STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445253	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Grove Health and Rehabilitation	1520 Grove St Box 190 Loudon, TN 37774

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and interviews the facility failed to store frozen food items properly, failed to maintain kitchen equipment in a sanitary condition, and failed to discard undated cold food items, which had the potential to affect 95 of 97 residents residing in the facility. The findings include: Review of the facility's policy titled, Equipment Cleaning Procedures, dated 5/2018, revealed .all dietary equipment and the environment are cleaning and sanitized in a manner that meets .federal regulations .equipment .soiled between scheduled cleanings must be properly cleaned and sanitized .wash soil from equipment . Review of the facility's policy titled, Food Storage: Cold, dated 10/2019, revealed .frozen and refrigerated food items will be appropriately stored .Director insures [ensures] that all food items are stored properly in covered containers, labeled and dated .in a manner to prevent cross contamination . During an observation and interview with the Certified Dietary Manager (CDM) on 7/28/2025 at 11:36 AM, in the walk-in freezer area, revealed one 10-pound box of frozen [NAME] wedges, uncovered, which left the frozen food contents opened to air and potential contamination. Further observation revealed 2 of 8 [NAME] wedges had visible signs of discoloration on the food's surface from direct exposure to the air inside the freezer. The CDM confirmed the frozen [NAME] was available for resident use and was not sealed or stored properly. During an observation and interview with the CDM on 7/28/2025 at 11:41 AM, in the cooking and meal preparation area, revealed thick, brownish-yellow food debris present to 4 of 6 temperature dials (#1, #3, #4, and #6) located on the top and bottom convection ovens. Further observation revealed the lower convection oven had the presence of a thick, black, grease-like substance to the inner perimeter of the door handles. The CDM confirmed the temperature dials and door handles were not maintained in a sanitary condition and needed to be cleaned. During an observation and interview with the CDM on 7/28/2025 at 11:56 AM, of the reach-in refrigerator, revealed one 32-ounce (oz) container of nectar thick milk (1/4 full) with no open date present and directions written on the product's label to discard 7 days after opening, one 46-oz container of nectar thick water (1/2 full) with no open date present and directions written on the product's label to discard 7 days after opening, and one 46-oz nectar thick apple juice (1/2 full) with no open date present and directions written on the product's label to discard 7 days after opening. The CDM stated the nectar thick milk, nectar thick water, and nectar thick apple juice should be discarded 7 days after opening as directed on the product's label and stated she could not verify the opened dates. The CDM confirmed the thickened liquids were available for resident use, were not labeled appropriately, and should be discarded. During an observation and interview with the CDM on 7/29/2025 at 11:58 AM, revealed the can opener blade had a thick, black, sticky substance to the end of the blade. The CDM stated the thick, black, sticky substance was .probably the adhesive label from one of the cans . and confirmed the can opener blade needed to be cleaned and was not sanitary.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on facility policy review, observations, and interviews, the facility failed to ensure the residents' health information remained private and confidential on 1 medication cart (Station 2 Cart 1) of 3 medication carts observed, which had the potential to allow unauthorized individuals access to the residents' private health information. The findings include:Review of the facility's policy titled, Confidentiality of Personal and Medical Records, dated 3/23/2022, revealed .?Keep confidential' is defined as safeguarding the content of information including written documentation .or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative .Paper notes or reminders with resident's personal or medical information shall not be left unattended or viewable by unauthorized persons .During an observation on 7/29/2025 at 8:10 AM, on the Station 2 hall, revealed there was a written shift-to-shift communication sheet which listed the residents' names and various medical conditions stored on top of the medication cart (Stations 2 Cart 1). Further observation revealed a medication card label which listed resident's name was stored above clean plastic drinking cups on the side of the medication cart. Continued observation revealed the residents' personal and confidential medical information was visible on the medication cart and was left unattended by Licensed Practical Nurse (LPN) D. During an observation and interview with LPN D on 7/29/2025 at 8:14 AM, on the 200 hall, revealed there was a written shift-to-shift communication sheet which listed the residents' names and various medical conditions stored on top of the medication cart (Stations 2 Cart 1) and a medication card label which listed resident's name was stored above clean plastic drinking cups on the side of the medication cart. LPN D stated she should have ensured the resident's personal and medical information was not visible prior to leaving the medication cart.During an interview on 7/30/2025 at 7:45 AM, the Director of Nursing (DON) stated staff were expected to ensure the residents' personal and confidential information was secured and covered prior to leaving the medication cart.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and interviews the facility failed to maintain a safe, clean, homelike environment for 1 resident (Residents #28) on 1 of 5 hallways observed. The findings include: Review of the facility's policy titled, Safe and Homelike Environment, revised 5/2025, revealed .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms . A homelike environment is one that de-emphasizes the institutional character of the building .allows the resident to use personal belongings that support a homelike environment .determination of homelike should include the resident's opinion of the living environment .Housekeeping and maintenance services will be provided as necessary to maintain and sanitary, orderly and comfortable environment . Medical record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Unspecified Focal Traumatic Brain Injury, Hemiplegia, Dysarthria (slurred slowed or distorted speech), Anarthira (inability to articulate speech despite cognitive abilities), Epilepsy, Mood Disorder with Depressive Features, and Anxiety. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. During an observation and interview in Resident #28's room on 7/28/2025 at 11:00 AM, revealed one missing tile pulled from the floor lying to the right side of the resident's bed and one loose tile under the resident's bed. Resident #28 shook his head no when asked if he recalled how long the floor tiles had been damaged. Resident #28 shook his head yes when asked if he like to have them repaired. During an observation in Resident #28's room on 7/29/2025 at 1:00 PM, revealed one missing tile pulled from the floor lying to the right side of the resident's bed and one loose tile under the resident's bed. During an observation and interview in Resident #28's room on 7/29/2025 at 3:00 PM, with the Administrator and Maintenance Director revealed one missing tile pulled from the floor lying to the right side of the resident's bed and one loose tile under the resident's bed. The Administrator and Maintenance Director confirmed Resident #28's room was not maintained in a safe, clean, homelike environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) 3.0 User's Manual, medical record review, and interview, the facility failed to accurately complete a MDS assessment for 1 resident (Resident #37) of 25 residents sampled. The findings include:Review of the CMS MDS RAI User's Manual with an effective date of 10/2024, revealed .SECTION L: ORAL/DENTAL STATUS .DEFINITIONS .CAVITY .A tooth with a discolored hole or area of decay that may have debris in it .Steps for Assessment .Conduct exam of the resident's lips and oral cavity .Visually observe and feel all oral surfaces .Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums .Coding Instructions .obvious or likely cavity or broken natural teeth .if any cavity or broken tooth is seen . Review of the medical record revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Abdominal Aortic Aneurysm, Acute Kidney Failure, and Dementia. Review of the admission MDS assessment dated [DATE], revealed Resident #37 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Resident #37 had no dental problems including .Obvious or likely cavity or broken natural teeth . Review of the Nutritional assessment dated [DATE], revealed .Initial .Dental .Unable to examine .Review of the medical record revealed Resident #37 had no weight loss or oral pain.Review of the quarterly MDS assessment dated [DATE], revealed Resident #37 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Resident #37 had no weight loss. During an observation on 7/28/2025 at 3:43 PM, Resident #37 had poor dentition with multiple missing top and bottom teeth with areas of decay/discoloration present to remaining teeth. Resident #37 denied any trouble chewing or mouth pain. Resident #37 stated his teeth had been missing and in poor condition prior to being admitted to the facility. During an observation on 7/29/2025 at 8:38 AM, Resident #37 was lying in bed watching TV. The resident's breakfast tray was on the bedside table. Resident #37 ate 100% of his breakfast meal. Resident #37 had poor dentition with multiple missing top and bottom teeth with decay/discoloration to remaining teeth. During an interview on 7/29/2025 at 4:19 PM, the MDS nurse stated MDS filled out section L of the MDS assessment. An oral examination was performed to complete the assessment. Resident #37's admission MDS assessment dated [DATE] stated Resident #37 had no broken or missing teeth. During an interview on 7/29/2025 at 4:28 PM, the MDS nurse and the Social Worker stated they had visited Resident #37 and performed an oral examination. The MDS nurse and the Social Worker confirmed Resident #37 had multiple missing, broken, and .rotted . teeth. Resident #37 confirmed his teeth had been missing prior to admission and stated they had been like that .for a long time . The MDS nurse confirmed Resident #37's admission MDS assessment was not accurate and the .Obvious or likely cavity or broken natural teeth . choices should have been marked on the MDS assessment. The MDS nurse confirmed the facility followed the RAI Manual to code MDS assessments. During an interview on 7/30/2025 at 9:55 AM, the Director of Nursing (DON) stated she observed Resident #37's teeth on 7/29/2025 and confirmed the resident had multiple missing teeth and poor dentition. The DON stated section L of the MDS was completed by the remote MDS Coordinator. The DON confirmed the resident's admission MDS assessment dated [DATE] that stated Resident #37 had no dental problems was not accurate. The DON stated it was the expectation that MDS assessments were accurate. The DON confirmed Resident #37 had no weight loss or mouth pain. During a telephone interview on 7/30/2025 at 10:31 AM, the remote MDS Coordinator stated she worked remote and was not onsite at the facility. The remote MDS Coordinator stated she reviewed resident observations and progress note documentation to complete section L since she was not onsite to complete the assessment. The admission MDS assessment dated [DATE] stated Resident #37 had no dental concerns. The remote MDS Coordinator stated she was unable to find any information in the medical record regarding the resident's oral/dental status and . I just put none of the above were present since nothing was documented .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, review of the medical record, observations, and interviews, the facility failed to revise the comprehensive care plan for 3 residents (Resident #21, #72, and #83) of 25 residents reviewed for care plans. Review of the facility’s policy titled, “Comprehensive Care Plans,” dated 3/3/2025, revealed “ .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident’s medical, physical, mental, and psychosocial needs .The comprehensive care plan will describe .The services that are to be furnished .Resident specific interventions that reflect the resident’s needs and preferences .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .” Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Metabolic Encephalopathy, Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, and Depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #21 required supervision or touching assistance for personal hygiene. Review of the quarterly MDS assessment dated [DATE], revealed Resident #21 was dependent on staff for personal hygiene. Review of the care plan for Resident #21 dated 6/13/2025, revealed “ .ADLs [Activities of Daily Living] Functional Status/Rehabilitation Potential .has an ADL self-care performance deficit r/t [related to] generalized weakness, oxygen dependence, and COPD .PERSONAL HYGIENE/ORAL CARE .requires supervision/touching assistance .for personal hygiene .” During a telephone interview on 7/30/2025 at 10:38 AM, the remote MDS Coordinator stated Resident #21’s quarterly MDS assessment dated [DATE] stated the resident was dependent on staff for personal hygiene. Resident #21’s current comprehensive care plan stated Resident #21 required supervision and touch assistance for personal hygiene. The remote MDS Coordinator stated “ .care plans are a work in progress right now .” The remote MDS Coordinator confirmed Resident #21’s care plan had not been revised to reflect that the resident was dependent on staff for personal hygiene. During a telephone interview on 7/31/2025 at 6:33 PM, the Regional Director of Clinical Reimbursement stated MDS staff were responsible to update the care plan after the MDS assessment. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Cerebral Infarction, Type 2 Diabetes Mellitus, Severe Morbid Obesity, Dementia, Chronic Pain Syndrome, Dysphagia (difficulty or discomfort) in swallowing, Unspecified Psychosis, and Adjustment Disorder with Anxiety. Review of the care plan for Resident #72 dated 1/29/2025, revealed “ .[Resident #72] is a risk for alterations of nutritional status R/T [related to] DM [Diabetes Mellitus], mechanically altered diet, therapeutic diet .” Continued review revealed the care plan had not been revised after (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72's significant weight loss was identified. Review of the quarterly MDS assessment dated [DATE], revealed Resident #72 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #72 required set up/clean up assistance with eating. Resident #72 had a weight loss of 5% in the last month or loss of 10% or more in last 6 months and was not on a physician prescribed weight loss regimen. During an interview on 7/31/2025 at 6:33 PM, the Director of Nursing (DON) confirmed Resident #72 had significant weight loss and confirmed the resident’s care plan had not been revised to reflect the resident’s actual weight loss. During a telephone interview on 7/31/2025 at 6:33 PM, the Regional Director of Clinical Reimbursement stated the quarterly MDS assessment dated [DATE] revealed the resident had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and was not on physician prescribed weight loss regimen. The MDS Coordinator was responsible for updating the care plan after an MDS assessment. The Regional Director of Clinical Reimbursement confirmed the care plan had not been revised to reflect Resident #72’s weight loss. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Diabetes, Hemiplegia and Hemiparesis affecting the Right Side, and Acquired Absence of Toe(s). Review of a quarterly MDS assessment dated [DATE], revealed Resident #83 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident was dependent upon staff assistance for personal hygiene and mobility. Review of a Physician’s Order for Resident #83 dated 7/1/2025, revealed “ .Off-loading [pressure reducing] boots to be worn while in bed .” Review of the comprehensive care plan for Resident #83 revised 7/2/2025, revealed “ .at risk for skin breakdown R/T [related to] immobility, impaired physical limitations .eliminate risk factors to extent possible .ADL [activities of daily living] self-care performance deficit .requires total assistance from staff member .” Further review revealed Resident #83’s order and use of the offloading-pressure reducing boots was not revised on the care plan. During an observation on 7/28/2025 at 1:00 PM, in Resident #83’s room, revealed Resident #83 was lying in bed with the bilateral offloading boots present to both heels. During an observation on 7/29/2025 at 3:55 PM, in in Resident #83’s room, revealed Resident #83 was lying in bed with the bilateral offloading boots present to both heels. During an interview on 7/30/2025 at 9:30 AM, Certified Nursing Assistant A stated Resident #83 required the use bilateral off-loading boots while in bed. During an interview on 7/30/2025 at 9:35 AM, the Wound Care Nurse stated Resident #83 wore the bilateral off-loading boots while in bed to offload pressure to the bilateral heels. During an interview on 7/30/2025 at 10:00 AM, Resident #83 stated he wore the offloading pressure (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	boots to both of his heels and stated he “ .wears them all the time .” During an interview on 7/30/2025 at 11:00 AM, the MDS Nurse stated the care plan should be revised and updated when new care interventions are ordered for each resident. The MDS Nurse confirmed the facility failed to revise and update Resident # 83’s comprehensive care plan to reflect the required use of the off-loading boots to bilateral heels. During an interview on 7/30/2025 at 11:04 AM, the Assistant Director of Nursing (ADON) confirmed the facility failed to revise and update Resident # 83’s comprehensive care plan to reflect the resident’s required use of the off-loading boots to the bilateral heels.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview the facility failed to follow physician orders for 1 resident (Resident #72) of 25 residents reviewed for physician's orders.The findings include:Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Cerebral Infarction, Diabetes Mellitus, Severe Morbid Obesity, Dementia, Chronic Pain Syndrome, Dysphagia (difficulty or discomfort) in swallowing, Psychosis, and Adjustment Disorder with Anxiety.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #72 had a weight loss of 5% in the last month or loss of 10% or more in last 6 months and was not on a physician prescribed weight loss regimen.Review of the Registered Dietitian (RD) notes for Resident #72 dated 6/18/2025, revealed .RD Review Wt [weight] Loss: wt 271.5# 6/4 [6/4/2025], down from 312.6# x 1 mo [month] .signif [significant] wt loss 13%. Wt stable since 6/2 [6/2/2025]. BMI [body mass index] = 47, high .Will monitor weekly wts until stabilized.Review of the Physician Order Report for Resident #72 revealed an order dated 6/26/2025 for .Weekly weight Once A Day on Sun [Sunday] .Review of the Vitals Report for Resident #72 revealed weights for the resident were obtained as follows: 6/29/2025 - 273 lbs.; 7/2/2025 - 265.5 lbs.; 7/6/2025 - 265.0 lbs.; and 7/13/2025 - 258 lbs. Resident #72 refused to be weighed on 7/20/2025.Review of the Physician Order Report for Resident #72 revealed a Nurse Practitioner (NP) order dated 7/9/2025 for .Speech therapy [ST] evaluation for possible upgrade in diet . Further review revealed there was no order to discontinue the ST evaluation for Resident #72.Review of the ST notes for Resident #72 revealed an ST evaluation was not performed for the resident as ordered by the NP on 7/9/2025.Review of the physician order for Resident #72 dated 7/21/2025, revealed an order to discontinue weekly weights. Further review revealed .DC [discontinue reason] .Condition [weight loss] resolved . Further review revealed the order to discontinue weekly weights was initiated by the Director of Nursing (DON) and was not ordered to be discontinued by the physician or the NP.Review of the Vitals Report for Resident #72 revealed the resident was weighed on 7/31/2025 and was noted as 246.8 lbs. (2 weeks and 4 days since the previous weight on 7/13/2025).During a telephone interview on 7/31/2025 at 9:35 AM, ST C confirmed Resident #72 was not evaluated by ST according to the order on 7/9/2025, because the resident had recently been discharged from ST services on 6/24/2025. ST C stated she did not recommend upgrading the resident's diet because the resident was unable to safely consume a mechanical soft diet during the treatment sessions. During an interview on 7/31/2025 at 3:18 PM, the NP stated she was under the impression Resident #72 had been evaluated by ST as ordered. The NP stated she was not aware ST had not evaluated Resident #72 according to the order until 7/31/2025 (after identified by the Surveyor and 22 days after the order was written). The NP stated Resident #72 should have been on weekly weights, the weekly weights should not have been discontinued, and confirmed she had not written an order for the weekly weights to be discontinued. The NP stated she was not aware the weekly weights had been discontinued for the resident.During a telephone interview on 7/31/2025, the Medical Director stated increased weight monitoring should have been implemented at the point Resident #72 exhibited significant weight loss. The Medical Director stated she did not recall having a conversation regarding the resident's weekly weights and did not specifically recall giving the order to discontinue the resident's weekly weights. The Medical Director was not aware the ST evaluation ordered on 7/9/2025 for Resident #72 had not been done. The Medical Director stated she expected physician orders should be followed.During an interview on 7/31/2025 at 6:03 PM, the DON stated she discontinued Resident #72's weekly weights because the resident no longer flagged for significant weight loss. The DON stated weekly weights were discontinued if weights were stable for 4 consecutive weeks. Resident #72's weights were reviewed with the DON, who stated .looking at it now, weekly weights should not have been discontinued [for Resident #72]. I did not take into account, the weight refusal on 7/20/2025 . The DON confirmed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #72 should be on weekly weights and confirmed she had not discussed discontinuing the resident's weekly weights with the resident's physician.During an interview on 7/31/2025 at 6:45 PM, the Director of Therapy stated Resident #72 had been evaluated/treated by ST services. The resident was discharged from Speech Therapy services on 6/28/2025. The Director of Therapy stated an order was issued by the NP for a new ST evaluation for Resident #72 on 7/9/2025. The Director of Therapy stated she and the SLP (ST C) spoke with the Assistant Director of Nursing (ADON) by telephone. She stated the SLP explained the ST evaluation was not indicated due to the resident's recent discharge from ST, and the ST was not comfortable upgrading Resident #72's diet. The Director of Therapy stated she and the ADON spoke with the NP who was unaware the resident had recently been discharged from ST. The NP stated she understood and was going to address it (ST Order) accordingly. The Director of Therapy was under the impression the NP was going to cancel the order for the ST evaluation.

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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 the facility contract for nutrition services, review of the facility policy, review of the medical record, observation, and interview the facility failed to implement appropriate interventions to prevent weight loss for 1 resident (Resident #72) of 3 residents reviewed for weight loss. The findings include:Review of a facility document titled, Contract for Nutrition Services, dated 12/1/2023, revealed .Subcontractor Service Duties .provide one or all of the following services .Correlate and integrate the nutritional aspects of client care with other client care services to include directing the following .Reviewing the clients medical record history and assessing the client's nutritional status .Interviewing and counseling clients .Recording client information in the medical record .Assessing, planning, and implementing nutrition care for clients .Developing nutrition care goals .Completing nutrition assessment forms .Work as part of the medical team .Subcontractor Services shall include, but are not limited to .Visit FACILITY on days specified and agreed upon by both parties and assure that the professional dietary clinical needs of FACILITY are met .Complete monthly assessments on residents experiencing significant weight loss .Provide consultation to FACILITY employees regarding diet, nutritional problems and management including patient care plans and case review .Review resident care plans and participate in development of dietary policies .Provide FACILITY monthly written reports which shall be signed and dated and contain a summary of areas reviewed and recommendations .Chart nutritional information in accordance with the policies of FACILITY and accepted professional practice .RECORDS .FACILITY and Subcontractor shall prepare and maintain complete and detailed records concerning Facility's residents receiving Services under this Agreement, in accordance with prudent record-keeping procedures . Review of the facility's policy titled, Weight Assessment/Monitoring, dated 1/2025, revealed .The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents .Any weight change of 5% [percent] or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the Dietitian .The Dietitian will review the unit Weight Record by the 15th of the month to follow individual weight trends over time. Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .1 month - 5% weight loss is significant; greater than 5% is severe .3 month - 7.5% weight loss is significant; greater than 7.5% is severe .6 months - 10% weight loss is significant; greater than 10% is severe .Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the .Resident's target weight range (including rationale if different from ideal body weight) .Approximate calorie, protein, and other nutrient needs compared with the resident's current take .Whether and to what extent weight stabilization or improvement can be anticipated .The Physician and the multidisciplinary team will identify conditions and medications that may be causing .weight loss or increasing the risk of weight loss. For example .Cognitive or functional decline .Increased need for calories and/or protein .The Physician and the multidisciplinary team will identify conditions and medications that may be causing .weight loss .For example .Cognitive or functional decline .Chewing or swallowing abnormalities .Interventions for undesirable weight loss shall be based on careful consideration of the following .Resident choice and preferences .Nutrition and hydration needs .Functional factors that may inhibit independent eating .Chewing and swallowing abnormalities and the need for diet modifications .The use of supplementation and/or feeding tubes . Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Cerebral Infarction, Diabetes Mellitus, Severe Morbid Obesity, Dementia, Chronic Pain Syndrome, Dysphagia (difficulty or discomfort) in swallowing, Psychosis, and Adjustment Disorder with Anxiety. Review of the comprehensive care plan for Resident #72 dated 1/29/2025, revealed .[Resident #72] is a risk for alterations of nutritional status R/T [related to] DM (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Diabetes Mellitus], mechanically altered diet, therapeutic diet . Review of the Physician Orders for Scope of Treatment (POST) form for Resident #72 dated 1/30/2025, revealed the box was checked for .Long-term artificial nutrition by tube [tube feeding] . Review of the Vitals Report for Resident #72 for 1/30/2025-7/31/2025 revealed the following weights:1/30/2025 - 323.6 pounds (lbs.)2/9/2025 - 315.5 lbs.2/17/2025 - 314.2 lbs.2/25/2025 - 314.2 lbs.3/8/2025 - 312.8 lbs.4/11/2025 - 312.8 lbs.4/15/2025 - 312.6 lbs.5/2/2025 - 312.6 lbs.6/2/2025 - 271.5 lbs. (13.15% weight loss in 1 month)6/4/2025 - 271.5 lbs. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #72 required set up/clean up assistance with eating. Resident #72 had a weight loss of 5% in the last month or loss of 10% or more in last 6 months and was not on a physician prescribed weight loss regimen. Review of the Registered Dietitian (RD) notes for Resident #72 dated 6/6/2025, revealed the RD's quarterly review for Resident #72 revealed the resident was on a mechanical soft (diet which is easy to chew and swallow) Consistent Carbohydrate (CCHO-diet for managing blood sugar levels) diet. The resident's weight was 271.5 lbs., which was down from 312.6 lbs. for 1 month. The resident had a significant weight loss of 13% in 1 month. The plan was to continue to monitor, follow the resident as needed, and to continue the plan of care. Further review revealed no evidence the RD recommended interventions to prevent further weight loss for Resident #72. Review of the Speech Therapy (ST) notes for Resident #72 dated 6/16/2025, revealed the resident was evaluated by ST due to difficulty taking medications and decreased oral (by mouth) intake. The ST recommended a puree diet for Resident #72. Review of the physician orders for Resident #72 dated 6/16/2025, revealed an order for a CCHO, puree diet. Review of the RD notes for Resident #72 dated 6/18/2025, revealed .RD Review Wt] [weight Loss: wt 271.5# [pounds] 6/4 [6/4/2025], down from 312.6# x 1 mo [month] .signif [significant] wt loss 13%. Wt stable since 6/2 [6/2/2025] .Intakes good per nsg [nursing] doc. [documentation] Will monitor weekly wts until stabilized. Cont [continue] POC plan of care]. Continued review revealed the RD provided no recommendations to prevent further weight loss for Resident #72. Review of the nurse's notes for Resident #72 dated 6/23/2025 at 7:55 PM, revealed .Resident #72] dislikes pureed food and not eating as much as she normally does. Nurse crushes medications d/t recent choking episode on morning medications Review of the ST SLP (Speech-Language Pathologist) Discharge Summary for Resident #72 dated 6/24/2025, revealed .Assistance/Support to be Provided [with meals] .pt [patient] to be assisted by caregiver/staff .Progress & [and] Response to Treatment .At this time, pureed diet and thing liquids is the safest and most appropriate diet level .pt to discharge from therapy due to max potential achieved at this time .Prognosis to Maintain CLOF [continued level of functioning] .Good with consistent staff follow-through . Review of the Physician Order Report for Resident #72 revealed an order dated 6/26/2025 for .Weekly weight Once A Day on Sun [Sunday] . Review of the nurse's notes for Resident #72 dated 6/28/2025 at 1:13 PM, revealed .Patient [Resident #72] refuses to eat pureed food. Pudding offered and accepted. Patient's [Resident #72] food intake has decreased since the pureed diet was ordered . Review of the Vitals Report for Resident #72 for 1/30/2025-7/31/2025 revealed the following weights:6/29/2025 - 273.2 lbs.7/2/2025 - 265.5 lbs. (2.82% weight loss (6/29/2025; 2.21% from 6/2/2025, and 15.07% weight loss from 5/2/2025). Review of the Nurse Practitioner (NP) notes for Resident #72 dated 7/2/2025, revealed nursing staff reported Resident #72 had not been eating as well .since changing to a pureed diet, which was recommended by speech therapy . Continued review revealed no documentation of a plan to address the resident's refusal to eat and no documentation of the resident's significant weight loss. Review of the Vitals Report for Resident #72 for 1/30/2025-7/31/2025 revealed the following weights:7/6/2025 - 265.0 lbs. Review of the nurse's notes for Resident #72 dated 7/8/2025 at 6:13 PM, revealed the resident reported .she could not swallow. Continued to drink water and other drinks throughout shift. Refused to eat pureed food. NP notified . Review of the NP notes for Resident #72 dated 7/9/2025, revealed Resident #72 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a history of Dysphagia. The resident was being evaluated related to nursing staff concerns regarding Resident #72's refusal to eat and complaints of difficulty swallowing. Continued review revealed Resident #72 reported .ongoing swallowing difficulties, which have been previously evaluated by speech therapy. [Resident #72] is currently on a pureed diet but express dissatisfaction with it while simultaneously [at the same time] acknowledging her swallowing issues . The plan was to continue the pureed diet and refer the resident to speech therapy for diet upgrade evaluation. Review of the Physician Order Report for Resident #72 revealed an NP order dated 7/9/2025 for .Speech therapy evaluation for possible upgrade in diet . Review of the ST notes for Resident #72 revealed no evidence the ST evaluation was performed according to the order dated 7/9/2025. Review of the Vitals Report for Resident #72 for 1/30/2025-7/31/2025 revealed the following weights:7/13/2025 - 258.0 lbs. (17.47% weight loss from 5/2/2025-7/13/2025) Review of the RD notes for Resident #72 dated 7/16/2025, (44 days after Resident #72's significant weight loss of 13% had been identified on 6/2/2025), revealed wt 258# 7/13 [7/13/2025], down from 312.6# x 3 mo .signif wt loss 17.5% .Resident refusing to eat pureed diet [foods are blended or mashed to a smooth, pudding-like consistency and requiring no chewing] per nsg doc. ST reports resident was unable to chew mechanical soft diet when evaluated. Will provide Boost glucose control [nutritional drink designed to provide complete, balanced nutrition] BID [twice a day] between meals [ordered 2 months 2 weeks after Resident #72's significant weight loss of 13% had been identified] .Will cont to monitor and follow as needed, cont POC . Review of the physician order for Resident #72 dated 7/16/2025, revealed .Boost diabetic control .BID [two times a day] between meals Twice A Day . (44 days after Resident #72's significant weight loss had been identified on 6/2/2025). Review of the Medication Administration Record for 7/2025 for Resident #72 revealed the resident refused to be weighed on 7/20/2025. Review of the physician order for Resident #72 dated 7/21/2025, revealed an order to discontinue weekly weights. Further review revealed .DC [discontinue reason] .Condition [weight loss] resolved . Further review revealed the order was discontinued by the Director of Nursing (DON) and not by the physician or the NP. Review of the nurse's notes for Resident #72 on 7/21/2025 at 2:37 PM, revealed the resident refused to eat her pureed food. The NP was notified of the resident's refusal to eat the pureed diet. Review of the medical record for Resident #72 revealed no further documentation to show the RD had monitored/followed the resident's weight loss and had not made recommendations to prevent further weight loss since 7/16/2025. Review of the medical record revealed no Interdisciplinary Team (IDT- team of staff working together to coordinated patient care) meeting notes to address Resident #72's from 1/29/2025-7/31/2025. Review of the medical record revealed no lab tests had been performed since Resident #72's significant weight loss was identified on 6/2/2025. During an observation and interview on 7/28/2025 at 1:00 PM, of the lunch meal, revealed a Certified Nursing Assistant (CNA) brought Resident #72's tray into the resident's room, placed the tray on the overbed table in front of the resident, set up the resident's meal tray, and exited the room. Further observation revealed staff did not return to the resident's room to offer the resident assistance with eating. The resident at zero% of the lunch meal. When asked why she did not eat her lunch, Resident #72 stated .it's puree . She shook her head no, when asked if she did not like the pureed diet. During an observation on 7/29/2025 at 7:45 AM, revealed Resident #72 was in her room, lying in the bed, with her breakfast tray sitting on the overbed table in front of the resident. The resident ate zero % of the breakfast meal. Staff were not observed assisting the resident with her meal. During a telephone interview on 7/29/2025 11:09 AM, Resident #72's husband stated the resident had not been eating since her diet was changed to a pureed diet a couple of weeks ago. The resident's husband stated the resident was evaluated by speech who recommended she be on a pureed diet. During an observation on 7/30/2025 at 8:06 AM, revealed Resident #72 was in her room, lying in the bed, with her breakfast tray sitting on the overbed table in front of the resident. Continued observation revealed Resident #72 attempted to eat 2 or 3 bites of pureed scrambled eggs, but the eggs dropped off the spoon before she could eat it. Staff did not assist the resident with eating the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast meal. During a telephone interview on 7/30/2025 at 2:22 PM, the RD stated she had .not recently . observed Resident #72 eating meals. The RD was unable to say when she had observed the resident eating a meal. The RD stated residents with significant weight loss were discussed weekly with the IDT. The RD was unable to verbalize what the IDT had discussed regarding Resident #72's weight loss. The RD confirmed Resident #72's current meal intake and Boost twice a day was not sufficient to meet Resident #72's nutritional needs. Review of the nurse's notes for Resident #72 dated 7/30/2025 at 3:50 PM, revealed .This nurse [Assistant Director of Nursing-ADON] was present in the room while NP spoke with resident and husband about the risks associated with upgrading diet per resident and family request. Resident and husband in agreement with new diet order and both verbalized with this nurse present that they understand the risks associated with this change in diet. NP upgraded diet to mechanical soft with chopped meats, resident and husband aware . Review of the NP notes for Resident #72 dated 7/30/2025 at 7:28 PM, revealed .[Resident #72] has experienced weight loss due to refusing to eat pureed food. She was previously seen by speech therapy, who had not recommended an upgraded diet. A meeting was held with [Resident #72], her spouse, and the assistant director of nursing to discuss her request for a diet upgrade .[Resident #72] and her spouse have expressed a preference for quality of life over the current puree diet. They have requested an upgrade to a mechanical soft diet with chopped meats, despite understanding the associated risks including aspiration pneumonia, choking, and death. Both the patient [Resident #72] and her spouse acknowledged these risks but still wished to proceed with the diet upgrade, citing it as a quality of life issue . During a weight observation on 7/31/2025 with a surveyor present revealed the resident weighed 246.8 lbs. (21.05% weight loss from 5/2/2025-7/31/2025 and 23.73% weight loss for past 6 months). During a 2nd telephone interview on 7/30/2025 at 4:42 PM, the RD stated during ST treatment, Resident #72 told the ST she could not eat mechanical soft food, so the resident's diet could not be upgraded. The RD reported she ordered Boost 2 times per day and stated the resident should have been on weekly weights. When asked what the IDT plan was for the resident's weight loss, the RD responded .They upgraded her diet . The RD confirmed she had not recommended ordering laboratory values to check Resident #72's nutritional status or if the weight loss had impacted Resident #72's health. During an observation and interview on 7/30/2025 at 6:00 PM-6:45 PM, revealed Resident #72 was in her room, lying in the bed, with her dinner tray sitting on the overbed table in front of the resident. The meal consisted of a mechanical soft diet which included a ground turkey sandwich, diced beets, vegetable beef soup, and peach slices. Continued observation of the dinner meal revealed Resident #72, only ate 2 bites of a peach slice during the meal. Resident #72's husband stated the resident did not like the meal, stating .beets were not her favorite and the ground turkey was dry . Resident #72's husband stated they had not requested an alternative meal, as staff had not been back in the resident's room. Continued observation revealed staff did not check on the resident during the meal and did not offer to assist the resident with eating. During an observation on 7/31/2025 at 7:33 AM-8:10 AM, revealed Resident #72 was lying in the bed. A male CNA delivered the resident's breakfast tray and placed the tray on the resident's overbed table. The CNA set up the breakfast tray for the resident, added butter to the toast, and exited the room. Resident #72 picked up a piece of toast and took a small bite. At 7:40 AM, CNA B (a different CNA) entered Resident #72's room and offered to assist the resident with eating the breakfast meal, but the resident declined assistance. Resident #72 continued to attempt to eat independently. Resident #72 indicated she was finished eating at 8:10 AM. She consumed approximately 25% of the meal. During a telephone interview on 7/31/2025 at 9:35 AM, ST C stated Resident #72 had received speech therapy after the resident had experience a choking episode after taking medications and was discharged (6/24/2025). Resident #72 was unable to chew the mechanical soft diet and either refused the mechanical soft food, or spit out partially chewed food. ST C stated a mechanical soft diet was not in the best interest of Resident #72. ST C stated after the resident was discharged from ST, an unknown nurse approached her on an unknown date and asked if she had evaluated Resident #72. ST C informed the (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to properly store a nebulizer mask for 1 resident [Resident #72] of 3 residents observed on nebulizer treatments. The findings include:Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Cerebral Infarction, Obstructive Sleep Apnea, and Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #72 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had moderate cognitive impairment. Review of a physician's order dated 1/29/2025, revealed an order for Ipratropium-Albuterol [a medication used to open up the airway] solution for nebulizer. Review of the Medication Administration Record (MAR) dated 7/1/2025 - 7/31/2025, revealed Resident #72 received inhalation treatment on 7/28/2025 during the 7:00 PM-11:00 PM medication administration. During an observation on 7/28/2025 at 11:30 AM, in Resident #72's room revealed the nebulizer mask was laying on the bedside table, uncovered and open to air. During an observation on 7/29/2025 at 7:45 AM, in Resident #72's room revealed the nebulizer mask was laying on the bedside table, uncovered and open to air.During an observation on 7/29/2025 at 2:00 PM, in Resident #72's room revealed the nebulizer mask was laying on the bedside table, uncovered and open to air. During an observation and interview on 7/29/2025 at 3:00 PM, with the Wound Care Nurse, in Resident #72's room, revealed Resident #72's nebulizer mask was laying on the bedside table, uncovered and open to air. The Wound Care Nurse confirmed Resident #72's nebulizer mask was uncovered and should have been stored in a plastic bag.During an interview on 7/29/2025 at 3:05 PM, the Director of Nursing (DON) confirmed nebulizer masks were to be stored in a plastic bag and labeled with the resident's name.

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	445253	A. Building B. Wing	08/11/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility contract for nutrition services review, facility policy review, medical record review, observation, and interview the facility failed to ensure adequate dietary services were provided to prevent weight loss for 1 resident (Resident #72) of 3 residents reviewed for weight loss. The findings include: Review of a facility document titled, Contract for Nutrition Services, dated 12/1/2023, revealed .Subcontractor Service Duties .provide one or all of the following services .Correlate and integrate the nutritional aspects of client care with other client care services to include directing the following .Reviewing the clients medical record history and assessing the client's nutritional status .Interviewing and counseling clients .Recording client information in the medical record .Assessing, planning, and implementing nutrition care for clients .Developing nutrition care goals .Completing nutrition assessment forms .Work as part of the medical team .Subcontractor Services shall include, but are not limited to .Visit FACILITY on days specified and agreed upon by both parties and assure that the professional dietary clinical needs of FACILITY are met .Complete monthly assessments on residents experiencing significant weight loss .Provide consultation to FACILITY employees regarding diet, nutritional problems and management including patient care plans and case review .Review resident care plans and participate in development of dietary policies .Provide FACILITY monthly written reports which shall be signed and dated and contain a summary of areas reviewed and recommendations .Chart nutritional information in accordance with the policies of FACILITY and accepted professional practice .RECORDS .FACILITY and Subcontractor shall prepare and maintain complete and detailed records concerning Facility's residents receiving Services under this Agreement, in accordance with prudent record-keeping procedures . Review of the facility's policy titled, Weight Assessment/Monitoring, dated 1/2025, revealed .Any weight change of 5% [percent] or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will notify the Dietitian .Negative trends will be evaluated by the treatment team whether or not the criteria for significant weight change has been met .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .1 month - 5% weight loss is significant; greater than 5% is severe .3 month - 7.5% weight loss is significant; greater than 7.5% is severe .6 months - 10% weight loss is significant; greater than 10% is severe .Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the .Approximate calorie, protein, and other nutrient needs compared with the resident's current take .Whether and to what extent weight stabilization or improvement can be anticipated .The Physician and the multidisciplinary team will identify conditions and medications that may be causing .weight loss or increasing the risk of weight loss. For example .Cognitive or functional decline .Increased need for calories and/or protein . Review of the medical record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Cerebral Infarction, Diabetes Mellitus, Severe Morbid Obesity, Dementia, Chronic Pain Syndrome, Dysphagia (difficulty or discomfort) in swallowing, Psychosis, and Adjustment Disorder with Anxiety. Review of the comprehensive care plan for Resident #72 dated 1/29/2025, revealed .[Resident #72] is a risk for alterations of nutritional status R/T [related to] DM [Diabetes Mellitus], mechanically altered diet, therapeutic diet . Review of the Physician Orders for Scope of Treatment (POST) form for Resident #72 dated 1/30/2025, revealed the resident desired full treatment including artificial treatment with a feeding tube. Review of the Vitals Report for Resident #72 for 1/30/2025-7/31/2025 revealed the following weights:1/30/2025 - 323.6 pounds (lbs.)2/9/2025 - 315.5 lbs.2/17/2025 - 314.2 lbs.2/25/2025 - 314.2 lbs.3/8/2025 - 312.8 lbs.4/11/2025 - 312.8 lbs.4/15/2025 - 312.6 lbs.5/2/2025 - 312.6 lbs.6/2/2025 - 271.5 lbs. (13.15% weight loss in 1 month)6/4/2025 - 271.5 lbs. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 scored an 8 on the Brief Interview for Mental (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #72 required set up/clean up assistance with eating. Resident #72 had a weight loss of 5% in the last month or loss of 10% or more in last 6 months and was not on a physician prescribed weight loss regimen. Review of the Registered Dietitian (RD) notes for Resident #72 dated 6/6/2025, revealed .Quarterly Review: Diet: CCHO [Consistent Carbohydrate-diet of managing blood sugar levels], Mechanical soft [diet which is easy to chew and swallow]. Intakes good per nsg [nursing] doc [documentation]. wt [weight] 271.5# [pounds], down from 312.6# x [times] 1 mo [month] .signif [significant] wt loss 13%, likely R/T fluid shifts .Will cont [continue] to monitor and follow as needed, cont POC [plan of care] . No further nutritional interventions were recommended or implemented and there was no documentation of the resident's weight loss being a desired or planned weight loss. Review of the Speech Therapy (ST) notes for Resident #72 dated 6/16/2025, revealed the resident was evaluated by ST due to difficulty taking medications and decreased oral (by mouth) intake. The ST recommended a puree diet for Resident #72. Review of the physician orders for Resident #72 dated 6/16/2025, revealed an order for a CCHO, puree diet (foods are blended or mashed to a smooth, pudding-like consistency and requiring no chewing). Review of the Registered Dietitian (RD) notes for Resident #72 dated 6/18/2025, revealed .RD Review Wt Loss: wt 271.5# 6/4 [6/4/2025], down from 312.6# x 1 mo .signif wt loss 13%. Wt stable since 6/2 [6/2/2025] .Intakes good per nsg doc. Will monitor weekly wts until stabilized. Cont POC. Continued review revealed the RD provided no recommendations to prevent further weight loss for Resident #72. Continued review revealed no documentation of the resident's weight loss being desired or a planned weight loss. Review of the nurse's notes for Resident #72 dated 6/23/2025 at 7:55 PM, revealed Resident #72's meal intake had decreased because the resident did not like the puree diet. Review of the ST SLP (Speech-Language Pathologist) Discharge Summary for Resident #72 dated 6/24/2025, revealed the resident required assistance/support with meals. ST recommended pureed diet and thin liquids as the safest and most appropriate diet for the resident. Resident #72 was discharge from ST services due to maximum potential had been achieved. Further review revealed .Prognosis to Maintain CLOF [continued level of functioning] .Good with consistent staff follow-through . Review of the nurse's notes for Resident #72 dated 6/28/2025 at 1:13 PM, revealed Resident #72 refused to eat pureed food. The resident's food intake had decreased since the pureed diet was ordered. Review of the Vitals Report for Resident #72 for 6/29/2025-7/31/2025 revealed the following weights:6/29/2025 - 273.2 lbs.7/2/2025 - 265.5 lbs. (2.82% weight loss (6/29/2025; 2.21% from 6/2/2025, and 15.07% weight loss from 5/2/2025).7/6/2025 - 265.0 lbs. Review of the nurse's notes for Resident #72 dated 7/8/2025 at 6:13 PM, revealed Resident #72 drank water and other drinks throughout the shift but refused to eat pureed food. The NP was notified of the resident's refusal to eat. Review of the Vitals Report for Resident #72 for 7/6/2025-7/31/2025 revealed the following weights:7/13/2025 - 258.0 lbs. (17.47% weight loss from 5/2/2025-7/13/2025) Review of the RD notes for Resident #72 dated 7/16/2025, (44 days after Resident #72's significant weight loss of 13% had been identified on 6/2/2025), revealed wt 258# 7/13 [7/13/2025], down from 312.6# x 3 mo .signif wt loss 17.5% .Resident refusing to eat pureed diet per nsg doc. ST reports resident was unable to chew mechanical soft diet when evaluated. Will provide Boost glucose control [nutritional drink designed to provide complete, balanced nutrition] BID [twice a day] between meals [ordered 2 months 2 weeks after Resident #72's significant weight loss of 13% had been identified] .Will cont to monitor and follow as needed, cont POC . Review of the physician order for Resident #72 dated 7/16/2025, revealed .Boost diabetic control .BID between meals . (44 days Resident #72's significant weight loss of 13% had been identified on 6/2/2025). Review of the medical record for Resident #72 revealed no further documentation to show the RD had monitored/followed the resident's weight loss and had not made recommendations to prevent further weight loss since 7/16/2025. Review of the nurse's notes for Resident #72 on 7/21/2025 at 2:37 PM, revealed the resident refused to eat her pureed food. The NP was notified of the resident's refusal to eat the pureed diet. Review of the nurse's notes for Resident (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#72 dated 7/30/2025 at 3:50 PM, revealed the Assistant Director of Nursing (ADON) and NP spoke with Resident #72 and her husband regarding the risks of upgrading the resident's diet to mechanical soft. The resident and resident's husband verbalized understanding and wanted to proceed with an upgraded diet. The resident's diet was upgraded to mechanical soft with chopped meats. Review of the medical record for Resident #72 revealed no further documentation to show the RD had monitored/followed the resident's weight loss and had not made recommendations to prevent further weight loss since 7/16/2025. Review of the medical record revealed no laboratory tests had been performed since Resident #72's significant weight loss was identified on 6/2/2025. During an observation and interview on 7/28/2025 at 1:00 PM, of the lunch meal, revealed Resident #72 ate zero% of the lunch meal. During an observation on 7/29/2025 at 7:45 AM, revealed Resident #72 ate zero % of the breakfast meal. During a telephone interview on 7/29/2025 at 11:09 AM, Resident #72's husband stated the resident had not been eating since her diet was changed to a pureed diet a couple of weeks ago. The resident's husband stated the resident was evaluated by speech who recommended she be on a pureed diet. During a telephone interview on 7/30/2025 at 2:22 PM, the RD stated she had .not recently . observed Resident #72 eating meals. The RD was unable to say when she had last observed the resident eating a meal. The RD stated residents with significant weight loss were discussed weekly with the IDT. The RD was unable to verbalize what the IDT had discussed regarding Resident #72's weight loss and was unable to provide documentation the resident was discussed during the IDT meetings. The RD confirmed Resident #72's current meal intake and Boost twice a day was not sufficient enough to meet or sustain Resident #72's nutritional needs. During a weight observation on 7/31/2025 with a surveyor present revealed the resident weighed 246.8 lbs. (21.05% weight loss from 5/2/2025-7/31/2025 and 23.73% weight loss for past 6 months). (The last recorded weight was on 7/13/2025 of 258 lbs.) During a 2nd telephone interview on 7/30/2025 at 4:42 PM, the RD stated she ordered Boost 2 times per day for Resident #72 and stated the resident should have been on weekly weights. When asked what the IDdT plan was for the resident's weight loss, the RD responded .They upgraded her diet . The RD confirmed she had not recommended ordering laboratory values to check Resident #72's nutritional status. During an interview on 7/31/2025 at 10:30 AM, the DON stated she reviewed resident weights weekly and weights were followed by RD. The RD came to the facility weekly on Wednesdays. The DON stated if a resident was .on their [DON and RD] radar for weight loss . the DON and RD got together and discussed.We are following her [Resident #72] in risk [weekly IDT] . The DON stated the last IDT meeting was .last Wednesday [7/23/2025] .honestly don't remember if she was discussed in IDT last week or not . The DON was unable to verbalize why weekly weights were discontinued for Resident #72 on 7/21/2025, even though the resident continued to lose weight. During an interview on 7/31/2025 at 3:18 PM, the NP stated she had seen Resident #72 because someone had notified her of the resident's weight loss . The NP reviewed Resident #72's weights and confirmed the resident had experienced significant weight loss. The NP reported the RD ordered Boost for the resident on 7/16/2025 (44 days after Resident #72's significant weight loss was identified on 6/2/2025). The NP stated she and the RD had not discussed Resident #72's weight loss until 7/29/2025. The NP confirmed Resident #72 had lost a significant amount of weight.I'm not going to say the word harm, but she probably has lost muscle mass .Obviously, the Boost twice daily wasn't enough to sustain her weight . It was my impression that dietary was following her and putting in interventions . The NP confirmed Resident #72's weight loss was unplanned and significant. The NP confirmed no labs had been ordered to evaluate Resident #72's nutritional status. The NP confirmed the only interventions which addressed Resident #72's significant weight loss were the ST evaluation ordered on 7/9/2025 (which was not completed) and the Boost ordered twice daily on 7/16/2025. During a telephone interview on 7/31/2025, the Medical Director stated she could not say she was specifically aware of Resident #72's weight loss. The Medical Director stated reports of a significant weight loss (5%) would prompt a medical evaluation to establish if something medical was causing the weight loss. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a significant weight loss was identified, the Medical Director expected the RD to implement interventions, protein supplement .what would be appropriate for the resident . Increased weight monitoring should have been implemented at the point Resident #72 exhibited significant weight loss. The Medical Director stated .Some weight loss would be desirable [referring to Resident #72], but not at that rate .I would have expected we would have started Boost sooner . The resident needed to be re-evaluated, have a conversation by IDT with the resident or resident representative and determine the most reasonable interventions for the resident. The Medical Director stated she relied on the RD to assist with calculating caloric needs or to determine if the resident's diet was sufficient to maintain nutritional status.The fact that she [Resident #72] had weight loss would suggest it [diet] was not sufficient to maintain nutrition . The Medical Director stated .some weight loss is desirable, but again, not at that rate . During a 3rd telephone interview on 7/31/2025 at 6:02 PM, the RD stated .When they [nursing staff] told me she [Resident #72] was not eating the pureed diet, I added the Boost . The RD confirmed the resident's significant weight loss occurred prior to initiating the pureed diet on 6/16/2025. The RD stated she had spoken with the Director of Therapy about the ST evaluation which had been ordered on 7/9/2025.She was working on getting that [ST evaluation] done .It [ST evaluation] had been done before .I don't think they were going to upgrade the [resident's] diet . The RD confirmed the resident was not on a prescribed weight loss program. The RD confirmed the only interventions implemented to prevent further weight loss for Resident #72 was Boost twice a day (on 7/16/2025-44 days after Resident #72's significant weight loss was identified) and upgrading to a mechanical soft diet (7/30/2025-58 days after Resident #72's significant weight loss was identified on 6/2/2025). The RD confirmed labs to evaluate Resident #72's nutritional status had not been performed since the resident's significant weight loss. When asked about the goal for Resident #72, the RD responded .We were trying to get her diet upgraded so she would eat her meals . The RD confirmed she was aware ST's recommendation was a pureed diet for Resident #72's safety.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on facility policy review, observations, and interviews, the facility failed to ensure garbage and refuse were properly contained and failed to ensure the outside dumpster area was maintained in a sanitary and orderly condition. he findings include: Review of the facility's policy titled, Dispose of Garbage and Refuse, dated 10/2019, revealed .it is the center policy all garbage and refuse will be collected and disposed of in a safe and efficient manner .Director coordinates .to insure [ensure] that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish and other debris .lids are provided for all containers . During an observation of the outside dumpster area on 7/28/2025 at 12:36 PM, with the Certified Dietary Manager (CDM), revealed 4 dumpsters for waste disposal. Further observation revealed there were 2 alternate trash receptables present to the right side of the main dumpster area. Continued observation revealed the 2 alternate trash receptacles had the lids propped open which exposed both trash receptacles' contents to the elements and potential pests. Observation of the area adjacent to dumpster A revealed one broken bedside table, one broken wooden shelf, one broken office desk, and one broken wooden table. Observation of the area adjacent to dumpster D revealed one broken over-the-bed table, multiple broken wooden pallets, and one blue barrel with various pieces of rusted metal, broken wooden planks, and unidentified trash items observed floating in approximately 12 inches of brown, turbid water in the bottom of the blue barrel. During an interview on 7/28/2025 at 12:40 PM, the CDM confirmed the 2 alternate trash receptacles' contents were not properly contained and the outside dumpster area was not maintained in a sanitary or orderly condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview the facility failed to ensure appropriate Personal Protective Equipment (PPE) was worn for 1 resident (Resident #96) of 5 residents reviewed for Enhanced Barrier Precautions (used to reduce the transmission of multidrug-resistant organisms-MDRO).The findings include:Review of the facility's policy titled, Enhanced Barrier Precautions, dated 1/2025, revealed .?Enhanced barrier precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .Enhanced barrier precautions will be utilized for residents with .indwelling medical devices .urinary catheters .even if the resident is not known to be infected or colonized with a MDRO .Review of the medical record revealed Resident #96 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Urinary Tract Infection, and Hypertension.Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #96 had an indwelling catheter and required moderate to partial assistance with rolling from left to right.Review of the physician orders for Resident #96 revealed an order dated 7/10/2025 for 4% (percent) Lidocaine patch (topical pain reliever) to be applied to the resident's left hamstring (back of thigh) .on for 12 hours off for 12 hours . Continued review revealed an order for EBP related to urinary catheter.During an observation on 7/29/2025 at 8:00 AM, of Resident #96's room door, revealed signage indicating the resident was on EBP. Continued observation revealed PPE was readily available for use.During an observation on 7/29/2025 at 8:04 AM, of Resident #96, revealed the resident had an indwelling urinary catheter.During an observation on 7/29/2025 at 8:22 AM, of medication administration, revealed Licensed Practical Nurse (LPN) D entered Resident #96's room, donned gloves, leaned over the resident and assisted the resident to turn on his right side. Continued observation revealed LPN D's top touched the resident's blanket while assisting with turning the resident. Further observation revealed LPN D's top continued to touch the resident's blanket while LPN D applied a Lidocaine patch to the resident's left hamstring area.During an interview on 7/29/2025 at 8:27 AM, LPN D confirmed Resident #96 was on EBP and confirmed she did not wear appropriate PPE (gown and gloves) while repositioning the resident. LPN D stated she should have worn a gown in addition to gloves while applying Resident #96's Lidocaine patch.During an interview on 7/30/2025 at 7:48 AM, the Director of Nursing (DON) confirmed staff were expected to wear appropriate PPE, including gown and gloves, when providing care and/or repositioning residents on EBP.