), anxiety, and depression. Review of the resident's admission Minimum Data Set (MDS - a federally-mandated assessment tool completed by facility staff), dated 02/05/25, showed the following: -Cognitively intact; -No behavioral symptoms; -Independent with eating; -Diagnosis of sacral (lower base of spine) pressure ulcer, stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle, slough (dead tissue that accumulates in the wound, generally yellow, white, or gray in color) or eschar (dead tissue, usually brown or black in color] may be present in parts of the wound bed)); (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Height of 5 foot 11 inches and weight of 242 pounds; -No swallowing problems. Review of the resident's care plan, dated 02/10/25, showed the following: -Resident was admitted to the facility with a stage 4 pressure ulcer to his/her coccyx (tailbone), related to morbid obesity and decreased mobility; -Serve diet per physician orders; -Diet of level 7 (L7 - easy to chew), regular. Review of the resident's physician orders showed an active order, dated 02/04/25, for Level 7 (easy to chew) regular diet. Review of the resident's initial comprehensive nutrition assessment, dated 02/13/25, completed by the RD showed the following: -Diagnoses of anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues) and obesity; -Resident able to make preferences known; -Location of most meals was resident room; -Resident's current height of 71 inches and current weight of 248 pounds; -Resident independent with eating and drinking; -Resident had dentures/partial; -Resident had pressure ulcer, stage 4; -Pressure wound to buttocks with wound vac (a medical device that uses negative pressure (suction) to help wounds heal by removing fluid and dead tissue, promoting new tissue growth, and improving blood flow). Review of the resident's progress note dated 02/13/25, at 8:35 A.M., showed the following: -Resident received a regular diet without additional supplementation; -Resident dined in his/her room per preferences with good appetite. Meal intake had been variable but about 50% on average. -Resident had dentures and no difficulty chewing/ swallowing; -Resident had pressure wound to buttock with wound vac in place; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Current weight was 248 pounds with BMI (body mass index) of 34.6 (optimum range is 18.5 to 24.9); -Recommend adding 30 milliliter's (mL) Pro-Stat (a concentrated liquid protein) twice per day (BID) to support wound healing; -RD will continue to monitor and follow up as needed (PRN). Review of the form, RD Recommendations Requiring Physician Order, dated 02/13/25, showed a list of residents with recommendations including the resident with a concern of wound healing and a recommendation of 30 mL of Pro-stat BID. The column titled date completed was left blank. Review of the resident's progress note dated 03/07/25, at 5:28 P.M., showed a new order received via fax from the resident's nurse practitioner (NP) for fortified foods (foods enriched with additional nutrients, vitamins/minerals) with meals. Review of the resident's physician orders (including current and discontinued orders) showed an active order, dated 03/07/25, for fortified foods with meals every day. (The physician orders did not show an order for Pro-Stat.) Review of the form titled, RD Recommendations Requiring Physician Order, dated 03/14/25, showed a list of residents with recommendations including the resident with a concern of wound healing and a recommendation of continued: 30 mL of Pro-stat BID to support wound healing. The column titled date completed was left blank. During an interview on 03/25/25, at 3:34 P.M., the Dietary Manager (DM) said the following: -He/she retrieved the white meal tray cards, as well as an index card box containing pink diet order slips; -He/she said the previous DM said the index card box contained the current resident diet orders; -The meal tray cards and diet slips should match; -The cook used the white meal tray cards when preparing/serving the resident meals; -The resident's white meal tray card, dated 03/01/25, showed a regular diet; -The resident's pink diet order slip, dated 03/07/25, showed fortified foods with meals. During an interview on 03/25/25, at 4:02 P.M., [NAME] A said he/she was not giving the resident any type of supplement or fortified foods and was not aware of any recommendations to do so. During an interview on 03/26/25, at 11:17 A.M., the resident said the Director of Nursing (DON) told the resident earlier today, on 03/26/25, that the facility was going to start giving him/her increased protein at each meal for wound healing. He/she had not received fortified foods or protein supplements before today. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/26/25, at 12:30 P.M., the DON said on 03/14/25, the RD recommended Pro-Stat, but the DON had not obtained physician orders and had not implemented the RD recommendations. The increased protein could help with the resident's pressure ulcer wound healing. 2. Review of Resident #2's face sheet showed the following: -admission date of 02/26/25; -Diagnoses included chronic obstructive pulmonary disease (COPD - a lung disease with narrowing of the airways), Parkinson's disease, dementia, anxiety, depression, and dysphagia (difficulty swallowing). Review of the resident's admission MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills; -Independent with eating, oral hygiene, toileting hygiene, transfers, and upper and lower body dressing; -Exhibited coughing or choking during meals of medication administration; -Height of 5 foot, 7 inches and weight of 74 pounds; -No significant weight loss of gain; -At risk for development of pressure ulcers. Review of the resident's physician orders showed an order, dated 02/26/25, for Level 7 regular diet. Review of the resident's weight record showed the following: -On 02/28/25, staff recorded a weight of 78.6 pounds; -On 03/03/25, staff recorded a weight of 77.4 pounds; -On 03/07/25, staff recorded a weight of 74.0 pounds; -On 03/10/25, staff recorded a weight of 73.1 pounds. Review of the resident's initial comprehensive nutrition assessment, dated 03/14/25, completed by the RD showed the following: -Diet was L7; -Resident able to make food preferences known; -Resident ate most meals in his/her room; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Current weight of 73 pounds; -Resident required assist/supervision to eat/drink; -Resident has his/her own teeth; -Greater than 5% weight change in the last month; -Resident's skin was intact. Review of the resident's progress note, dated 03/14/25 at 8:15 A.M., showed the following: -Resident received a regular diet with poor appetite. Meal intake had been less than 50% on average; -He/she took amortization (an antidepressant medication used to help resident's gain weight) which can help increase appetite; -Resident had his/her own teeth with no difficulty chewing/swallowing; -Current weight was 73 pounds, with an underweight BMI of 11.45; -The 03/06/25 skin assessment showed skin intact with no edema; -Given underweight BMI and poor intake, recommend super cereal (nutrient rich and fortified) with breakfast and house shakes three time per day; -RD will continue to monitor and follow up as needed. Review of the form titled, RD Recommendations Requiring Physician Order, dated 03/14/25, showed a list of residents with recommendations including the resident with a concerns of underweight and poor intake and recommendations of super cereal with breakfast and house shakes TID. The column titled date completed was left blank. Review of the resident's care plan, updated 03/18/25, showed the following: -Resident at risk for inadequate nutrition related to poor intake, and disease process; -Determine in collaboration with the RD, as appropriate, the number of calories and type of nutrients needed to meet my nutritional requirements; -Resident was currently level 7 regular diet; -Resident preferred to eat meals in his/her room, but will at times go to the dining room for meals, depending on mood and behaviors at mealtime; -Snacks as appropriate; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Weigh resident as ordered and inform physician of any significant changes. Review of the resident's weight record showed the following: -On 03/19/25, staff recorded a weight of 76.2 pounds; -On 03/25/25, staff recorded a weight of 76.4 pounds. Observation and interview of the resident on 03/25/25, at approximately 12:30 P.M. showed the following: -The resident sat in a wheelchair in his/her room with visitors; -Staff served the resident lunch in his/her room. The resident had smothered steak with gravy, mashed potatoes, peas, a roll, and angel food cake for dessert; -The resident consumed approximately 50% of his/her meal. Staff did not serve the resident a health shake or any other supplements; -The resident said he/she was not getting shakes and was unsure about super cereal. During an interview on 03/25/25, at 3:34 P.M., the DM said the following: -He/she retrieved the white meal tray cards, as well as an index card box containing pink diet order slips; -He/she said the previous DM said the index card box contained the current resident diet orders; -The resident's pink diet order slip, dated 02/27/25, showed a regular diet; -The resident's printed white meal tray card, dated 03/01/25, showed a regular diet; -The resident did not have any listed supplements on either card; -The pink order slips and white meal tray cards should list all supplements and should match. During an interview on 03/25/25, at 4:02 P.M., [NAME] A said the following: -He/she was not aware of the 03/14/25 dietary recommendations for the resident; -He/she was not giving the resident super cereal or house shakes. During an interview on 03/26/25, at 12:30 P.M., the DON said on 03/14/25, the RD recommended super cereal and health shakes for the resident, but the DON had not implemented these recommendations until today 03/26/25. The increased calories could potentially help the resident gain weight. 3. Review of Resident #3's face sheet showed the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-admission date of 06/17/24; -Diagnoses of anemia and dementia. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills; -Dependent on staff assistance for eating and other activities of daily living (ADLs); -No swallowing issues; -Height of 5 foot, 2 inches and weight of 91 pounds; -No significant weight loss or gains; -Provided mechanically altered diet; -Expressed mouth or facial pain/discomfort or difficulty with chewing; -At risk for development of pressure ulcers. Review of the resident's weights showed the following: -On 09/03/24, staff recorded a weight of 96.0 pounds; -On 10/03/24, staff recorded a weight of 81.6 pounds; -On 10/14/24, staff recorded a weight of 87.0 pounds; -On 10/15/24, staff recorded a weight of 87.2 pounds; -On 10/31/24, staff recorded a weight of 81.0 pounds; -On 11/11/24, staff recorded a weight of 82. 0 pounds; -On 12/30/24, staff recorded a weight of 90.0 pounds; -Staff did not record a weight in January 2025. Review of the resident's physician order sheet an order, dated 01/02/25, for diet L5 (minced and moist). Review of the resident's care plan, dated 01/16/25, showed the following: -Resident at risk for inadequate nutrition related to poor intake, need for mechanically altered diet, and disease process; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Communicate with family regarding any food and wight issues; -Create a pleasant and relaxing atmosphere [NAME] eating to increase intake. Required one assist for eating; -Determine, in collaboration with the RD, as appropriate, the number of calories and type of nutrients needed to meet his/her nutritional requirements; -Encourage fluid intake; -Resident was a slow eater. Allow sufficient time to eat; -Resident currently on a mechanical diet; -Prefers to eat in the main dining room; -Nutritional supplements as appropriate; -Snacks as appropriate; -Weigh the resident as ordered and inform the physician of any significant changes. Review of the form titled, RD Clinical Reminders and Recommendations for Facility Staff, dated 02/13/25, showed a list of residents including the resident with a concern of no monthly weight (last weight in December). Review of the resident's weights showed: -On 02/28/25, staff recorded a weight of 90.8 pounds; -On 03/11/25, staff recorded a weight of 88.0 pounds. Review of the resident's progress note dated 03/14/25, at 9:25 A.M., showed the RD documented the following: -Resident received an MM5 diet and was assisted by staff at mealtimes; -Appetite was fair and meal intake had been about 50% on average; -Current weight was 88 pounds, indicated a 3% loss in the last week, but a desired 8% gain the last 5 months; -BMI remained underweight at 16.1; -Recommend providing 237 ml of Boost Breeze (supplement) with breakfast daily in place of juice to provide additional calories; -RD will continue to monitor and follow up as needed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the form titled, RD Recommendations Requiring Physician Order, dated 03/14/25, showed a list of residents with recommendations including the resident with a concern of under weight and weight loss and a recommendation of providing 237 mL of Boost Breeze with breakfast daily in place of juice. The column titled date completed was left blank. Review of the resident's weights on 03/19/25, staff recorded a weight of 90.0 pounds. Review of the resident's nutrition quarterly review, dated 03/24/25, completed by the RD, showed: -Current diet of MM5; -Current weight of 90 pounds; -Weight change of 10% gain in 6 months; -Average intake percentage of 51%-75%; -Assistance provided; -Primary dining location was main dining room. Review of the resident's progress note dated 03/24/25, at 9:13 A.M., showed the RD documented the following: -RD completed quarterly review; -Resident received MM5 diet and was assisted by staff at mealtimes; -Resident appetite was fair and meal intake had been about 50% on average; -Current weight was 90 pounds and indicated a desired 10% gain in the last 5 month; -Resident remained underweight, BMI = 16.5; -Continue the recommendation to provide Boost Breeze with breakfast daily in place of juice to provide additional calories; -RD will continue to monitor and follow up as needed. Observation on 03/25/25, at 12:15 P.M., showed the Housekeeping Supervisor seated at the resident's table assisting the resident to eat. The resident did not appear to have any dietary supplements. During an interview on 03/25/25, at 3:34 P.M., the DM said the following: -He/she retrieved the white meal tray cards, as well as an index card box containing pink diet order slips; -He/she said the previous DM said the index card box contained the current resident diet orders; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's printed white meal tray card, dated 03/01/25, showed a MM5 (minced and moist) diet, but did not list any supplements; -The resident had a total of three pink order slips in the index card box; -The first pink order slip, dated 06/17/24, showed a regular diet; -The second pink order slip, dated 07/02/24, showed mechanical soft diet; -The third pink order slip, dated 12/16/24, showed an order to discontinue house shakes, with no other information; -The DM said the resident should only have one pink order slip with current diet order including any supplements. During an interview on 03/25/25, at 4:02 P.M., [NAME] A said he/she generally gave the resident fortified cereal at breakfast. He/she was not aware of recommendations to give the resident Boost Breeze. During an interview on 03/26/25, at 9:19 A.M., the Housekeeping Supervisor said the following: -He/she assisted the resident with breakfast and lunch, approximately 3-4 times per week for the past 6 months; -The resident ate 50-75% of meals and drinks all fluids; -Over the last approximate 6 months when he/she was assisting the resident with his/her meal, dietary did not provide the resident with super cereal at breakfast, any shakes, or any Boost Breeze supplements. During an interview on 03/26/25, at 10:20 A.M. Certified Nurse Assistant (CNA) B said he/she assisted the resident at mealtime. Staff did not provide the resident with any shakes or Boost Breeze supplements. Observation and interview on 03/26/25 at 12:15 P.M., showed the following: -CNA C assisted the resident with eating his/her lunch; -The resident had a chocolate health shake; -CNA C asked the resident if he/she wanted to try the shake and the resident said yes. The CNA held the shake up to the resident mouth with a straw in it and the resident drank; -The CNA said this was the first time he/she had seen dietary provide a health shake to the resident. During an interview on 03/26/25, at 12:30 P.M., the DON said the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/14/25, the RD recommended Boost Breeze, but the DON did not follow up on the RD's recommendations; -The added calories could help with weight gain; -The resident has expressed a desire to gain weight. 4. Review of Resident #4's face sheet showed the following: -admission date of 02/13/25; -Diagnoses included spastic quadriplegia cerebral palsy (a congenital disease affecting the muscles and movement of both the arms and legs and often the torso and face), and malnutrition. Review of the resident admission MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills for daily decision making; -Dependent on staff assistance for eating and all other ADLs; -Swallowing disorder. Resident exhibited coughing or choking during meals, or administration of medications; -Height of 5 foot, 4 inches and weight of 127 pounds; -No significant weight loss or gain; -Provided mechanically altered diet. Review of the resident's physician order sheet showed the following diet order, dated 02/13/25, showed Level 4 pureed diet with nectar thick liquids. Review of the resident's weights showed the following: -On 02/17/25, staff recorded a weight of 126.6 pounds; -On 02/24/25, staff recorded a weight of 115.4 pounds. Review of the resident's initial comprehensive nutrition assessment, dated 02/25/25, and completed by the RD, showed the following: -Current diet order L4 puree with nectar consistency thickened liquids; -Unable to make food preferences known; -Location of most meals was in the main dining room; -Current height 5 foot 4 inches and current weight of 115 pounds; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Totally dependent on staff for assistance with eating and drinking; -No significant weight change; -Oral food intake 0%-25%. Review of the resident's progress note dated 02/25/25, at 9:01 A.M., showed the RD documented the following: -Resident was on a puree diet with nectar thick liquids; -Resident assisted to eat by staff at meals with poor appetite; -Resident had limited speech and could not make preferences known; -Meal intake had been less than 50% on average; -Current weight was 115 pounds with a low BMI of 19.8; -Given low BMI and poor intake, recommend adding 90 ml of VHC (very high calorie, a supplement) three times per day (TID); -RD will continue to monitor and follow up as needed. Review of the form titled, RD Recommendations Requiring Physician Order, dated 02/25/25, showed a list of residents with recommendations including the resident with a concern of poor intake and low BMI and a recommendations of 90 mL of Pro-stat TID. The column titled date completed was left blank. Review of the resident's care plan, dated 02/26/25, showed the following: -Resident at risk of inadequate nutrition related to dental concerns, poor intake, need for mechanically altered diet, and disease process; -Communicate with family regarding any food and wight issues; -Create a pleasant and relaxing atmosphere while eating to increase intake; -Determine, in collaboration with the RD, as appropriate, the number of calories and type of nutrients needed to meet his/her nutritional requirements; -Encourage fluid intake; -Resident currently on a pureed diet with nectar thick liquids; -Preferred to eat in the main dining room; -Required assist of one with eating (continued on next page)

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	265455	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willard Care Center	400 West Walnut Lane Willard, MO 65781

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nutritional supplements as appropriate; -Snacks as appropriate; -Weigh the resident as ordered and inform the physician of any significant changes. Review of the resident weights showed the following: -On 03/03/25, staff recorded a weight of 114.8 pounds; -On 03/07/25, staff recorded a weight of 107.6 pounds; -On 03/10/25, staff recorded a weight of 106.2 pounds. Review of the resident's progress notes, dated 03/14/25 at 8:47 A.M., showed the RD documented the following: -Resident was on pureed diet with nectar thick liquids; -Resident was assisted at meals with eating with poor appetite; -Resident had been refusing all meals as of late; -Resident had noted limited speech and could not make preferences known. Staff anticipated needs; -Current weight of 106 pounds with underweight BMI of 18.2; -Weight showed a 16% loss of 20 pounds in one month; -Skin stage 4 pressure ulcer to sacrum; -Continue recommendation to add 90 ml of VHC TID with medication pass; -Also recommend adding 30 mL of Pro-stat BID to support wound healing -Honor preferences and provide support/encouragement; -RD will continue to monitor and follow up as needed. Review of the form titled, RD Recommendations Requiring Physician Order, dated 03/14/25, showed a list of residents with recommendations including the resident with concerns of wound, weight loss, and underweight and a recommendation to continue recommendation to add 90 mL of Pro-stat TID with medication pass. Also recommended adding 30 mL Pro-stat BID to support wound healing. The column titled date completed was left blank. Review of the resident's weights showed the following: -On 03/19/25, staff recorded a weight of 106.0 pounds; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 03/25/25, staff recorded a weight of 104.0 pounds. During an interview on 03/25/25, at 3:34 P.M., the DM said the following: -He/she retrieved the white meal tray cards, as well as an index card box containing pink diet order slips; -He/she said the previous DM said the index card box contained the current resident diet orders; -The resident's pink diet order slip, dated 02/13/25, showed a pureed diet with thickened liquids; -The resident's printed white meal tray card, dated 03/01/25, showed a pureed diet with nectar thick liquids. During an interview on 03/25/25, at 4:02 P.M., [NAME] A said the resident was challenging because he/she would not each much. He/she tried fortified foods, shakes, pudding, or ice cream in the past, but the resident would refuse those items. During an interview on 03/26/25, at 9:19 A.M., the Housekeeping Supervisor said the following: -He/she assisted the resident with breakfast and lunch 3 to 4 days per week; -He/she received thickened liquids and a pureed diet; -Dietary used to give the resident shakes, but their have been shakes for approximately 2 weeks; -The resident had a poor appetite, but would drink thickened coffee and tea. During an interview on 03/26/25, at 12:30 P.M., the DON said the RD had made recommendations for the resident to receive VHC and Prostat, but the DON had failed to follow up on the recommendations. The increased protein could help with the healing of the resident's pressure ulcer. 5. During an interview on 03/25/25, at 3:34 P.M., the DM said the following: -Management had not instructed him/her to review any recommendations from the RD; -He/she had not seen any recommendations from the RD; -He/she was unsure what fortified foods and super cereal were; -The diet order cards should match the tray cards and each resident should have one order card with current orders for meal/supplements. During an interview on 03/25/25, at 4:02 P.M., [NAME] A said the following: -Generally, if the RD made recommendations, the DON would bring the pink order slips to the DM; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Sometimes the RD made recommendation to the DM and he/she would go to nursing to obtain the physician order for diet changes/additions; -The index box of pink diet orders, was his/her, Bible and should contain the current orders for diet/supplements for each resident; -He/she made shakes at times, but he/she/he had not made any shakes for the past week; -The facility had not had a weight loss meeting that he/she could recall since January 2025; -For approximately the last month, he/she had not had time to update the resident diet cards. During an interview on 03/28/25, at 9:20 A.M., the RD said the following: -He/she visited the facility two times per month; -He/she followed up by sending all dietary/supplement recommendations in an e-mail to the DON and to the DM; -He/she expected the facility to follow up with the physician regarding implementation of his/her recommendations; -He/she sent the recommendations on the day of his/her visits/consults; -He/she checked to see if dietary recommendations from the previous visit were followed and if not, he/she documented continue the recommendation; -He/she had noticed issues, on occasion, with the facility not following up on his/her recommendations. During an interview on 03/26/25, at 12:30 P.M., the DON said the following: -The RD generally came to the facility two times per month; -He/she had not yet met the RD, because the RD came on days when the DON was not in the facility; -He/she did not get an e-mail of RD recommendations, but the Administrator printed off the RD recommendations and placed on the DON's desk; -He/she reviewed all resident progress notes daily Monday through Friday, when he/she was at work; -He/she was aware from reading progress notes, that the RD had made several recommendation for changes/supplements, but he/she was waiting on the printed off list of recommendations from the Administrator before making any dietary changes; -He/she generally reviewed the recommendations and notified the physician and placed the orders onto the physician order sheet and filled out pink dietary order slip and give to the DM; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents should have one dietary pink sheet containing all the current orders for diet and supplements; -The DON pulled the recommendations out of his/her desk and said he/she had not reviewed or implemented the recommendation form 02/13/25 or from 03/14/25; -Review and follow up on the RD recommendations was his/her responsibility, but he/she did not get it done; -He/she reviewed resident weights and mentioned residents with weight loss at morning stand-up meeting with department heads, but could not say that the facility had a formal weight loss meeting since he/she started in December 2024; -He/she planned to begin weekly weight meetings to discuss weight loss and any recommendations. During an interview on 03/25/25, at 4:28 P.M., the Administrator said the following: -The RD generally came to the facility two times per month; -The RD reviewed resident weights; -He/she received the RD recommendations via email and printed the recommendations; -He/she then placed the RD recommendations on the DON's desk; -The DON was responsible for reviewing the recommendations and obtaining physician orders and sending the orders/recommendations to the DM; -The DON should add the dietary orders to the resident's medical record or assign and nurse to do so; -The DM was responsible for adding to the meal ticket; -The Administrator was unsure if the DON had reviewed the 03/14/25 RD recommendations; -The Administrator was unsure if he/she gave a copy of the 03/14/25 RD recommendations to the DM; -The DON should review and address the RD recommendations within 24 to 48 hours; -The current DM had not yet received training; -The facility conducted a weekly at risk meeting on Thursday, but on 03/13/25, the staff did not have any RD recommendations and at the 03/20/25 meeting, staff failed to discuss residents with weight loss or the RD recommendations; -The pink diet order slip should be the most current diet order for each resident and each resident should have one card. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MO00250213