STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365826	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continuing Healthcare of Cuyahoga Falls	300 East Bath Road Cuyahoga Falls, OH 44223

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure sufficient supervision and intervention was implemented to prevent Resident #11's from eloping, failed to ensure Resident #71 was transferred with staff assistance in a safe and dignified manner, and failed to ensure proper smoking procedures were implemented for five residents (#32, #34, #42, #48 and #52). This finding affected one (Resident #56) of three residents reviewed for elopement; one (Resident #71) of three residents reviewed for transfers; and five residents (#32, #34, #42, #48 and #52) of 17 smokers who reside in the facility. Facility census was 65. Findings include:1. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including alcohol abuse, depression and anxiety. Resident #11 resides on the secured memory care unit (SMCU). Review of Resident #11's admission Elopement assessment dated [DATE] revealed the resident was at a moderate risk of elopement. Review of Resident #11's Elopement Risk Care Plans dated 10/23/25 revealed the resident would maintain safety through a structured environment through the review date including frequent checks, maintain safety during increased episodes of wandering, initiate elopement protocols, monitor resident's location frequently throughout shift, offer engaging activities, offer fluids and snacks, provide comfort measures and routinely monitor placement and functionality of the wander guard. Review of Resident #11's physician orders revealed an order dated 10/23/25 for a wander guard and to ensure proper functionality daily; and an order dated 11/11/25 for the secured unit. Review of Resident #11's progress notes revealed no documentation from 10/23/25 to 10/29/25 regarding the resident eloping from the facility. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility elopement investigation report revealed on 10/27/25 at 2:00 P.M., Resident #11 was observed by Certified Nursing Assistant (CNA) #801 walking from his room to the nursing station and back to the room. At 2:50 P.M. the resident approached CNA #802 regarding a smoke break and at 3:18 P.M. Licensed Practical Nurse (LPN) #803 checked placement of the resident's wander guard. At 3:20 P.M., the resident was escorted to therapy by Physical Therapy Assistant (PTA) #804 who reported the resident attempted to stretch his legs by attempting to open the exterior door to the outside. The resident returned to the secured unit at 3:50 P.M. At 3:51 P.M., Registered Nurse (RN) #805 observed the resident walking and entering his room. At 5:00 P.M. the resident was observed by RN #805 and LPN #803 at the nursing station asking for a cigarette break. At 5:15 P.M., the resident's daughter arrived to bring cigarettes and the resident's room was observed open. At 5:16 P.M. to 5:21 P.M., the facility was searched, and a head count was completed (Resident #11 was not located). At 5:24 P.M., the police and the daughter were notified. At 6:00 P.M., the resident showed up at the family's farm property approximately four miles from the facility. At 7:18 P.M., the resident was returned to the facility, and an assessment was completed. At 7:50 P.M. all room windows on the secured unit were checked. Review of Resident #11's Skin Assessment form dated 10/27/25 upon return to the building revealed the resident had no redness, bruising, swelling or open areas. Review of Resident #11's Elopement Risk Assessment form dated 10/27/25 revealed the resident was high risk for elopement. Review of the facility documentation revealed the Administrator emailed to the State agency the report of Resident #11's elopement on 10/28/25 at 5:12 P.M. Review of Resident #11's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Interview on 11/19/25 at 10:31 A.M. with Maintenance Director (MD) #806 revealed Resident #11 told him he climbed out of the bedroom window, walked across the courtyard, scaled the six-foot privacy fence onto the roof of the building, walked across the building and down the other side. MD #806 revealed he put screws in the window to keep the window from opening greater than four inches and did an audit of all the other rooms and determined no other rooms opened greater than four inches. MD #806 revealed the resident must have worked at dislodging the screws to get out of the window. Observation on 11/19/25 at 10:32 A.M. with MD #806 of Resident #11's room revealed two silver screws were lying on the silver track of the windowsill and not in place to prevent the window from opening. The window was able to be opened fully during the observation. Telephone interview on 11/19/25 at 10:51 A.M. with Resident #11's daughter revealed she had arrived at the facility on 10/27/25 (unknown time) to drop some stuff off and the resident was not in his room. She stated that approximately an hour later, the resident showed up on family property in [NAME], Ohio approximately four miles away. Resident #11's daughter revealed the resident told her he crawled out a window, walked to the gas station and hitched a ride with someone he might have known to the property. She stated [NAME] police picked the resident up and transported him back to the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/19/25 at 11:21 A.M. with LPN #803 revealed Resident #11 was in therapy and came back and said he wanted to smoke a cigarette. LPN #803 revealed she had observed the resident going into his room to lay down and he was gone when she went to check on him. Interview on 11/19/25 at 11:29 A.M. with PTA #804 revealed on 10/27/25 she brought Resident #11 from the SMCU to the therapy room for therapy. She stated the resident was exit seeking and she had informed LPN #803 upon return to the SMCU. Review of the Elopement Policy and Procedures form revised 05/2024 revealed the facility would engage in active elopement prevention measures to mitigate the occurrence of elopement incidents. The facility would deploy a prompt investigation and search if a resident was considered missing. 2. Review of Resident #71's medical record revealed the resident was admitted on [DATE], readmitted on [DATE] and discharged on 11/01/25 with diagnoses including Alzheimer's disease, vascular dementia and generalized anxiety disorder. Resident #71 resided on the SMCU. Review of Resident #71's Falls Care Plan revealed an intervention dated 07/13/25 to encourage the resident to reach back prior to sitting. Review of Resident #71's Quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment and resides on the SMCU. Review of Resident #71's progress note dated 10/09/25 at 11:57 P.M. authored by LPN #839 revealed the nurse received a phone call from the resident's power-of-attorney (POA) and granddaughter who stated that the CNA who put the resident to bed was rough with her and made the resident hit the head on the wall. The family member stated that the CNA abused the resident, and they can see it from the camera inside the resident's room. The family was upset and wanted the nurse to assess the resident and ensure the resident was safe and free from injuries. A head-to-toe assessment including vital signs was completed. Review of the Physical Abuse Self-Reported Incident (SRI) Investigation Tracking Number #266222 dated 10/09/25 revealed Resident #11's son alleged that CNA #843 was a little rough with the resident when putting the resident in bed. CNA #843 was immediately suspended. A head to toe assessment was completed for Resident #71 with no adverse findings. The physician and son were notified. An investigation was initiated. The SRI was unsubstantiated. Review of Resident #71's Police Department Incident Supplement Report dated 10/10/25 at 2:17 P.M. revealed staff reported an incident between CNA #843 and Resident #71 on 10/09/25. The facility stated the family of Resident #71 had a video camera in her room and was concerned with how CNA #843 treated Resident #71 while transferring her from a wheelchair into her bed. The facility stated on the video, it seemed as though CNA #843 was being rough with Resident #71, and she stated you could hear her say ouch when he put her legs on the bed. The facility stated the family of Resident #71 did not want to contact the police and that it did not appear this act was intended to cause Resident #71 harm. CNA #843 had since been suspended and would soon be terminated. The facility wanted to document the incident and did not want to pursue charges. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/25/25 of the video surveillance from a camera in the resident's room provided by Resident #71's family dated 10/09/25 at 9:17 P.M. revealed CNA #843 was observed rolling the resident into the room in a wheelchair with the wheelchair facing the bed and the CNA standing between the wheelchair and the bed. CNA #843 lifted the resident under her arms roughly, turned and sat the resident on the bed. CNA #843 was then observed grabbing the resident's lower legs and throwing them over the bed, at which point a thump could be heard on the video and the resident stated oooo. Review of Resident #71's Skin Observation form dated 10/10/25 revealed no injuries noted. Telephone interview on 11/25/25 at 12:07 P.M. with CNA #843 revealed he assisted Resident #71 into the resident's room because she was falling asleep and the CNA had helped the resident into bed. CNA #843 denied he roughly put the resident in bed which caused her to hit a body part against the wall. He confirmed he was terminated due to this incident. Observation and subsequent interview on 11/25/25 at 12:25 P.M. of Resident #71's video surveillance (with family approval) with the Director of Nursing (DON) confirmed it was not clear in the video surveillance due to part of the wall blocking the view which part of the resident's body hit the wall and made a thump. The DON confirmed CNA #843 conducted an inappropriate transfer of Resident #71 from the wheelchair to the bed and was terminated. Review of the undated Transfers and Lifts policy revealed the procedure was used to assist a resident in moving from one surface to another (e.g. bed to wheelchair, wheelchair to car). It was a dynamic cooperative action between the resident and the caregiver. The resident must be able to bear weight through at least one or both arms. When doing the transfer, the caregiver must encourage the resident to help as much as possible. 3. Observation on 12/01/25 from 4:05 P.M. to 4:26 P.M. of smoking revealed there were five residents (Residents #32, #34, #42, #48, and #52) on the porch in the courtyard directly outside the activity area, smoking under the supervision of Activity Assistant #922. During the observation, no self-closing or flip-top ashtrays were noted in the area where residents were smoking, but there were two cigarette tower or chimney-style receptacles on either end of the porch area. During the observation, ashes from the cigarettes were flicked onto the ground below (cement pavement). Only two of the five residents observed (#42 and #52) were noted extinguishing their cigarettes and placing them into the tower receptacles before leaving the smoking area. Residents #32, #34, and #48 had no access to the tower receptacles (the receptacles were too far away, and the residents were not physically capable of getting themselves to the receptacles) and handed their lit cigarettes to Activity Assistance #922 to extinguish and place into the receptacle. During the smoking break on 12/01/25 between 4:05 P.M. and 4:26 P.M., the courtyard was observed to have cigarette butts scattered throughout the area near the Buckeye unit exit and adjacent areas, including on the patio just outside the doorway, the gravel on each side of the doorway (at least 50 were observed between these two areas), inside the trash can, which was lined with a plastic bag, on the lip of the lid of the trash can, and in the grass adjacent to the walkway. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/01/24 from 4:28 P.M. to 4:35 P.M. with Activity Aide #922 confirmed there were no ashtrays used during the smoking break, there were multiple cigarette butts in the courtyard near the Buckeye Unit entrance, including multiple butts scattered on the grass, at least 25 in the gravel to the right of the entrance, many butts scattered throughout the pavement, two visible in a trash can lined with a trash bag (not non-combustible), and one on the top of the lip of the lid of the trash can. Activity Assistant #922 also confirmed the presence of a cigarette butt lying in a pile of leaves to the left of where residents were smoking. During the interview, Activity Assistant #922 confirmed residents flicked their ashes onto the ground and verbalized uncertainty as to the facility's common practice or protocols, stating she was a new employee and had no formal training regarding ashtrays or where ashes were to be disposed of while residents were actively smoking. Activity Assistant #922 did, however, point out the two smoking tower receptacles and red fire suppression bucket for cigarette disposal, but then also acknowledged they were not in an area accessible to all residents who were outside during the smoking break. Interview on 12/03/25 at 2:15 P.M. with Maintenance Director #806 confirmed there was still one cigarette butt in the pile of dried leaves outside the café, adjacent to the new designated smoking area. Maintenance Director #806 further confirmed the cigarette butts remained in the trash can, and on the gravel, pavement, and grass near the Buckeye unit exit in the courtyard, and that he would not dispute that approximately 80 cigarette butts were counted in the courtyard on 12/01/25, when touring the grounds with Surveyor #42375. During the interview, Maintenance Director verbalized frustration, stating that what was most irritating was that he spent two hours, just a few weeks prior, picking up cigarette butts from the courtyard and re-educating smokers on proper disposal of their cigarette butts. Maintenance Director #806 verbalized that there were two residents who no longer resided in the facility (Residents #23 and #29) who had been sneaking out in the past and smoking without staff supervision, but now that they have been discharged , did not believe it was an ongoing problem. At the time of the interview, Maintenance Director #806 stated that staff taking residents out for smoking breaks were educated on who needed a smoking blanket, which included only one resident, Resident #16, who had not been participating in the smoking breaks recently. Maintenance Director #806 confirmed there were no flip-top or self-closing ashtrays for residents to dispose of burning ashes into during their smoking breaks, but that he had just ordered two ashtrays for the facility. Review of the policy titled Safe Smoking last revised March 2024 revealed designated smoking areas would include a fire blanket and a life safety approved ashtray and that safety guidelines during smoking were to be followed. 4. Review of the medical record for Resident #34 revealed an admission date of 11/14/25. Pertinent diagnoses included schizoaffective disorder, intestinal obstruction, unspecified visual loss, unspecified psychosis not due to a substance or known physiological condition, tobacco use, blindness of an unspecified eye, disorganized schizophrenia, legal blindness, ocular laceration and rupture with prolapse or loss of intraocular tissue of unspecified eye, unqualified visual loss of both eyes, and unspecified extrapyramidal and movement disorder (an involuntary movement disorder affecting daily life). Review of the admission Minimum Data Set (MDS) 3.0 assessment completed on 11/18/25 revealed Resident #34 had intact cognition and severely impaired vision. Further review of the MDS revealed Resident #34 required supervision or touching for all transfers, walking 50 feet. The MDS also indicated Resident #34 had unqualified visual loss in both eyes was a current tobacco user. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Smoking – Safety Screen (V2) assessment completed on 11/14/25 indicated Resident #34 did not have visual deficits and did not have hand movement or dexterity concerns. Further review of the smoking safety assessment revealed Resident #34 was deemed safe to smoke with supervision and without smoking safety or adaptive equipment and was educated on the designated smoking area and smoking times, but not educated on safe storage of smoking materials, or adherence to the smoking policies and procedures. Review of the baseline care plan completed on 11/15/25 revealed Resident #34 was a smoker and was at risk for injury related to smoking. Interventions included assistive devices were needed, such as a smoking apron or holding apparatus, which was check-marked, but the safety device needed was not further specified. The baseline care plan further indicated Resident #34 was to have a safe smoking assessment, be educated on the facility's smoking policy, and receive adequate smoking supervision as indicated. Review of the comprehensive care plan finalized 11/26/25 revealed Resident #34 was a smoker, preferred cigarettes, and had the potential for injury related to smoking. Interventions included providing adequate supervision as indicated and routine completion of a safe smoking risk assessment to assess the level of supervision required and smoking assistive devices needed. Further review of the care plan revealed the only assistive device listed was Staff supervision. Observation on 12/01/25 from 4:05 P.M. to 4:26 P.M. of smoking revealed Resident #34 was outside smoking with an additional four residents (Residents #32, #42, #48, and #52) in the courtyard directly outside the activity area, accompanied by Activity Assistant #922. During the observation, Resident #43 was observed holding a lit cigarette in the left hand that was resting on the left pantleg, wearing no clothing protector, and the ash burning at the end of the cigarette growing longer, just alongside the edge of Resident #34's sweatpants. At the time of the observation, Activity Assistant #922, leaned forward and assisted Resident #34 to flick the ashes onto the pavement by gently moving Resident #34's hand off the pantleg and then tapping the ashes onto the ground. Interview on 12/01/24 at 4:28 P.M. with Activity Assistant #922 confirmed Resident #34 had visual impairment and required staff to prompt or assist with flicking the ashes off the cigarette when needed. Interview on 12/04/25 at 11:35 A.M. with the Director of Nursing (DON) confirmed Resident #34 was blind and had motor/dexterity concerns and that the smoking risk assessment did not accurately reflect Resident #34's status. Further interview with the DON confirmed that, had the smoking risk assessment been filled out correctly, it would have indicated Resident #34 needed a clothing protector during smoke breaks for safety. Review of the policy titled Safe Smoking last revised March 2024 revealed smoking safety assessments were to be completed upon admission, quarterly, and with changes, and accurately reflect the residents' cognitive status, visual status, dexterity, ability to light their own smoking material, and need for adaptive equipment. Further review of the care plan revealed that resident care plans should contain an accurate safe smoking plan. This deficiency represents non-compliance investigated under Complaint Number 2670740, 2673792 and 2673996.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to ensure a medication error rate of less than 5%. A total of 28 medications were administered with two errors for a medication error rate of 7.14%. This finding affected two (Residents #11 and #49) of six residents observed for medication administration. Findings include:1. Review of Resident #11's medical record revealed the resident was admitted on [DATE] with diagnoses including alcohol abuse, depression and anxiety.Review of Resident #11's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #11's physician orders revealed an order dated 11/17/25 for Sertraline (Zoloft) antidepressant, give 75 milligrams (mg) by mouth in the morning for depression.Observation on 11/19/25 at 8:03 A.M. with Licensed Practical Nurse (LPN) #817 of Resident #11's medication administration revealed two medications were administered with one error. LPN #817 administered 25 mg of Sertraline antidepressant, and the physician ordered 75 mg.Interview on 11/19/25 at 1:15 P.M. with LPN #817 confirmed she administered the wrong dose of Zoloft antidepressant to Resident #11.2. Review of Resident #49's medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including alcohol abuse, muscle weakness and difficulty in walking.Review of Resident #49's admission MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment.Review of Resident #49's physician orders revealed an order dated 10/17/25 for Thiamine oral capsule 100 mg by mouth one time a day for a supplement.Observation on 11/19/25 at 8:35 A.M. with LPN #821 of Resident #49's medication administration revealed six medications were administered; however, the physician ordered Thiamine was not administered.Review of Resident #49's medication administration records (MARS) and treatment administration records (TARS) from 11/01/25 to 11/20/25 revealed LPN #821 documented she administered the resident's Thiamine as ordered on 11/19/25.Interview on 11/19/25 at 8:37 A.M. with LPN #821 confirmed Resident #49's Thiamine was not administered as ordered.Interview on 11/20/25 at 10:26 A.M. with the Director of Nursing (DON) confirmed LPN #817 had documented she administered Resident #49's Thiamine as administered on 11/19/25 inaccurately. The DON confirmed the Thiamine was on another cart in the building.A total of 28 medications were administered with two errors for a medication error rate of 7.14%.Review of the Medication Administration policy revised 06/2019 revealed it was the policy of the facility that the facility would implement a Medication Management Program that incorporates systems with established goals to meet each resident's needs as well a regulatory requirement. This deficiency represents non-compliance investigated under Complaint Number 2673792.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure meals were served per the dietitian approved menu. This finding affected seven (Residents #14, #21, #22, #27, #40, #44 and #57) residents and had the potential to affect all residents who eat meals in the facility. The facility census was 65.Findings include:1. Review of Resident #14 medical record revealed the resident was admitted on [DATE] with diagnoses including vascular dementia, altered mental status and anxiety disorder. The resident resides on the secured memory care unit (SMCU).Review of Resident #14's Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited severe cognitive impairment.Review of Resident #14's Mini Nutritional Assessment form dated 08/22/25 revealed the resident was at risk for malnutrition and had a weight loss between 2.2 pounds and 6.6 pounds.Review of Resident #14's physician orders revealed an order dated 08/26/23 for a regular diet, regular texture with a regular/thin consistency.Review of Resident #14's Increased Risk for Malnutrition Care Plan dated 02/21/25 revealed an intervention to provide the physician prescribed diet and notify nursing or the dietitian of any changes in appetite, feeding performance, or compliance concerns.Review of Resident #14's breakfast meal ticket dated 11/19/25 revealed the resident was on a regular diet.Review of the menus and spreadsheets for 11/19/25 for the breakfast meal included four ounces of juice of choice, four ounces of scrambled egg, six ounces of cereal of choice, one slice of toast, one milk, eight ounces of beverage of choice, one packet of margarine, one packet of jelly, salt, and pepper.Observation on 11/19/25 at 7:55 A.M. revealed Resident #14 was sitting in the dining room of the SMCU, and the breakfast tray consisted of scrambled eggs, half a bagel and orange juice. The resident did not have milk or cereal of choice per the stated menu, and the resident was not interviewable.Interview on 11/19/25 at 8:00 A.M. with Certified Nursing Assistant (CNA) #816 confirmed the above findings.2. Review of Resident #21's medical record revealed the resident was admitted on [DATE] with diagnoses including vascular dementia, anxiety disorder, and depression. The resident resides on the SMCU.Review of Resident #21 Increased Risk for Malnutrition Care Plan dated 07/11/25 revealed to provide finger foods and provide the physician prescribed diet and notify the nursing or dietitian of any changes in appetite, feeding performance or compliance concerns.Review of Resident #21's Mini Nutritional Assessment form dated 07/18/25 revealed the resident was malnourished.Review of Resident #21 Significant Change in Status MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem.Review of Resident #21's Nutrition Assessment form dated 09/18/25 revealed the resident was on a regular diet with finger foods and a health shake twice daily.Review of Resident #21's physician orders revealed an order dated 09/30/25 for a house shake two times a day with lunch and dinner and an order dated 11/10/25 for a regular diet, pureed texture with a regular/thin consistency.Review of Resident #21's breakfast meal ticket dated 11/19/25 revealed the resident was on a pureed diet and disliked pork.Review of the menus and spreadsheets for 11/19/25 for the breakfast meal included four ounces of juice of choice, four ounces of scrambled egg, six ounces of cereal of choice, one slice of toast, one milk, eight ounces of beverage of choice, one packet of margarine, one packet of jelly, salt, and pepper.Observation on 11/19/25 at 8:06 A.M. revealed Resident #21 was assisted by CNA #818 with the breakfast meal which consisted of pureed bread, scrambled eggs, and juice. The resident did not have milk or cereal of choice.Interview on 11/19/25 at 8:07 A.M. with CNA #818 confirmed the above findings.Observation on 11/24/25 at 7:59 A.M. with Licensed Practical Nurse (LPN) #803 of Resident #21's breakfast meal revealed the resident was served mechanical ground sausage, scrambled eggs, and juice. LPN #803 was assisting the resident with the breakfast meal.Interview on 11/24/25 at 8:00 A.M. with LPN #803 confirmed Resident #21 did not receive the cereal of choice, milk, and coffee cake per the menu.Interview on 11/24/25 at 8:15 A.M. with the Administrator in attendance of Dietary Manager (DM) #820 revealed he did not serve cold or hot cereal and milk to residents on the SMCU unless the meal tickets stated the residents were to receive hot/cold cereal and milk even though it was listed on the menu including for Resident #21.3. Review of Resident #22's medical record revealed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia, adult failure to thrive and depression. The resident resides on the SMCU.Review of Resident #22's Discharge Return Anticipated MDS 3.0 assessment dated [DATE] revealed the resident exhibited a memory problem. Review of Resident #22's Nutrition Note dated 09/30/25 at 10:15 A.M. revealed the resident was on a regular diet and texture with thin liquids and the resident refused weights Review of Resident #22's physician orders