STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395338	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Immaculatemarycenter for Rehabilitation&healthcare	2990 Holme Avenue Philadelphia, PA 19136

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews with resident and staff and review of clinical records and facility documentation determined the facility did not ensure a resident's dignity was maintained during care for one of 35 resident records reviewed (Resident R85). Findings include: Review of Resident R85's clinical record revealed that the resident was admitted to the facility in February 2023 with the diagnosis of diabetic retinopathy, (a complication of diabetes that affects the eye), and legally blind. Review of R85's clinical record indicated the resident was incontinent of bowel and care planned to have the resident's activities of daily living needs met with staff assistances due to blindness. Review of documentation received by the facility dated August 7, 2025, indicated Resident R85 stated (she/he) was hit in the face during care by a nurse aide (NA) Employee E8. Review of a witness statement from the Assistant Director of Nursing (ADON), Employee E6 stated she and the unit manager (UM), Employee E9 heard Resident R85 yelling from the resident's room and went to investigate. Resident R85 told ADON that the NA, Employee E8, had hit her on the face. Review of the NA, Employee E8 witness statement stated that when the NA, Employee E8 lowered the head of the bed Resident R85 told her ?B***h I can't breathe.' The NA, Employee E8 stated she told the resident, Don't speak to me like that you asked to be changed. The NA, Employee E8 stated that Resident R85 began to get louder, and the NA walked out of the room. Continue review of the ADON's witness statement stated the NA was educated verbally about customer services. Further documentation received by the facility dated August 7, 2025, revealed Nurse Aide Employee E8 received counseling/education on being more attentive and validate the residents' needs. To reapproach the resident when calm, ask another staff member to assist, and to explain all tasks. Interview with Resident R85 on March 26, 2026, at 12:00 pm stated, I am blind, staff need to go slower and tell me what steps they are about to take before they just do it. The aide came into my room and without asking first and put my bed down. I couldn't see what she was about to do and I couldn't breathe. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of facility documentation, review of clinical records, and staff interviews, it was determined that the facility failed to ensure one resident received a gradual dose reduction of a psychotropic medication for one of five residents reviewed (Resident R193). Findings Include: Review of facility policy Psychotropic Medications revised September 2025 revealed psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Review of Resident R193's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 28, 2026, revealed the resident was assessed with severe cognitive impairment and had diagnoses of dementia (dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), depression (mood disorder characterized by low mood, a feeling of sadness, and a general loss of interest in things), and bipolar disorder (is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior). Continued review of Resident R193's quarterly MDS dated [DATE], revealed the resident was taking antipsychotic and antidepressant medications. Review of Resident R193's comprehensive care plan revised September 20, 2024, revealed the resident was at risk for behavior symptoms related to dementia and bipolar. Intervention dated July 29, 2021, included attempt psychotropic drug reduction per physician orders. Review of Resident R193's clinical record revealed a physician order dated December 27, 2023, to administer Zoloft (also known as Sertraline) 25 milligrams one time per day for depression. Review of Resident R193's Consultant Pharmacist Review, Physician Report dated December 8, 2025, revealed recommendations to consider a gradual dose reduction for Sertraline 25 milligrams. The report was signed, but not dated, by the physician noting that he/she agreed with the recommendations and to further consult psych to adjust the medication dosage. Review of Resident R193's clinical record revealed a psychiatric exam was not conducted until March 20, 2026. Review of Resident R193's Comprehensive Psychiatric Exam dated March 20, 2026, revealed recommendations to stop Sertraline. Review of Resident R193's clinical record revealed the physician order for Sertraline was still active as of March 26, 2026, and no follow-up from the physician. 28 Pa. Code 211.10 (a) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and review of clinical records, it determined the facility failed to develop a comprehensive care plan related to diagnoses Diabetes Mellitus and urinary catheter for two of 35 resident records reviewed (Resident R15). Findings include: Review facility policy on Resident Plan of Care revealed that under section Policy Statement: Our facility's care planning interdisciplinary team is responsible for the development of a plan of care for each resident. Under section Policy Interpretation and Implementation: The care plan is based on the resident's assessment and is developed by a care planning/interdisciplinary team. The interdisciplinary disciplinary team, resident, the resident's family and or resident's legal representative or surrogate are encouraged to participate in the development under visions for the residence care plan. Review of Resident R26's clinical record revealed that Resident R26 was admitted to the facility on [DATE], with a diagnosis of but not limited to Urinary Tract Infection, Essential Hypertension (high blood pressure). Review of nursing evaluation dated February 21, 2026, revealed that the resident had indwelling urinary catheter (foley catheter). Review of Resident R26's admission MDS (minimum data set, a federally required resident assessment completed at a specific interval) Dated February 27, 2026, section H0100. Appliances, A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) was coded yes. Review of physician's orders dated February 21, 2026, revealed the followingCatheter: Urinary Catheter Care every shift every shift for Foley catheter care AND every shift for catheter care Catheter Secure: Secure catheter with catheter secure or tape. Replace as needed. Monitor for placement every shift. as needed for Secure catheter Secure catheter with cath secure or tape. Replace as needed and every shift for prevention and Urinary Catheter Drainage Bag - Change as needed as needed CHANGE DRAINAGE BAG AS NEEDED. Review of Resident R26's care plan revealed a care plan for the use of a urinary catheter was not initiated developed until March 5, 2025. Continued review of the resident's care plan revealed that a care plan for At risk for infection r/t indwelling medical device r/t: Indwelling foley catheter. was not initiated until March 21, 2026. Observation conducted on March 23, 2026, at 1:45PM revealed that Resident R26 had a urinary catheter connected to a urinary drainage bag. Review of Resident R15's clinical record revealed the resident was alert and oriented, admitted to the facility diagnosed with type Diabetes Mellitus (failure of the body to produce insulin) with bilateral proliferative diabetic retinopathy with macular edema, (a complication of diabetes that affects the eyes). Review of Resident R15 clinical record revealed the resident was seen by an eye specialist approximately monthly indicating that the resident was instructed to sleep with the head of the bed elevated and to avoid bending over at the waist. Interview with Resident R15 on March 24, 2026, at approximately 11:30 a.m. indicated she was not aware of the above orders, and only does she sleep with the head of the bed elevated when she is short of breath. Further review of Resident R15 clinical record revealed the facility failed to develop a care plan for the resident's diagnosis of type Diabetes Mellitus. The above was confirmed with the Assistant Director of Nursing, Employee E6, on March 24, 2026, at 10:00 a.m. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 review of clinical records, review of facility policy and interview with staff, it was determined that facility did not ensure that residents received treatment and care in accordance with professional standards of practice related to abnormal laboratory values for one of 35 residents reviewed (Resident R8)Findings include: Review of facility policy ?Charting documentation,' unknown revision date, indicates that the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.' Review of Resident R2's clinical record revealed medical history of acute pulmonary edema, infection and inflammatory reaction due to indwelling urethral catheter (subsequent encounter), epilepsy (brain condition that causes recurring seizures), hypotension (low blood pressure), secondary malignant neoplasm of breast, down syndrome (a genetic condition cause by an xtra copy of chromosome 21), and intellectual disability. Review of Resident R8's Minimum Data Set (MDS- Resident Assessment and Care needs) revealed a brief interview for mental status (BIMS) score of 99 (resident interview was not successful). Review of Resident R2's laboratory results, collected on November 20, 2025, indicate ACTH, Plasma = 5.0 (Low) and Cortisol = 30 (High) Review of Resident R8's clinical record revealed physician progress note, completed by Physician, Employee E7, on November 24, 2025, at 2:55 pm, stated that laboratory data suggests the possibility of adrenal adenoma***or carcinoma***or primary adrenal hyperplasia***causing the disparity in the ACTH level (adrenocorticotropic hormone- test measures the level of ACTH in the blood, helping to diagnose conditions related to the adrenal and pituitary glands). and cortisol level. Due to Resident R8's underlying cognitive impairment due to down syndrome, Physician Employee E7 was reluctant to pursue diagnostic procedures, and will continue to monitor status. Further review of Resident R8 clinical record revealed no further explanation of what Resident R8 was to be monitored for and no evidence of documented nursing interventions to indicate steps were taken to prevent complications post abnormal laboratory results. 28 Pa. Code 211.2 (d)(3) Medical director 28 Pa Code 211.12(d)(5) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical record, review of facility policy, interview with staff and residents, it was determined that the facility failed to ensure that a urine bags (nephrostomy bag) were draining by gravity for one of 35 residents reviewed. (Resident R17)Findings include: Review facility policy on care of nephrostomy 2 with the most recent revision date of May 2025 revealed that under section PURPOSE: the purpose of this procedure is to provide guidelines for the care of the resident with nephrostomy tube Under section GERNERAL GUIDELINES: #1. When evaluating the nephrostomy tube check placement and integrity of the tubing letter A encouraged resident to have placement of nephrostomy tube below the level of the kidneys. Under section IRRIGATION: #7. Slowly aspirate the saline back into the syringe. If there is resistance, remove the syringe and reattach the nephrostomy tube to the drainage tube and allow the solution to drain by gravity. Review of Resident R17's clinical record revealed that Resident R17 was admitted to the facility on [DATE], with their diagnosis of but not limited to Chronic Kidney Disease. Review of physician's orders dated December 7, 2025, revealed Left nephrostomy (a surgical procedure that involves inserting a thin tube, known as a nephrostomy tube through the back to drain directly from the kidney), monitor and record output every shift and Right nephrostomy monitor and record output. every shift. Continued review of physician orders revealed an order dated March 19, 2026, for Nephrostomy drain: Monitor and change q (every) shift and prn every day-shift AND as needed Review of Resident R17's MDS (minimum data set a federally required Resident assessment completed at a specific interval) dated December 13, 2026, reveal that section C-0500 BIMS (Brief interview for mental status) score was 11suggesting that Resident R17 had a moderate cognitive impairment. Further, section C0400. Recall-Resident R17 was able to recall with no cue required on all three recall testing conducted. Observation conducted om March 23, 2026, at 12:04PM revealed that Resident R17 had left and right nephrostomy bag, was lying flat on the bed. Interview with Resident R17 conducted at the time of the observation revealed that she has nephrostomy tube on both the left and right kidneys. Further interview with Resident R17 revealed that the nephrotomy bag was always placed by the staff on her bed and never hanging under her bed. Interview with Assistant Director of Nursing Employee E16 conducted on March 23, 2026, at 12:13PM confirmed that both Resident R17's had left and right nephrostomy bag. Further, Employee E16 confirmed that both left and right nephrostomy bags were lying flat on the bed. 28 Pa Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 review of facility policy, review of clinical records, and staff and resident interviews, it was determined that the facility failed to identify, implement, monitor, and modify interventions to maintain acceptable parameters of nutrition for two of five residents reviewed for nutrition (Resident R173 and R282). Findings include: Review of Resident R173's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated October 24, 2025, revealed the resident was admitted to the facility on [DATE], assessed with severe cognitive impairment and had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), dysphagia (difficulty swallowing), muscle weakness, and muscle wasting. Continued review of Resident R173's comprehensive MDS dated [DATE], revealed Section K - Swallowing/Nutritional Status that indicated Resident R173 sustained a weight loss of 5% or more in the last month, or weight loss of 10% or more, in the last 6 months and was not on a physician prescribed weight-loss regimen. Review of Section K further revealed Resident R173 had complaints of difficulty or pain when swallowing and holding food in mouth/cheeks after meals. Review of Resident R173's clinical record revealed the following weight history:10/18/2025: 120 pounds10/19/2025: 110.8 pounds10/22/2025: 100.2 pounds11/5/2025: 95.8 pounds11/18/2025: 97.8 pounds Review of Resident R173's documented weight history reflected a significant weight loss of 16.5% from October 18, 2025, to October 22, 2025. The significant weight loss was not addressed by the until October 30, 2025. Review of Resident R173's clinical record revealed a nutrition assessment dated [DATE], but not signed and completed until November 19, 2025. Review of Resident R173's nutrition assessment dated [DATE], revealed weight loss was probable due to cognitive impairment, dysphagia, and increased calorie and protein needs to support wound healing.Per Resident R173's nutrition assessment dated [DATE], revealed supplements to be initiated for nutrient repletion and weight gain. The nutrition assessment failed to identify the type and frequency of supplements being recommended. Review of Resident R173's clinical record revealed oral nutrition supplements were not initiated until November 20, 2025. Review of Resident R173's documented weight history revealed the resident's weight continued to have a downward trend of 2.4 pounds to a weight of 97.8 pounds on November 18, 2025. Review of Resident R282's clinical record revealed that resident was admitted to the facility on [DATE], with diagnosis of but not limited to Dysphagia (difficulty swallowing), Muscle Wasting and Atrophy. Review of nutrition assessment dated [DATE], revealed admission weight is pending. Nutrient needs estimated using IBW. Noted weight documented at 136lbs on 12/16/25 during hospitalization. Per review of transfer records, h/o (history) weight declines prior to facility admission noted. Review of Resident R282's care plan dated December 18, 2025 revealed a care plan for at risk for malnutrition r/t(related to) dx (diagnoses) of communication deficit, dysphagia, HF (heart failure), anemia, CKD (chronic kidney disease), HTN (hypertension), altered lab values, need for therapeutic/mechanically altered diet, need for thickened liquids, impaired skin integrity, and BMI(body mass index-Calculates a person's body weight relative to their height to estimate total body fat) less than 24. Review of Resident R282's physician's order dated December 17, 2025, revealed an order for: Weekly weight x 4 weeks from admission every day shift every 7 day(s) for Baseline for 4 Weeks. Review of Resident R282's weight record revealed that there was no admission weight. Further review of Resident R282's weight record revealed that Resident R282's initial weight was taken on January 8, 2026, at 127.6 lbs. (pounds), an 8.4 lbs. weight loss from the hospital weight record of December 15, 2025, at 136 lbs. Review of clinical records revealed that there was no dietary notes/intervention for the 8.4 lbs. difference between the hospital weight record dated December 16, 2025, at 136 lbs, and the initial weight dated January 8, 2026, at 127.6 lbs. Further review of Resident R282's weight record revealed that on March 17, 2026, Resident R282's weight was 136.7 lbs. and on March 18, 2026, Resident R282's weight was 87.8 lbs. (35.77% weight loss). Further, the next weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was on March 25, 2026, at 88.4 lbs. A re-weigh done on March 25, 2026, revealed a weight of 124.6 lbs. Further review of Resident R282's clinical records revealed that there was no dietary notes/intervention for the significant weight difference between March 17, 2026, and March 18, 2026. Further, there was no re-weight after the significant weight difference between March 17, 2026, and March 18, 2026. Continue review of weight records revealed a re-weigh obtained on March 25, 2026, of 88.4 lbs. Follow-up re-weigh done on March 25, 2026, revealed a weight of 124.6 lbs. Interview with Registered Dietician, Employee E4 and Dietetic technician, Employee E5 conducted on March 26, 2026, at 9:48AM revealed that Resident R282's was under weight for (his/her) height of 6'1 (73 inches). Further, Employee E5 also confirmed that there was no documented evidence of dietary intervention for the weight loss episodes. Further Employee E4 also confirmed that there was no admission weight for Resident R282. Interview with Regional nurse, Employee E3 conducted on March 26, 2026, at 10:50AM revealed that the weight for March 18, 2026, and March 25, 2026, were erroneous and new weight was taken on March 25, 2026, during the evening shift. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies and procedures, and interview with staff, it was determined facility did not ensure that drugs and biologicals were stored according to professional standards of practice for one of two medication storage rooms reviewed on 4th floor unit. (medication storage room [ROOM NUMBER] South) Findings include: Review of facility policy ?Medication storage,' effective on March 2020, indicates its purpose is to store all drugs and biologicals in a safe, secure, and orderly manner. On Wednesday, March 26, 2026, the medication storage room temperature indicated an ambient temperature of 80 F, exceeding the generally accepted controlled room temperature range of 68 F to 77 F. During a medication room inspection on Wednesday, March 26, 2026 at 9:30 am, 15 medications were stored at temperatures exceeding recommended limits. During a medication storage room observation on Wednesday, March 26, 2026, at 11:40 am, multiple over the counter (OTC) medications, were observed stored in an area where the ambient temperature exceeded the recommended storage range of 68 F to 77 F, as indicated on manufacturer labeling. During interview with unit manager, employee E11, on Wednesday, March 26, 2026 at 11:45 am, it was confirmed the medication storage room temperature was exceeding recommended temperature, at 80F; as well as no evidence of prior documented room temperature logs. Further review of medication storage room on unit 4 South revealed the following OTC medications stored at 80F: Five bags of 0.9% sodium chloride injections;15 Lidocaine relief gel patches;Three bottles of Acetaminophen 325 mg;11 nicotine transdermal patches;Seven tubes of CareAll Muscle Rub Pain Relieving Cream;Deep Sea nasal moisturizing spray;Omeprazole 20 mg;Two packs of Sevelamer carbonate tab 800 mg;Three tubes of Procure hemorrhoidal ointment;Two bottles of zinc 50mg;Three bottles of vitamin D3, 400 IU/10 mcg;Three bottles of docusate sodium soft gels 100mg;Fish liver oil 3000 mcg;Nine tubes of Microdot Glucose Gel Fast Acting Gel 40% w/w;Four packs of loperamide tablets 2mg. 28 Pa Code 211.12(c)(d)(1) Nursing services

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on review of facility policy, review of clinical records, and staff interviews, it was determined that the facility failed to ensure laboratory values were timely reviewed for one of 35 residents reviewed (Resident R215).Findings Include: Review of facility policy Diagnostic & Lab Testing dated March 2020 revealed the physician will identify and order lab testing based on diagnostic and monitoring needs of a resident. Continued review of facility policy revealed a nurse will review lab results and communicate results to a physician who will review and be prepared to discuss. Review of Resident R215's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 31, 2025, revealed the resident was assessed with severe cognitive impairment and had a diagnosis of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). Review of Resident R215's clinical record revealed a nursing note dated March 3, 2026, that at approximately 8:30 a.m. Resident R215 had episode of what appeared to be seizure like activity for approximately three minutes. Per the nurse note, the physician was made aware and ordered a panel of labs. Review of Resident R215's clinical record revealed labs were drawn and resulted on Marh 3, 2026, with ten lab values noted to be out of range. Further review of Resident R215's clinical record revealed no documented evidence that the labs were reviewed and followed up on by the physician. Interview on March 26, 2026, at 11:45 a.m. with Licensed Nurse, Employee E13, confirmed no evidence Resident R215's labs were discussed with and reviewed by the physician. 28 Pa. Code 211.12 (d)(5) Nursing services.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of clinical records, observations, and interviews with staff and residents it was determined that the facility failed to ensure residents received modified diets consistent with assessed needs for one of 35 residents reviewed (Resident R215).Findings Include: Review of facility diet manual, dated 2023, revealed pureed foods are eaten and swallowed with minimal chewing and minimal jaw movement. Foods are pureed, homogenous, and smooth; and have pudding-like consistency. Review of Resident R215's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated December 31, 2025, revealed the resident was assessed with severe cognitive impairment and had diagnoses of dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), malnutrition (when the body lacks the proper amount of nutrients for proper function), and dysphagia (difficulty swallowing). Continued review of Resident R215's comprehensive MDS dated [DATE], revealed the resident received a mechanically altered diet (require change in texture of food or liquids). Review of Resident R215's speech therapy Discharge summary dated [DATE], by Speech Therapist, Employee E15, revealed puree consistency diet texture was recommended secondary to Resident R215 pocketing (holding food in the mouth without swallowing) trials of ground and chopped diet consistencies. Continued review of Resident R215's speech therapy Discharge summary dated [DATE], revealed the resident was unable to follow directions and had difficulty clearing pocketed food with liquids. Speech therapist, Employee E15, documented that on multiple occasions had to physically remove food from oral cavity. Review of Resident R215's physician order summary revealed a diet order dated September 26, 2025, for a pureed textured diet consistency. Observations on March 25, 2026, at 1:25 p.m. during lunchtime in the 3 Floor dining room revealed Resident R215 was sitting with a plate full of pureed food placed in front of him/her on the table but was eating a piece of regular (no texture modifications) cake with his/her hands. A review of Resident R215's meal ticket, located directly on the resident's meal tray, revealed the resident was ordered a pureed diet. Immediate interview conducted on March 25, 2026, at 1:25 p.m. with licensed nurse, Employee E12, who was standing nearby, reported Resident R215 was allowed to have the cake, although confirming that the meal ticket specified pureed texture diet consistency. Interview on March 25, 2026, at 1:27 p.m. with the Speech Therapist, Employee E14, confirmed Resident R215 was ordered a puree textured diet consistency without any exceptions or modifications to the diet. 28 Pa. Code 201.14 (a) Responsibility of licensee.