STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275025	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kalispell Rehabilitation and Nursing LLC	171 Heritage Way Kalispell, MT 59901

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide necessary care and services to maintain the highest practicable physical well-being for 1 (#1) of 8 sampled residents. The facility failed to administer an anticoagulant medication as ordered, resulting in the omission of 27 doses of Eliquis (Apixaban), increasing the risk for complications including stroke and blood clots; and failed to implement physician-ordered medication hold instructions before a scheduled vascular procedure, resulting in the cancellation and rescheduling of the resident's fistula surgery on two separate occasions and causing the resident frustration. These failures delayed medically necessary treatment. Findings include:1. During an interview on 6/15/26 at 2:28 p.m., NF1 stated she was contacted by the nursing home staff and they informed her they had made an error and had mistakenly taken resident #1 off his blood thinner for a period of time.Review of resident #1's physician's office visit showed resident #1 was to be seen by the vascular physician on 3/5/26 at 1:00 p.m. The physician notes and physician orders showed, will need to stop/hold Eliquis 48 before surgery - 4/28/26 . The physician orders and notes were acknowledged by staff members on 3/5/26 and again on 3/9/26.Review of resident #1's Medication Administration Record (MAR) for March 2026 showed:-Eliquis Oral Tablet 5 MG (Apixaban), Give 1 tablet by mouth two times a day, related to unspecified Atrial Fibrillation (I48.91) until 3/25/26 23:59 (11:59 p.m.), order dated 3/9/26 at 0036 (12:36 a.m.).-The Eliquis 5 mg, po BID was put on hold 48 hours before the resident's surgery on 4/28/26. The MAR showed, Check with vascular after surgery to see if this should be restarted, one time only for follow-up for 2 days, ordered dated 3/9/26 at 0038 (12:38 a.m.).Review of resident #1's MAR for April 2026 showed:-Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day related to Long Term (Current) Use of Anticoagulants (Z79.01), order dated 4/8/26 1759 (5:59 p.m.).Resident #1 did not receive Eliquis, a blood thinner, from 3/26/26 to 4/8/26, resulting in the omission of 27 prescribed doses.During an interview on 6/17/26 at 11:36 a.m., staff member B said resident #1's Eliquis was discontinued rather than placed on hold, which caused the resident to miss multiple doses of his Eliquis in March and April 2026.Review of the facility's Medication Error Reported, date and time of the error 4/8/26, identified that a nurse had discontinued the Eliquis order instead of placing the medication on hold. The report classified the error as a dose omission and documented the reason for the error as D/C instead of hold.Review of resident #1's progress notes showed an event note template on 4/16/26 at 9:17 a.m. that showed event description: Eliquis 5 mg order was discontinued by [Staff Member's Name] instead of it being held. She wrote to hold it but it appears that she discontinued on accident. Notified patient, MD and DON. Notified [family member] about incident. MD stated there is no concern for harm. Requested to restart it and hold 48 hours before surgery.2. During an interview on 6/15/26 at 2:28 p.m., NF1 stated resident #1's fistula surgery had been scheduled on two occasions and was cancelled both times due to the facility's medication errors. NF1 stated that during the first scheduled procedure, hospital staff discovered resident #1 had received Ozempic despite physician orders requiring the medication to be held before surgery, resulting in the cancellation and rescheduling of the procedure. NF1 further stated that when the procedure was rescheduled for 6/9/26, the facility staff administered resident #1's anticoagulant despite orders to hold the medication, resulting in cancellation of the procedure for a second time. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NF1 stated that resident #1 was already on the procedure table when the surgeries were cancelled. NF1 reported that the repeated cancellations caused him fear and frustration.During an interview on 6/16/26 at 2:26 p.m., resident #1 reported the fistula procedure had been cancelled twice because medications that were ordered to be held had been administered. Resident #1 stated the repeated postponements were frustrating.During an interview on 6/17/26 at 11:36 a.m., staff member B said resident #1's procedure scheduled for 4/28/26 was put on hold because the medication Ozempic was given in error.Review of resident #1's electronic health record showed the following:- Nurse's Note, dated 4/8/26 at 17:47 (5:47 p.m.), Note Text: Orders received from pre-anesthesia appt.Other: Eliquis 5 mg BID do not take after 4/25, Ozempic do not inject after 4/20. Held and edited orders. [sic]- Nurse's Note, dated 4/28/26 at 16:48 (4:48 p.m.), Note Text: Resident's procedure for a fistula will have to be rescheduled, nurse call [Physician's Name] office and the procedure will be on June 9th at 0830am (8:30 a.m.), all previous hold orders and insulin order will remain the same. [sic]- A communication with Family/NOK/POA, dated 4/29/26 at 3:32 p.m., showed, Note Text: Spoke with [family member's Name], she was upset about residents procedure needing to be rescheduled. Try to explain that once the Ozempic dose was increased, that hold medication order changed into a new order and the system did not catch the hold order. Updated [family member's Name], letting her know that I will be putting in TARS and MAR orders for 2 weeks so all staff is notified about med hold orders that will need to be flagged/important for his procedure. [sic]- The physician orders, Administration Note, dated 6/9/26 at 11:25 a.m., showed, Note Text: Resident to have a fistula procedure on June 9th with [Physician Name] (vascular) at 0830 (8:30 a.m.). one time only for Fistula procedure June 9th 0830 (8:30 a.m.) related to DEPENDENCE ON RENAL DIALYSIS (Z99.2) for 1 Day Resident unable to have procedure d/t eliquis administration. [sic]Review of resident #1's preoperative note from [Hospital Name] dated 4/28/26 at 13:24 (1:24 p.m.) showed, .Pt surgery cancelled for Hight potassium and had taken Ozempic prior to surg.Review of resident #1's preoperative note from [Hospital Name], dated 6/9/26 at 8:41 a.m., showed, .procedure canceled. [Facility Name] failed to hold Eliquis 48 hours prior to procedure.Review of the facility's Medication Error Report Form for resident #1 showed the date and time of the error were on 4/16/26 and showed the Ozempic was given in error. The root cause was determined to be that the medication was placed on hold, but the physician's order changed, and it didn't get pulled over.Review of the facility's Medication Error Report Form for resident #1, showed the date and time of the error, which was on 6/9/26. The staff documented Eliquis 5mg twice daily was not placed on hold due to surgical procedure, and the outcome to the resident showed the surgery was cancelled.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively and systematically identify, assess, implement, monitor, and modify interventions timely after the identification of facility-acquired pressure injuries, which resulted in the progression of bilateral heel pressure injuries, including the development of an additional pressure injury to the plantar aspect of the left heel for 1 (#2) of 3 sampled residents for pressure injuries. The facility actions being taken for the wound(s) were not sufficient to meet the resident's needs related to wound care and the prevention of wounds. Findings include:During an interview on [DATE] at 11:26 a.m., NF2 reported that resident #2 had developed wounds on her feet during her stay at the facility.During an interview on [DATE] at 11:55 a.m., NF3 stated that resident #2 had two heel wounds when she assessed the resident on the day of discharge when she was admitted to hospice. NF3 said the wound on the right heel had eschar and odor present, and the left heel was open with granulation tissue and surrounding callus formations.Review of resident #2's Braden Scale for Predicting Pressure Sore Risk dated [DATE] showed resident #2 scored 13, reflecting the resident was at moderate risk of developing pressure injuries. Review of resident #2's Braden Scale for Predicting Pressure Sore Risk, dated [DATE], again showed resident #2 scored a 13, at moderate risk for developing pressure injuries. Review of resident #2's Admit/Readmit Screener, dated [DATE], showed, . Section C: .10. Integrity Skin Assessment . Site and Description:53) Sacrum Open wound covered with meplex,55) Right gluteal fold yellow slough25) Right trochanter (hip) Sutures. Nothing was documented for the resident having heel pressure injuries. Review of resident #2's Occupational Therapy treatment encounter progress note, dated [DATE], showed, . Patient did not have socks on and therapist (noted) what appeared to be large blood blisters (one on the back of each heel). Notified the nurse immediately.Review of resident #2's weekly wound observation tool showed: Left Heel:- [DATE]: The left heel wound was facility-acquired, with a wound onset date of [DATE], although it was noted by the therapist on [DATE]. The notes showed the wound type as pressure, and it was a deep-tissue injury. The comments showed it was a fluid-filled blister. The measurement was 5 cm in length x 4 cm in width, with no depth documented. The wound treatment consisted of wiping it with sure prep twice daily. The notes did not show if the pressure wound was avoidable. -[DATE]: The left heel wound still measured 5 cm x 4 cm, no depth measurement was documented. The current treatment plan was to cleanse with wound cleanser and cover with a silicone foam border dressing and change daily. No debridement was performed (medical process of removing dead, damaged, or infected tissue to promote wound healing and prevent infection).-[DATE]: No measurements for the left heel wound were documented, and the current treatment plan showed the wound on the left heel was resolved. -[DATE]: Left heel - the plantar aspect was facility-acquired, and the date of onset was [DATE]. This was a new pressure area on the resident's left heel. The type of wound was identified as a pressure wound. The severity was a Stage II, with granulation (beefy red) tissue present. The plantar aspect wound of the left heel measured 1 cm x .5 cm. There was no depth measurement documented. The treatment plan was to cleanse the wound with wound cleanser, to apply collagen, and cover the wound with a silicone foam border dressing, and to change the dressing daily. No debridement was performed. The progress notes did not show if the pressure wound was avoidable. Right Heel:-[DATE]: The deep tissue injury was facility-acquired, and the date of onset was [DATE], although the therapist identified it and reported it to the nurse on [DATE]. The type of injury was classified as a pressure wound, but the notes did not show if it was avoidable. The wound measured 2 cm x 2 cm, and no depth measurement was documented. The treatment consisted of sure prep twice daily.-[DATE]: The right heel wound size in increased and it measured 3 cm x 4 cm, with no depth measurement documented. The treatment plan showed nursing staff was to continue with the sure prep treatment and float the resident's heels (offload pressure to heels).-[DATE]: The right heel wound was measured as 4.5 cm x 5 cm, and no (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depth measurement was documented. The treatment remained unchanged from the prior treatment of the sure prep and floating the heels. No debridement was performed throughout the documented wound progression.Review of resident #2's progress notes showed:- [DATE]: Nursing documented that resident #2 was seen during wound rounds for the bilateral heel wounds consisting of fluid-filled blisters.- [DATE]: The physician documented that the left heel blister had opened and was leaking serosanguineous drainage.- [DATE]: A physician's order was requested for an air mattress (for pressure relief), and the nursing staff requested a physician's order to float the resident's heels.- [DATE]: The nurse documented new treatment orders for the left heel, and there were no changes to the right heel treatment.- [DATE]: The physician documented the right heel pressure wound was a 3 cm x 4 cm dark hard discoloration. The left heel blister had ruptured and now measured 5 cm x 4 cm, with moderate serous drainage.- [DATE]: The physician documented the right heel measured 3 cm x 6 cm, with dark, hard skin discoloration, while the left heel remained soft and boggy. - [DATE]: The physician documented information for both heel wounds, but there were no measurements recorded. The physician referenced the wound note rather than personally documenting the wound details, even though the nursing assessments/notes were incomplete for the wounds. - [DATE]: The physician orders included documentation that the original left heel deep tissue injury had resolved; however, a new pressure sore had developed on the plantar aspect of the resident's heel. This showed that preventative measures identified and carried out by the facility prior to [DATE] did not prevent wound development from occurring on the resident's heel. - [DATE]: The physician documented the right heel deep tissue injury measured 4.5 cm x 5.5 cm with dark hard discoloration, while the plantar wound on the left heel measured 1 cm x 0.5 cm with 100% granulation tissue and moderate sanguineous drainage.- [DATE]: The interdisciplinary team met, and the registered dietitian going to discuss options with the resident and recommend Arginaid (nutritional support for individuals with pressure ulcers, diabetic foot ulcers, etc., which are not healing), and assess the resident's protein needs.Review of resident #2's comprehensive care plan, last reviewed on [DATE], and cancelled on [DATE] showed:Focus: [Resident Name] has limited physical mobility r/t delirium, dementia, Alzheimer's disease, physical behavioral symptoms directed toward others, long-standing mental health problem associated with behavioral symptoms, and pain. The focus was initiated on [DATE].Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown, fall related injury through the next review date. The date this was initiated was [DATE].Interventions: Wound care to L (left) heel and Wound care to R heel were interventions initiated on [DATE].Focus: Resident has a pressure injury (location). This was initiated on [DATE] and revised on [DATE].Goal: The pressure injury will show sign/symptoms of health with decease risk of infection through next review. The goal was initiated [DATE], and it was revised on [DATE].Interventions:a. Monitor Dressing QS to ensure it is intact and adhering. Report concerns to nurse. Nurse to change dressing as needed/ordered. This was initiated on [DATE] and revised on [DATE].b. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth) stage. c. Measure wounds weekly and report non-healing and worsening wounds to provider. Date initiated [DATE], revision on [DATE]. No other interventions for wound prevention and/or care were added. The care plan did not reflect ongoing attempts to add, modify, or show that the interventions were assessed and found to be beneficial for wound prevention. Review of resident #2's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for [DATE] showed the required weekly skin assessment scheduled for [DATE] was not completed. The TAR included documentation showing changes in wound care orders; however, the resident's record showed the continued progression and worsening of both heel wounds, despite ongoing treatments and documented interventions. Review of resident #2's diagnoses listing lacked any diagnoses related to pressure injuries to the resident's bilateral heels.Review of the facility's policy, Pressure Injury Prevention and Management, reviewed on [DATE], showed: Policy: This facility is committed to the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcer/injuries.Policy Explanation and Compliance Guidelines: .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.3. Assessment of Pressure Injury [NAME]. Licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale, on all residents upon admission, then quarterly or whenever the resident's condition changes significantly.4. Interventions for Prevention and to Promote Healing.C. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: .iii. Provide appropriate, pressure-redistributing, support surfaces; .6. Modifications of Interventionsa. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner.b. Interventions on a resident's plan of care will be modified as needed. Consideration for needed modifications include:i. Changes in resident's degree of risk for developing a pressure injury.ii. New onset or recurrent pressure injury development.iii. Lack of progression towards healing.iv. Resident non-compliance.v. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.The National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), and Pan Pacific Pressure Injury Alliance (PPPIA) Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline shows: Category/Stage III: Full Thickness Skin Loss, Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.Unstageable pressure ulcer: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth cannot be determined, but it will be either a Category III or IV pressure ulcer. Stable (dry, adherent, intact, without erythema or fluctuance) eschar on the heels serves as a natural (biological) cover and should not be removed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to promptly identify, evaluate, and implement interventions to address clinically significant weight loss and nutritional declines for 3 (#s 2, 7, and 5) of 3 sampled for weight loss; and failed to timely notify the resident representative of severe weight loss for 1 (#2) resulting in delayed intervention for a resident who experienced the severe 19.2 pound weight loss (14.0%) within approximately 30 days and met criteria for severe malnutrition for #2. This failure also resulted in delayed implementation and evaluation of nutritional interventions after resident #7 experienced progressive, clinically significant weight loss, which was severe, and subsequently met criteria for severe malnutrition; and the failure delayed evaluation and modification of nutritional interventions after resident #5 experienced an approximately 11% unplanned severe weight loss within 35 days despite multiple identified nutritional risk factors and meeting criteria for malnutrition for resident #5. Findings include:1. During an interview on 6/16/26 at 11:26 a.m., NF2 said resident #2 had lost 20 pounds during her stay at the facility and stated he was not notified of the weight loss until three weeks into her stay at the facility.Review of resident #2's electronic health record showed she was admitted to the facility on [DATE] following surgical repair of a right hip fracture.During an interview on 6/16/26 at 1:20 p.m., staff member B said residents with a weight variance of five pounds (more or less) were reviewed during weekly Nutrition at Risk (NAR) meetings.During an interview on 6/17/26 at 10:54 a.m., staff member G stated weekly weights were reviewed to monitor newly admitted residents and to recognize missed weekly weights or delayed identification of weight changes. Staff member G stated that when weights were not obtained, the process of identifying and addressing weight loss was delayed.During an interview on 6/17/26 at 11:55 a.m., NF3 stated resident #2 had experienced a weight loss of approximately 19.8 pounds within one month when admitted to hospice on 5/28/26.Review of resident #2's weights showed a 19.2 lb severe weight loss within approximately 30 days. The weights documented included:4/27/26 - 136.8 lbs.4/28/26 - 137.0 lbs.4/29/26 - 134.0 lbs.4/30/26 - 135.4 lbs.5/12/26 - 122.2 lbs.5/19/26 - 117.8 lbs.5/20/26 - 117.0 lbs.5/26/26 - 117.6 lbs.Review of resident #2's physician orders showed weekly weights were ordered beginning 4/27/26.Review of resident #2's May 2026 Medication Administration Record showed no weekly weight was obtained during the week of 5/3/26, as ordered.Review of resident #2's Mini Nutritional Assessment, completed shortly after admission, dated 4/29/26, showed resident #2 scored a 6, reflecting malnourishment. The assessment also included an inaccurate weight entry of 184.2 pounds, when the resident's actual weight was 134 pounds, creating an inaccurate baseline for nutritional monitoring.Review of resident #2's nutritional assessment dated [DATE] showed the identification of multiple nutritional risk factors, including declining meal intake with frequent refusals, medication-induced sedation limiting oral intake, increased nutritional needs related to wound healing, and recommendations for nutritional supplementation and interdisciplinary review.Review of meal documentation showed:- Five meals were documented as refused;- Nine meals were documented as 0% consumed;- Eight meals were documented as 1-25% consumed; and,- Twenty-four meal entries contained no intake documentation. Despite identified risks, poor oral intake, and documented weight decline, review of NAR meeting documentation dated 5/20/26 showed a 13.1-pound weight loss had been identified; however, the sections designated for current and new interventions were left blank. Resident #2 had not been reviewed during prior NAR meetings despite identified nutritional risk factors. It was unclear if the loss was avoidable, although the resident had multiple contributing factors for it. Review of resident #2's Medication Administration Record for May 2026 showed interventions addressing the resident's nutritional decline were not initiated until 5/10/26 and not revised with the order to offer high-protein snacks, Med Pass 2.0, and enhanced fluids until 5/21/26. Medication changes intended to address possible sedation affecting intake were not implemented until 5/23/26.Review of resident #2's progress notes showed the following:- Weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change Note, effective 5/21/26, documented resident #2 had experienced a severe 14.5% weight loss since admission and met criteria for severe malnutrition. The note identified poor oral intake, increased nutritional needs related to wound healing, and possible medication-induced sedation as contributing factors.- MD Progress Note, effective 5/21/26, documented that dietary staff had identified the weight loss associated with poor oral intake and frequent tray refusals. This documentation showed that physician review occurred after the resident's severe weight loss had already occurred.- Nurses Note, effective 5/24/26, referenced a severe 14.5% weight loss and documented the resident's POA was notified on 5/23/26.Review of resident #2's physical and occupational therapy documentation for her stay lacked goals with a focus on nutrition and/or weight loss.Review of resident #2's comprehensive care plan, last reviewed on 5/4/26, showed: .Focus: [Resident #2] meets AND/ASPEN diagnostic criteria for Severe Malnutrition in the context of an acute injury (post-op right hip ORIF), evidenced by severe non-volitional weight loss (-14.5% over 30 days) and severe energy restriction (75% EEN for >7days). Her nutritional decline is heavily compounded by advanced dementia, severe expressive aphasia, and a profound behavioral component. She frequently exhibits a clamped mouth defense mechanism, refusing both meal trays and oral medications. She has active bilateral heel Deep Tissue Injuries (DTIs) requiring elevated metabolic support. Date Initiated: 04/27/2026.Goal: Resident will meet >75% of her Estimated Energy Needs and elevated protein goals (71-88 g/day) to facilitate tissue synthesis and heal her bilateral heel DTIs. Date Initiated: 4/27/2026.Interventions: Administer Med Pass 2.0 (60cc TID) between meals to provide concentrated calories and protein to support intensive wound healing, particularly during periods of decreased PO meal intake. Date Initiated: 05/11/2026.Monitor for profound daytime sedation and somnolence (particularly following 12:00 PM scheduled psychotropic doses) that severely limits her ability to safely eat or drink. Report continued meal refusals related to sedation to the MD/Pharmacy for medication review. Date Initiated 5/11/26.Obtain weekly weights to monitor for significant fluctuations. Monitor and record meal intake percentages and total fluid consumed daily. Date Initiated 5/11/26.Provide and serve diet as ordered: Regular diet, regular texture, thin liquids. Date Initiated: 5/11/2026.Provide setup assistance, cueing, and 1:1 supervision during all meals to promote safety, address impulsivity/dementia, and encourage intake. Date Initiated: 05/11/2026.The resident needs assistance to eat at mealtimes and will be encouraged to eat in the dining room to facilitate assistance/supervision at meals as needed. Date Initiated: 04/27/2026.These findings demonstrated that although the facility identified and attempted to address the severe weight loss for resident #2, the medical record failed to show that the facility monitored, evaluated, and implemented effective, timely interventions to address resident #2's nutritional decline, resulting in delayed interventions for the weight loss. 2. During an observation on 6/16/26 at 2:59 p.m., resident #7 was observed seated in the day room at a table. Resident #7 was calm and was not exhibiting anxiety, pacing, or other behaviors that would interfere with activities of daily living, such as when eating a meal. During an interview on 6/16/26 at 9:22 a.m., staff member G stated that resident weight changes are identified during the facility's weekly Nutrition at Risk (NAR) meetings. Staff member G said implementation of weekly weights resulted in more weight-loss triggers being identified and reported, and she was notified of residents with weight loss during the weekly meeting.During an interview on 6/17/26 at 9:15 a.m., staff member B stated she was absent from the facility beginning on 5/11/26 for approximately two weeks. Staff member B stated that the Nutrition at Risk meeting documentation was not prepared for physician review during her absence, and she was unable to produce the missing NAR meeting documentation requested during the survey.During an interview on 6/17/26 at 10:54 a.m., staff member G stated that staff member B was the lead staff member for the Nutrition at Risk meetings. Staff member G said the task of completing the tracking was not delegated during staff member B's absence. Staff member G stated that weight variances were identified when she reviewed charts and through the NAR meetings, when staff member B reviewed weights before the meetings occurred.Review of resident #7's weight documentation showed a 10.2% (continued on next page)

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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 - Few	weight loss within approximately 60 days and an 8.5% weight loss within less than 90 days, which is a severe loss. The resident's weight decreased by 15.2 pounds from 4/12/26 to 5/19/26, per the weights documented in resident #7's medical records, which showed: 2/19/2026 - 130.6 Lbs.2/24/2026 - 127.8 Lbs.3/4/2026 - 131.6 Lbs.3/11/2026 - 130.8 Lbs.3/12/2026 - 128.0 Lbs.3/17/2026 - 131.2 Lbs.3/26/2026 - 132.4 Lbs.4/2/2026 - 131.2 Lbs.4/7/2026 - 133.0 Lbs.4/12/2026 - 133.0 Lbs.4/12/2026 - 133.0 Lbs.4/21/2026 - 128.8 Lbs.4/29/2026 - 128.7 Lbs.5/7/2026 - 127.2 Lbs.5/19/2026 - 117.8 Lbs.5/27/2026 - 118.0 Lbs.6/2/2026 - 116.2 Lbs.6/10/2026 - 118.8 Lbs.6/12/2026 - 120.0 Lbs.Review of resident #7's Speech Therapy documentation showed the speech therapy evaluation was completed on 4/16/26, and the swallow evaluation was completed the same day. The evaluation showed the identified goals for treatment of swallowing dysfunction and/or oral function for feeding. The resident was seen again on 4/23/26 for diet tolerance. Resident #7 was discharged from speech therapy services on 4/23/26.Review of resident #7's Occupational Therapy documentation showed that the goals for care for resident #7 were to increase the ability to feed herself and transfer to and from the commode as established in the evaluation completed on 4/27/26. The occupational therapy evaluation revealed a short-term goal: the resident will feed herself with encouragement from CNAs, set up so that she can fully reach her food, and complete at least 50% of her present food and drink, with a target date of 5/11/26. The documented long-term goal was that the resident would be set up at the table and be able to obtain food and consume over 50% with supplements if needed, with a target date of 6/22/26. However, treatment records showed occupational therapy did not address the resident's feeding or nutritional goals until 6/3/26, despite the goals being established on 4/27/26, and the resident had a severe weight loss.Review of resident #7's Medication Administration Records from January 2026 to June 2026 showed:- Mirtazapine 7.5 MG ordered on 11/12/25 for Major Depressive Disorder, but it was discontinued on 1/6/26.- Haldol orders were discontinued on 4/23/26 and 4/29/26.- Behavior monitoring documented eleven intervention episodes during May.Review of resident #7's behaviors from 5/19/26 to 6/16/26 showed the behaviors were consistently documented as None of the above observed, with one documented refusal. Review of psychiatric progress notes dated 5/21/26 and 6/4/26 described the resident as behaviorally stable without recurrence of previous severe aggression, paranoia, or psychotic behaviors.Review of resident #7's progress notes for May 2026 showed:- Orders-Administration Note, effective 5/5/26, included documentation that the resident was compulsive about staff care with other residents and required a back rub, redirection, to be spoken to gently, repositioning, food, and drinks.- Behavior Note, effective 5/7/26, showed, Resident is having some anxiety this evening but is easily redirected by having a conversation with staff and reassurance she does have a bed to sleep in for the night and a room here.Review of resident #7's Mini Nutritional assessment dated [DATE] showed a score of 10, reflecting the resident was at risk for malnutrition. However, the assessment contained inaccurate documentation of the resident losing 2.2 to 6.6 pounds during the previous three months. A review of documented weights showed the resident had actually lost approximately 12.8 pounds during those 3 months. Therefore, the assessment underestimated the resident's weight loss.Review of resident #7's quarterly nutritional assessment dated [DATE] showed, .Resident has experienced significant, unintentional weight loss. Current weight represents an 8.3% loss over 1 month (from 128.7), a 10.3% over 3 months (from 31.6 lbs) and 10.1% loss over 6 months (from 131.2). Resident now meets GLIM Criteria for Severe Malnutrition. The assessment also contained documentation of contributing factors such as discontinuation of Haldol, increased anxiety and agitation, and the prior removal of Mirtazapine.Review of the Nutrition at Risk meeting notes showed resident #7 was not discussed until the NAR meeting held on 5/27/26, despite the resident's ongoing documented weight loss.Review of the facility's document titled Clinical Diagnosis of Malnutrition (GLIM Criteria) dated 5/27/26 included documentation that resident #7 met the criteria for a formal diagnosis of Severe Malnutrition. Nutritional supplementation with Med Pass 2.0, three times daily, was initiated on the (continued on next page)

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	275025	A. Building B. Wing	06/17/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	same date.Review of resident #7's comprehensive care plan, last reviewed on 5/6/26 showed the facility identified severe malnutrition, significant unintentional weight loss, increased caloric expenditure, medication changes, dementia, and previous dysphagia as contributors to nutritional decline. The care plan included interventions to:- obtain weights per facility protocol;- provide increased encouragement and supervision during meals;- monitor meal intake each meal;- provide calorically dense supplementation; recommended psychiatric medication review; and- monitor weights according to facility protocol and NAR recommendations.Despite these identified risks and planned interventions, the record showed resident #7 continued to experience progressive weight loss before severe malnutrition was formally identified on 5/27/26. Nutrition at Risk (NAR) review implementation of Med Pass supplements, and recommendations for psychiatric medication review did not occur until after the resident met criteria for severe malnutrition. 3. During an interview on 6/17/26 at 10:54 a.m., staff member G said when a weekly weight was missed, she would request a reweight; however, the reweight was often not obtained until the following week. Staff member G said by the time weights were obtained and entered into the resident's medical record, identification and response to weight changes occurred later than preferred. Staff member G stated she obtained resident #5's weight of 107.6 pounds on 6/10/26.Review of resident #5's weights since admission reflected an 11% severe weight loss in approximately 35 days. Weights documented included: 5/8/2026 - 120.2 Lbs.5/9/2026 - 121.5 Lbs.5/10/2026 - 121.0 Lbs.5/11/2026 - 121.0 Lbs.5/14/2026 - 120.2 Lbs.5/22/2026 - 121.0 Lbs.6/5/2026 - 105.8 Lbs.6/10/2026 - 107.6 Lbs.6/12/2026 - 106.8 Lbs.Review of resident #5's Mini Nutritional Assessment, dated 5/12/26, was completed with a score of 6, categorized as malnourished, establishing that nutritional risk had been identified early in the resident's stay. Review of the facility's Nutrition at Risk (NAR) meeting notes showed resident #5 was not discussed until 5/27/26. The notes revealed no data in the columns for weight loss/gain, current weight versus prior eight weeks, and the notes showed the interventions to be Med Plus three times daily and Vitamin C and Zinc for two weeks.Review of resident #5's progress notes showed the resident consistently had no clinically significant edema documented throughout the period preceding the substantial weight decline, including Skilled Evaluation Notes dated 5/18/26 through 6/5/26, and physician progress notes dated 5/19/26, 5/26/26, and 6/2/26. A review of resident #5's Weight Change Note, effective: 6/16/26, showed the Resident triggered for significant weight loss, with an 11.7% decline (14.2 lbs.) from her 121.0 lbs. facility admit weight over the past 30 days. The initial rapid weight loss occurred following a traumatic fall at home, resulting in hospitalization for acute pelvic obturator fractures and subsequent transition to the facility. The weight decline from her 121 lbs. admit weight is also related to fluid shifts and fluid losses following her hospitalization. While this weight loss is multifactorial, it does indicate that true weight loss from her baseline has occurred.Review of resident #5's comprehensive care plan, last reviewed on 5/14/26, showed:Focus: NUTRITIONAL STATUS: [Resident #5] is at high nutritional risk related to the presence of severe pressure injuries (Left Ischium Stage 3, Right Proximal Hip Unstageable) and high metabolic demands following a recent pelvic fracture. Her nutritional status is heavily complicated by a history of Adult Failure to Thrive, severe dementia, acute agitation, and a German language barrier resulting in highly erratic meal and snack intake (ranging from 0% to 100%). Date Initiated: 05/08/2026, Revision on: 05/19/2026.[Resident #5] has nutritional problem or potential nutritional problem r/t difficulty making self understood, difficulty understanding others, arthritis, cardiovascular disease, pain, pressure injury, contractures, arthritis, functional limitation in ROM, hemiplegia/hemiparesis, cognitive loss and dementia. Date Initiated: 05/08/2026Revised Focus: NUTRITIONAL STATUS: Ute triggers for Severe Malnutrition (GLIM criteria) evidenced by severe significant weight loss (11.7% / 14.2 lbs. over 30 days) following a traumatic fall, acute pelvic fractures, hospitalization, and subsequent fluid shifts. Her weight has recently stabilized. She has high metabolic and nutritional demands to support healing of an active Stage 3 pressure injury to the proximal right hip. Nutritional status is heavily complicated by severe dementia, acute fracture pain, and a German language barrier, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which historically results in erratic meal and snack intakes. Date Initiated: 05/08/2026, Revision on: 06/16/2026.Goal: Resident will consume adequate food and fluid intakes to support stable weights and signs of healing/progression of wounds through next review date. Date Initiated: 5/14/2026, Revision on: 05/19/2026.The resident will maintain adequate nutritional status as evidenced by no unplanned/undesired significant weight changes, no s/sx of malnutrition, and adequate nutritional intake at meals through review date. Date Initiated: 05/14/2026.Revised Goal: Resident will maintain her recently stabilized weight and consume adequate food, fluids, and supplements to support the healing and progression of her Stage 3 pressure injury through the next review date. Date Initiated: 05/14/2026, Revision on: 06/16/2026.Interventions: Offer/Encourage fluids of choice. Date Initiated: 05/19/2026.Administer Med Plus 2.0 at 60cc TID between meals to provide concentrated protein and calories to support wound healing during periods of poor meal compliance. Date Initiated: 05/19/2026.Monitor intake at all meals, offer alternate choices as needed, alert Dietitian and Physician to any decline in intakes. Date Initiated: 05/14/2026, Revision on: 05/19/2026.Provide and serve diet as ordered: Regular diet, regular texture, thin liquids. Date Initiated: 05/19/2026.Provide assistance, visual cueing, and consistent, gentle verbal encouragement at all meals to maximize tray intake and safely navigate her cognitive and language barriers. Date Initiated: 05/19/2026.Revised Interventions: Actively offer and encourage 4-8 oz of preferred fluids between meals and with all medication passes to counteract diuretic use (Spironolactone) and support adequate tissue perfusion for wound healing. Date Initiated: 05/19/2026, Revision on: 06/16/2026.Administer Med Plus 2.0 at 60cc TID between meals to provide concentrated protein and calories to provide concentrated protein and calories to support weight stabilization and wound healing. Date Initiated: 05/19/2026, Revision on: 06/16/2026.Provide and serve diet as ordered: Regular diet, regular texture, thin liquids. Fortify foods. Date Initiated: 05/19/2026, Revision on: 06/16/2026.The documented records showed Resident #5 was identified as malnourished on 5/12/26 and experienced significant weight loss thereafter; however, review through the Nutrition at Risk process, recognition of severe malnutrition, and revision of the care plan did not occur until after the clinically significant weight loss had already occurred.Review of the facility's policy, Weight Monitoring, reviewed on 5/7/26, showed, .Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes:a. Identifying and assessing each resident's nutritional status and risk factorb. Evaluating/analyzing the assessment informationc. Developing and consistently implementing pertinent approachesd. Monitoring the effectiveness of interventions and revising them as necessary2. A comprehensive nutritional assessment will be completed upon admission on a residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status.3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible:a. Identified causes of impaired nutritional statusb. Reflect the resident's goals and preferencesc. Identify resident-specific interventionsd. Time frame and parameter for monitoringe. Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or a new causes of nutrition-related problems are identified.f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate.g. The resident and/or resident representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences.4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.5. A weight monitoring schedule will be developed upon admission for all residents:a. Weights should be recorded at the time obtained. (continued on next page)

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