

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2025
NAME OF PROVIDER OR SUPPLIER Falling Water Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 18840 Falling Water Strongsville, OH 44136	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, and review of facility policy the facility failed to ensure food was stored, prepared and served under sanitary conditions. This had the potential to affect 87 residents out of 91 residents who received food from the kitchen. Four residents (Resident #4, #37, #53, and #91) were identified as not receiving anything by mouth and received no food from the kitchen. The facility census was 91. Findings include: Observation on 07/28/25 from 8:22 A.M. through 8:36 A.M. with Registered Dietitian (RD) #950 revealed that in the dry storage area, there was a bottle of vanilla with a cracked lid. In the cooking area, the large floor mixer had dried batter on the back splash and the top of the mixing mechanism, and microwave had dried food splatter inside. The reach-in refrigerator had dried food splatter on the outside and there was vanilla pudding at labeled or dated. The cook's reach in refrigerator the following items were not labeled and dated: sliced American cheese, bologna, and a chef salad. In the reach-in freezer, there were pork chops not wrapped properly with no label or date on the unopened bag. In the dish area, the floor was greasy, and the three-compartment sink had food residue inside the empty compartments. [NAME] #800 stated that no one used the dish area yet. Observation of dishmachine on 07/29/25 at 10:12 A.M. revealed that the clean area of the dish machine had clumps of oatmeal on the drain board that when clean dishes finished the washing and sanitizing process, the racks pushed the oatmeal on the drainboard. Observation on 07/29/25 at 10:13 A.M. revealed that Dietary Manager (DM) #808 removed a clean rack of dishes after the warewashing process and placed it on the dirty drainboard of the three-compartment pot sink. Observation on 07/29/25 at 10:16 A.M. revealed Dietary Aide (DA) #806 was wearing gloves while putting dirty dishes on dish racks to get cleaned via dishmachine. DA #806 went to the clean side of the dishmachine and touched clean dishes to put away without changing gloves and performing hand hygiene. DM #808 explained to DA #806 that she must change gloves and perform hand hygiene prior to touching clean dishes. Review of the facility policy dated 05/2014 with a current revision date of 02/2023 titled, Warewashing, revealed that all dishware, serviceware, and utensils will be cleaned and sanitized after use using proper technique. Review of the facility policy dated 09/2017 titled, Receiving, revealed that safe handling practices will be followed. Review of the facility policy dated 05/2014 with a current revision date of 02/2023 titled, Food Storage: Cold Food, revealed that foods should be labeled and dated.		

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility did not ensure care conference meetings were offered or held for residents #6, #22, #41 and #80. This affected four residents (#6, #22, #41 and #80) of four residents reviewed for participation in care planning. The census was 91. 1.Review of the medical record for Resident #6 revealed an admission date of 10/27/24. Diagnoses included atrial fibrillation, hypertension and anemia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #6 had quarterly assessments completed on 03/15/25 and 06/13/25. Review of the miscellaneous tab in the electronic medical record (EMR) revealed the last documented care plan meeting was Resident #6's 72-hour meeting at admission. An interview on 07/28/25 at 2:29 P.M. with Resident #6 revealed he was only invited to one meeting, besides the 72-hour meeting, however he missed it. 2.Review of the medical record for Resident #22 revealed an admission date of 09/08/23. Diagnoses included hemiplegia and hemiparesis, diabetes and anxiety. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #22 was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #22 had quarterly assessments completed on 04/01/25 and 07/11/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was on 12/09/24 for Resident #22. Interview on 07/28/25 at 1:58 P.M. with Resident #22 and his mother revealed she used to receive invitations but had not gotten one in a while. Resident #22 stated he had not been invited to attend any care plan meetings. 3.Review of the medical record for Resident #41 revealed an admission date of 09/06/23. Diagnoses included end stage renal disease, respiratory failure and dysphagia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #41 was cognitively impaired. Review of the MDS report from March 2025 to July 2025 revealed Resident #41 had quarterly assessments completed on 03/06/25 and 06/06/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was 12/09/24. Phone interview on 07/28/25 at 1:10 P.M. with family of Resident #41 revealed the facility did not communicate with her even when she was visiting in the facility and she was not being invited to plan of care meetings. 4.Review of the medical record for Resident #80 revealed an admission date of 08/30/24. Diagnoses included quadriplegia, chronic pain syndrome and emphysema. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed he was cognitively intact. Review of the MDS report from March 2025 to July 2025 revealed Resident #80 had quarterly assessments completed on 03/07/25 and 06/06/25. Review of the miscellaneous tab in the EMR revealed the last documented care plan meeting was 02/10/25. An interview on 07/28/25 at 9:30 A.M. with Resident #80 revealed he was not involved in plan of care meetings in the year he had been there. An interview on 07/29/25 at 1:40 P.M. with licensed Social Worker (LSW) #560 revealed she identified an issue with the facility not offering care plan meetings possibly due to changes in LSW position and coverage from other buildings. She stated they had a few meetings for discharge planning. The team had not yet implemented a schedule or system for plan of care meetings. An interview on 07/30/25 at 10:07 A.M. with Licensed Practical Nurse (LPN) #538 revealed they have had some plan of care meetings for discharge planning however they have not had plan of care meetings for all residents as required. An interview on 07/30/25 at 3:00 P.M. with Regional MDS Registered Nurse (RN) revealed meetings should be held at 72-hour after admission, quarterly, annually and with a significant change. Review of the facility policy titled Plan of Care Overview, not dated, revealed the purpose of the policy was to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning. The policy read residents/representatives would be informed of their plan of care in the most understandable manner possible and would be offered opportunities to voice their view. They would (continued on next page)		

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be allowed to request meetings, be included in planning process and establish goals. The facility would hold meetings at a time when resident was functioning at his/her best and schedule meeting to accommodate a resident's representative that may include conference calls, video conference sessions of live sessions. This deficiency represents non-compliance investigated under Complaint Number 1300240.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, observations, resident interview, staff interview, and facility policy review, the facility failed to ensure dependent residents had access to call lights. This affected one resident (#9) of 24 residents reviewed for call lights. The facility census was 91. Findings include: Review of the medical record for Resident #9 revealed an admission date of 10/05/21 with diagnoses that included Parkinson's disease without dyskinesia, cerebral atherosclerosis, and dementia. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 3 that indicated short- and long-term memory impairment. Review of the MDS assessment revealed Resident #9 was dependent on staff for activities of daily living (ADLs). Review of the care plan dated 06/30/25 revealed Resident #9 had an ADL self-care performance deficit that required assistance with all ADLs including, but not limited to, all upper and lower body care and feeding with interventions that included placing call light within reach. Review of the progress note dated 07/24/25 at 8:49 P.M. revealed Resident #9 was currently receiving hospice services, had significant mobility limitations and was dependent on staff for all care including, but not limited to, bed mobility, hydration and feeding. Interview on 07/28/25 at 11:07 A.M. with Licensed Practical Nurse (LPN) #549 revealed Resident #9 was unable to have full conversations. LPN #549 revealed Resident #9 was able to give small responses that mainly consisted of yes and no answers. LPN #549 revealed Resident #9 required a call light to be within reach for staff assistance. Observation on 07/28/25 at 11:08 A.M. revealed Resident #9 in bed with no call light within reach. Resident #9 revealed a need for something to drink and could not reach the call light if wanted to. Resident #9's bed was observed pushed against another bed that allowed no space between the two. Resident #9's call light was not visible. Interview and observation on 07/28/25 at 11:11 A.M. with Registered Nurse (RN) #501 revealed Resident #9 gave yes and no responses when providing care. RN #501 revealed Resident #9 required a 2-person assist for all care needs including bed mobility, feeding and hydration. RN #501 revealed Resident #9 shared a room with their spouse and Resident #9's spouse would typically tell staff of needs. RN #501 revealed if Resident #9's spouse was out of the room while the call light was out of reach, Resident #9 would not be able to alert staff of needs. RN #501 revealed the call light was currently out of reach and Resident #9 would not be able to reach it. RN #501 observed Resident #9's call light was out of reach and on the floor between the two beds. RN #501 was observed moving both beds to retrieve call light from the floor underneath the beds and tangled up. RN #501 placed the call light on the right-side pillow next to Resident #9's head. Resident #9 was still unable to reach the call light. RN #501 confirmed and verified Resident #9's call light was out of reach. Interview on 07/30/25 at 1:24 P.M. with LPN #534 revealed Resident #9 was currently receiving hospice services and was completely dependent on staff for all care needs. LPN #534 revealed Resident #9 required to have the call light within reach for staff to meet all care needs. Observation on 07/30/25 at 1:30 P.M. revealed Resident #9 in bed with the call light not in reach. The call light was observed wrapped around the right-side bed rail. Resident #9 was unable to reach the call light. Interview and observation on 07/30/25 at 1:33 P.M. with Certified Nurse Assistant (CNA) #495 and #575 revealed Resident #9 was completely dependent on staff for everything including eating and drinking. CNAs #495 and #575 revealed Resident #9 was able to use the call light and it should always be within reach. Resident #9 was observed in bed with the call light between two beds pushed together. CNA #495 was observed reaching between both beds, retrieving call light and placed it in Resident #9 hand. Resident #9 demonstrated ability to utilize call light. CNA #495 and #575 confirmed and verified Resident #9 call light was out of reach. Review of the facility document titled Resident Rights undated, revealed the facility had a policy in place that the facility would ensure a method to communicate needs to staff via call light or bell access within reach.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident #68 had access to his social security allowance as required. This affected one resident (#68) of five residents reviewed for funds. The facility census was 91. Findings include: Review of the medical record for Resident #68 revealed and admission date of 03/01/24 with diagnoses including depression, quadriplegia, and need for personal care. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that Resident #68 was cognitively intact. Review of Resident #68's personal fund authorization was witnessed by two people that were not associated with the facility on 12/20/24. Review of the first quarterly statement for 2025 revealed that the facility received Resident #68's social security (SS) check was deposited into his personal funds account. Further review of the first quarterly statement of 2025 revealed that SS asked for his SS check to be returned, which was returned 02/18/25. Further review of the first quarterly statement of 2025 revealed that Resident #68's SS check was deposited, and he received his \$50.00 allowance in March 2025. Review of the receipt dated 03/25/25 revealed that Resident #68 signed that he withdrew \$50.00. Review of the second quarterly statement revealed that Resident #68's SS check for April was deposited on 04/03/25 and Resident #68's \$50.00 allowance was allotted to him. Further review of the second quarterly statement revealed that Resident #68's SS check for February was deposited on 04/14/25 however Resident #68 was not given his \$50.00 allowance retroactive from February. Resident #68 did not withdraw any monies in April 2025. Review of the second quarterly statement revealed that Resident #68's SS check for May was deposited on 05/02/25 and Resident #68's \$50.00 allowance was allotted to him. Review of the receipt dated 05/08/25 revealed that Resident #68 signed that he withdrew \$50.00. Review of the second quarterly statement revealed that Resident #68's SS check for June was deposited on 06/03/25 and Resident #68's \$50.00 allowance was allotted to him. Review of the receipt dated 06/10/25 revealed that Resident #68 signed that he withdrew \$10.00. Review of the receipt dated 06/18/25 revealed that Resident #68 signed that he withdrew \$40.00. Interview on 08/04/25 at 2:28 P.M. with Regional Business Office Manager (RBOM) #900 revealed that Resident #68's SS check in February was recalled by SS, so the check was not deposited. Resident #68's February check was deposited in April, so the system would not have recognized that Resident #68 should have been given his allowance of \$50.00 retroactive from February. RBOM #900 verified the facility did not ensure Resident #68 received his \$50 allowance from his February SS check as required. This deficiency represents non-compliance investigated under Complaint Number 1300243.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents had accurate advance directive orders and information in place throughout the medical record for Resident #86. This affected one resident (#86) out of 24 residents reviewed for advanced directives. The facility census was 91. Findings include: Review of the medical record for Resident #86 revealed an admission date of [DATE] with diagnoses including chronic kidney disease, vascular dementia, and heart failure. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #86 was severely cognitively impaired and dependent for activities of daily living. Review of the physician's orders for Resident #86 revealed cardiopulmonary resuscitation (CPR) will be performed. Review of the hard medical chart for Resident #86 revealed a Do Not Resuscitate Comfort Care-Arrest (DNRCCA) code status (meaning invasive or extreme life-supporting measures were allowed under any circumstance except for cardiac or respiratory arrest. In the event of cardiac or respiratory arrest only comfort measures would be initiated) dated [DATE]. Interview on [DATE] at 1:52 P.M. with Licensed Practical Nurse (LPN) #442 stated that she would check the electronic chart for code status. The electronic chart stated that the code status was CPR, while the hard chart had a signed DNRCC-A dated [DATE]. LPN #442 verified the mismatched code status for Resident #86. Review of the undated facility's policy titled, Advance Directives, revealed it is the policy to support and facilitate a resident's right to discontinue medical treatment and formulate an advance directive.		

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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. Based on observation, staff interview, medical record review, and review of facility policy, the facility failed to administer medications as ordered. There were two errors observed out of 28 opportunities for a medication error rate of 7.14 percent (%). This affected one resident (#10) out of seven residents observed for medication administration. The facility census was 91. Findings include: Review of the medical record for Resident #10 revealed an admission date of 02/27/24 with diagnoses including type two diabetes mellitus, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and chronic kidney disease with dependence on dialysis. Review of the physician orders dated 03/25/25 revealed Resident #10 had an order for 44 units of Lantus Insulin (long acting insulin) to be administered subcutaneously (SQ) by Insulin Pen injector in the morning as well as 14 units of Fiasp Insulin (short acting insulin) to be administered SQ by Insulin Pen injector before meals. Observation on 07/28/25 at 9:20 A.M. revealed Licensed Practical Nurse (LPN #559) preparing Resident #10's insulin medications. LPN #559 attached the needle to the Lantus insulin pen and dialed 44 units on the pen. LPN #559 then attached the needle to the Fiasp insulin pen and dialed 14 units on the pen. LPN #559 then administered each dose to Resident #10's left side of abdomen without priming either of the insulin pens to ensure no air bubbles were present and the pen was functioning appropriately. Interview on 07/28/25 at 9:25 A.M. with LPN #559 verified that she did not prime either insulin pens and stated she was not aware that they had to be primed prior to dialing the dosages. Review of both Lantus Solo Star Subcutaneous Pen Injector and Fiasp Flex Insulin Pen Injector's manufacturer instructions revealed before each injection small amounts of air could collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing turn the dose selector to two units. Hold the insulin pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. Review of the facility policy titled, Medication Administration, no date, did not address insulin administration via pen.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with foods to accommodate their allergies and preferences during meals. This affected three residents (#13, #40, and #46) of three reviewed for food/nutrition. The facility census was 91. Findings include: 1. Review of Resident #13's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and panic disorder. Review of Resident #13's physician orders for July 2025 revealed an order for a regular diet, thin liquid consistency. Resident #13 was ordered as allergic to eggs and egg products. Review of Resident #13's quarterly Minimum Data Set 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was independent for eating. Observation and interview on 07/30/25 at 12:04 P.M. revealed that Resident #13's tray was completed and put into the food cart to be delivered for lunch. Resident #13's tray ticket stated that she was to receive a #10 scoop of ground fruit cocktail as a preference. Dietary Manager (DM) #808 moved Resident #13's tray from food cart and verified that her diet ticket stated that Resident #13 was to get ground fruit cocktail but was served regular fruit cocktail. DM #808 removed the regular fruit cocktail and made ground fruit cocktail. This was verified by DM #808 at time of observation. 2. Review of Resident #40's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, major depressive disorder, and moderate protein malnutrition. Review of Resident #40's physician orders for July 2025 revealed an order for a regular dysphagia advance diet, thin liquid consistency. Resident #40 was to receive double entree all meals. Review of Resident #40's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited moderate impaired cognition and was independent for eating. Observation and interview on 07/30/25 at 11:53 A.M. revealed that Resident #40's tray was completed and put into the food cart to be delivered. Resident #40's tray ticket stated that he had an order for double portions. Dietary Aide (DA) #801 removed Resident #40's tray from the food cart and verified that his tray ticket stated that Resident #40 was to receive double portions and was served a regular size portion of chicken piccata. This was verified by Regional Dietary Manager (RDM) #809 at time of observation. 3. Review of Resident #46's medical record revealed the resident was admitted on [DATE] with diagnoses including anxiety disorder, depression, and chronic kidney disease. Review of Resident #46's physician orders for July 2025 revealed an order for a carbohydrate control renal diet, thin liquid consistency. Resident #46 was allergic to lactose. Review of Resident #46's quarterly MDS 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition and was independent for eating. Review of the recipe for chicken piccata revealed that an ingredient was two percent milk. Observation and interview on 07/30/25 at 11:47 A.M. revealed that Resident #46's tray was completed and put into the food cart to be delivered. Resident #46 tray ticket stated that she had a dairy allergen and was to receive a three ounce baked chicken breast instead of the chicken piccata being served as the main entree'. RDM #809 removed Resident #46's tray from the food cart and verified that her diet ticket stated that Resident #46 had a dietary allergen, was to receive a baked chicken breast but was served chicken piccata. This was verified by RDM #809 at time of observation. This deficiency represents non-compliance investigated under Complaint Number 1300241, Complaint Number 1300243, and Complaint Number 1300248.		