STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455724	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St Kerrville, TX 78028

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 3 residents reviewed for dignity. The facility failed to ensure Medication Aide A did not enter Resident #1's room in the 300 unit without knocking. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: Record review of Resident #1's face sheet dated 6/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included depression, muscle wasting and atrophy (loss of muscle mass), and limitation of activities due to disability. Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills. During an observation and interview on 6/11/25 at 4:11 p.m., Resident #1, while being interviewed by the State Surveyor, was interrupted by Medication Aide A. Medication Aide A was observed opening Resident #1's bedroom door without knocking. Medication Aide A stated, oh, I'll be back and exited the room and closed the door behind her. Resident #1 stated staff often entered his room without knocking and it bothered him. Resident #1 stated it bothered him when staff did not knock on the door because, I like my privacy, or my wife could be visiting me, and I don't want them bothering us. Resident #1 stated, when staff entered his room, they won't close the door behind them, and he liked the door closed because other people (Residents) wandered into his room. Resident #1 stated, having the bedroom door closed was his right. During an interview on 6/11/25 at 5:48 p.m., Medication Aide A stated she should have knocked before entering Resident #1's room but had forgotten. Medication Aide A stated, Resident #1 was considered part of the family and the resident's room was his home and it was his right to have privacy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 6:08 p.m., the interim DON stated it was her expectation for staff to knock on the resident's door before entering because their space needed to be respected and it was a matter of resident privacy and dignity. During an interview on 6/11/25 at 6:58 p.m., the Administrator stated, not knocking (on the resident's door), I'm always preaching it and I show it by example, and it needs to be done. I'm a very private person, (and) I would hate it. It's the resident's dignity and privacy, everybody should knock. Record review of the facility document titled, Resident Rights, undated, revealed in part, .Residents in Skilled Nursing Facilities (SNFs) are entitled to certain rights, which are protected by federal and state laws to ensure dignity, autonomy, and quality care .Right to Privacy .Residents are entitled to privacy in their personal and medical affairs. This includes the right to private communication with family, friends, and healthcare providers .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 10 residents (Resident #2) reviewed for accidents and hazards: The facility failed to ensure Resident #2 did not have disposable razors in his room. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident #2's face sheet dated 6/11/25 revealed a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included anxiety disorder (mental health condition characterized by excessive, persistent worry or fear that is difficult to control and interferes with daily life), lack of coordination, difficulty in walking, dementia (general term for a decline in cognitive function that interferes with a person's daily life and activities), and post-traumatic stress disorder (mental health condition that can develop after a person experiences or witnesses a traumatic event). Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills, and required partial/moderate assistance with personal hygiene, including shaving. Record review of Resident #2's comprehensive care plan with revision date 2/9/25 revealed the resident had visual impairment, had the potential to be physically aggressive, had poor impulse control, resided in the secure unit due to impaired cognitive function and impaired decision making, and had poor safety awareness. Record review of Resident #2's ADL Only Evaluation dated 4/11/25 revealed the resident required supervision with personal hygiene, including shaving. During an observation and interview on 6/10/25 at 10:09 a.m., Resident #2 was laying in the bed awake. Resident #2 was observed with two disposable razors on the resident's sink. Resident #2 stated he showered in the shower room across the hall and had shaved himself this morning. Resident #2 stated staff did not help with when he shaved. During an observation on 6/11/25 at 8:23 a.m. revealed Resident #2 observed laying in bed. Resident #2 had two disposable razors on the resident's sink. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/11/25 at 8:25 a.m., CNA B stated there were 10 male residents in the memory unit, including Resident #2. CNA B stated, Resident #2 could do his own shower, but needed supervision and could not be left alone. CNA B stated Resident #2 was able to shave himself, but we try to do it for him because he's unsafe. CNA B stated it was not safe to have disposable razors in Resident #2's room because he could nick himself. CNA B observed the two disposable razors on Resident #2's sink and stated the resident was not supposed to have access to the disposable razors because the resident could cut himself, other residents wandered within the unit, and the disposable razors could be used as a weapon. CNA B stated the razors were supposed to be disposed of in the sharp's container that was mounted in the shower room. During an interview on 6/11/25 at 8:40 a.m., CNA C stated, Resident #2 was able to make his needs known but required assistance. CNA C stated Resident #2 could not be left alone while in the shower room and the resident had tried to shave himself, he has tried and sometimes he's doing it too fast and nick himself. CNA C stated, we are not allowed to have disposable razors in the resident rooms, they are a safety hazard, (and) this is a memory care. CNA C stated the disposable razors were supposed to be kept in hygiene bags in the shower room and disposed of after use in the sharp's container mounted in the shower room. CNA C stated, other residents wandered and could use the disposable razors incorrectly and could cut themselves with it. During an interview on 6/11/25 at 8:50 a.m., LVN D stated, all the residents in the memory unit, including Resident #2 could not use disposable razors to shave without supervision. LVN D stated, residents in the memory unit could not keep disposable razors in their room because other residents wandered and could get hold of them and cut themselves or go after somebody else and could use it against them and could go after staff. LVN D stated, disposable razors should be disposed of in the sharp's container that was mounted in the shower room. During an interview on 6/11/25 at 6:08 p.m., the interim DON stated, disposable razors left in a resident's room was not safe because residents were unpredictable and could result in self-harm or patient harm. The interim DON stated, we don't have any residents who can shave themselves, at least not without oversight. Record review of the facility document provided by the interim DON, untitled and undated revealed in part, . Contaminated sharps are to be immediately discarded into designated containers (razors, syringes, lancets, infusion sets, etc.) .Sharps are to be handled only by designated staff .

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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. Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility reviewed for qualified dietary staff. 1. The facility failed to ensure the DM had the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services. These deficient practices could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition. The findings included: 1. During an interview on 6/11/25 at 1:14 p.m., the Administrator stated he had hired the DM but was not forthcoming about the DM's required qualifications. During an interview on 6/11/25 at 4:26 p.m., The DM stated she was hired as the Dietary Manager, 2 ½ maybe 3 weeks ago and had experience as a traveling chef, had worked in and out of nursing facilities, and hospitals. The DM stated she did not have DM certification but had an associate degree in culinary arts, and only needed to complete the on-line courses for the certification. The DM stated she was told by the Administrator she needed to obtain the CDM certification within 6 months of hire, I believe. The DM stated she had not yet enrolled in the certified dietary manager program. During an interview on 6/12/25 at 7:37 a.m., HR Staff stated she had not checked the DM's dietary manager certification prior to being hired because the DM was hired by the Administrator. HR Staff stated she asked the DM to provide her with the CDM certification a week after she was hired, and the DM told her she would provide the certification. HR Staff stated she never received the CDM certification from the DM and forgot about it and did not follow up. The HR Staff stated she had asked the DM again yesterday, 6/11/25 about providing her with the certification and the DM told her she would provide the certificate to the Survey Team. During a telephone interview on 6/12/25 at 10:07 a.m., the Dietician stated he visited the facility twice a month and performed nutritional assessments during his visits. Record review of the facility document provided by the HR Staff describing the DM's job description revealed DM's name at the top of the document, and revealed in part, Position Applied For: Dietary Manager .Today's Date: 05/12/2025 .Start date: 05/12/2025. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with §2-102.12.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview, and record review the facility failed to employ sufficient staff with the appropriate competencies, skills set and accreditations to carry out the functions of the food and nutrition service department for 1 of 10 kitchen staff (Dietary Aide E) reviewed for qualified dietary staff. The facility failed to ensure the Dietary Aide E met the requirements for food handling by obtaining a current and valid Food Handler's Certificate. This failure could place residents at risk of not having their nutritional needs met and placing them at risk for food born illnesses. The findings included: During an interview on 6/11/25 at 6:33 p.m., Dietary Aide E stated he had worked in the facility for the past 6 months and initially worked as a housekeeper. Dietary Aide E stated he currently worked as the cook in the facility kitchen and did not have his Texas Food Handler's certification because he had not had time to complete the course. Dietary Aide E stated, they (the facility) were just looking for staff to work the kitchen. Dietary Aide E stated he had worked in commercial kitchens before but not like this. During an observation and interview on 6/11/25 at 6:48 p.m., the Administrator stated he had informed Dietary Aide E that he needed to complete the Texas Food Handler's course to obtain a food handler's certificate three times and was not aware Dietary Aide E did not have it. The Administrator provided a copy of Dietary Aide E's Texas Food Handler's certificate dated 6/11/25.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents had suitable, nourishing meals and snacks outside of scheduled meal service times for 3 of 4 residents (Resident #1, Resident #3, and Resident #5) reviewed for snacks. The facility failed to ensure Resident #1, Resident #3, and Resident #5 were offered snacks at bedtime as prescribed by the physician. This failure could affect residents who received meals/snacks served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and inadequate nutrition status. The findings included: 1. Record review of Resident #1's face sheet dated 6/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (loss of muscle mass), diabetes with ketoacidosis (condition characterized by high blood glucose levels and elevated levels of ketones in the blood or urine), adult failure to thrive, and limitation of activities due to disability. Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, received a therapeutic diet, and received dialysis treatments (a medical treatment that performs the essential functions of the kidneys when they are no longer able to work effectively). Record review of Resident #1's Order Summary Report dated 6/11/25 revealed the following: - Renal (Dialysis) diet Regular texture, Regular/Thin consistency, Dairy Free, Large Protein Portions, no milk or anything made with milk, no cheese, no ice cream, no fortified pudding, no Yogurt, no health shakes, no cream causes, no butter, no dressing on salads with order date 10/1/24 and no end date - One High Protein Snack at HS in the evening for One High Protein Snack at HS with order date 11/24/24 and no end date Record review of Resident #1's MAR/TAR Schedule for June 2025 revealed the residents order to receive one high protein snack at HS was not included on the schedule therefore there was no documentation the resident was receiving the high protein snack. Record review of Resident #1's Dietary Profile dated 12/20/24 revealed the resident received a liberal renal diet with large protein portions, regular texture and 1 high protein snack daily. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's comprehensive care plan with revision date 1/22/25 revealed the resident was lactose intolerant, had a behavior problem related to obsessive/compulsive tendency about diet/foods, and had a nutritional problem related to dietary restrictions and preferences, with interventions that included to provide and serve diet as ordered. 2. Record review of Resident #3's face sheet dated 6/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included protein-calorie malnutrition, muscle weakness, feeding difficulties, muscle wasting and atrophy, Vitamin D deficiency, fatigue, and irritable bowel syndrome. Record review of Resident #3's most recent MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required supervision with eating. Record review of Resident #3's Order Summary Report dated 6/11/25 revealed the following: - Chopped Meats texture, Regular/Thin consistency, Health shakes HS, Sandwiches TID for snack with order date 10/22/24 and no end date. - Med pass 60 cc PO due to weight loss three times a day for weight loss with order date 3/27/25 and no end date. Record review of Resident #3's MAR/TAR Schedule for June 2025 revealed the residents order to receive health shakes at bedtime was not included on the schedule therefore there was no documentation the resident was receiving the health shakes. Record review of Resident #3's Dietary Profile dated 11/12/24 revealed the resident received a regular diet, regular texture with cut up meats, and the resident's intake had decreased due to cognitive decline. Record review of Resident #3's comprehensive care plan with revision date 2/21/25 revealed the resident received a regular diet, regular texture with cut up meats and regular/thin liquids, and had a potential nutritional problem related to poor eating habits and had unplanned/unexpected weight loss with interventions that included to administer medications as ordered, and to give the resident supplements as ordered. 3. Record review of Resident #5's face sheet dated 6/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dysphagia-oropharyngeal phase (problems with chewing or tongue control and delayed swallow reflex), muscle weakness, iron deficiency anemia, Vitamin D deficiency, symptoms and signs concerning food and fluid intake, muscle wasting and atrophy (muscle tissue deterioration caused by inactivity), deficiency of other vitamins, weakness, and fatigue. Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with eating, and required a mechanically altered diet. Record review of Resident #5's Order Summary Report dated 6/11/25 revealed the following: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Regular diet Mechanical Soft texture, Regular/Thin consistency, Request 1 sandwich with meal at lunch and supper. Prefers food in bowls and metal spoon. Health Shake with snacks TID with order date 10/2/24 and no end date. - ENCOURAGE PO FLUIDS EACH SHIFT every day and night shift with order date 10/2/24 and no end date. - Offer snack every night A = Accepted, R = Refused every night shift with order date 3/28/25 and no end date. Record review of Resident #5's MAR/TAR Schedule for June 2025 revealed the residents order to offer a snack every night and to mark A for accepted or R for refused was documented with a check mark. Record review of Resident #5's comprehensive care plan with revision date 3/20/25 revealed the resident had an ADL self-care performance deficit related to fatigue, limited mobility, limited range of motion, musculoskeletal impairment and pain with interventions that included, when eating, the resident was to be provided with finger goods when the resident had difficulty using utensils. Resident #5's comprehensive care plan revealed the resident had a swallowing disorder and interventions included to follow diet as prescribed. Record review of Resident #5's Dietary Profile dated 3/6/25 revealed the resident received a regular diet, cut up meats, House Shakes TID, House Snack TID, and required partial assistance with eating. During an interview on 6/11/25 at 10:13 a.m., CNA H stated snacks were provided by the kitchen and would often leave bags of food like sandwiches, cookies and other snacks. CNA H stated whatever the residents didn't eat was offered at night. CNA H stated sometimes some snacks came with names on them and others did not. CNA H stated when the snacks were delivered from the kitchen, she walked around the unit and offered the snacks to the residents. During an interview on 6/11/25 at 10:52 a.m., CNA F stated there was not a problem with the kitchen staff providing snacks, but the problem was the kitchen staff delivering the snacks to the units dropped them off at the nurse's station counter and would leave. CNA F stated it was a problem because residents from different units would go to the nurse's station counter and take the snacks. CNA F stated there were times snacks were labeled with a resident's name but not all the time. CNA F stated she believed the CNA staff were responsible for distributing the snacks. During an interview on 6/11/25 at 11:48 a.m., CNA I stated snacks were offered three times per day and the kitchen staff dropped off the snacks at the nurse's station counter. CNA I stated when residents requested a particular food item she would fill out a menu request and hand it over to the kitchen staff. CNA I stated, sometimes they (the kitchen staff) followed through but some kitchen staff questioned the request and won't follow through. CNA I stated the DM and the [NAME] have told her, we can't give them (the residents) what they want, this is not a hotel. CNA I stated if there were left over snacks, residents could help themselves to them, they just don't have the kind of food they want. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 1:14 p.m., the Administrator stated it was assumed the DM did not have the credentials she was supposed to have to be the DM. The Administrator stated he had heard of staff getting upset about residents and special meal requests. The Administrator stated there needed to be systemic changes about the process and understanding of snacks and meal tickets. During an interview on 6/11/25 at 2:09 p.m., CNA G stated the kitchen staff provided snacks three times per day but when the snacks were brought out into the units, they placed the snacks on top of the nurse's station counter and leave and half the time other residents from the other units see it and they grab them (the snacks). CNA G stated the CNA staff were responsible for distributing the snacks and stated, the nurses have nothing to do with the snacks, they don't help. CNA G stated sometimes the snacks had names on them and sometimes they didn't. CNA G stated Resident #3 did not get a health shake and usually received an oatmeal cake with a cream filling and the item sometimes had Resident #3's name on it and sometimes it did not. CNA G stated Resident #5 received a snack with her name on it and if it's a sandwich, she refuses. We tell the nurse; Resident #5 doesn't eat sandwiches. During an observation and interview on 6/11/25 at 3:20 p.m., Resident #5 stated she received snacks, and was given a milkshake about a week ago, but I won't take it because I don't want to gain weight. Resident #5 was observed sitting up in the dining room with two cups of water, one cup with a soft drink, one pack of crackers and one wrapped cream filled cake with the resident's name and House Snack, Morning Snack on the label. Resident #5 stated when there were agency staff working, they did not know where to find her and did not get a snack at all. Observation on 6/11/25 at 3:30 p.m. revealed a large metal bin on the nurse's station counter between the 300 and 400 halls. The counter was waist high, and the metal bin contained a package of peanut butter cookies, two half sandwiches and an open container of cookies to the right of the metal container. The food items did not have any labels with names on them. During an interview on 6/11/25 at 3:32 p.m., LVN J stated she was charged with the 300 hall and one resident on the 400 hall and she distributed some of the snacks. LVN J stated a resident who was unable to get out of bed without assistance was offered a snack. LVN J stated, typically the snacks just get dropped off at the nurse's station because most of the residents can get up and get their own. They can come get whatever they want. LVN J stated she only knew of one resident on the unit who she would try to make sure got a snack because this resident did not eat a whole lot. During an interview on 6/11/25 at 3:49 p.m., RN K stated she worked at the facility through an agency and stated the kitchen staff would bring out a metal bin with assorted snacks and dropped them off on the nurse's station counter. RN K stated she delivered the snacks and the CNAs helped. RN K stated she was unsure if any of the snacks came with a label with the resident's name on it, I don't think they were. RN K stated she was handed a house shake to give to Resident #3 by the night shift nurse at shift change. RN K stated, it says on the MAR if Resident #3's appetite was low, to offer the house shake to her. RN K stated she did not recall if Resident #5 had an order for a house shake on the MAR. During an interview on 6/11/25 at 4:06 p.m., Resident #1 stated he had not been getting snacks and stated it had been a long time since he had been offered a snack. Resident #1 stated he was not offered a high protein snack at night. (continued on next page)

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	455724	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterside Nursing & Rehabilitation	1213 Water St Kerrville, TX 78028

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 4:26 p.m., the DM stated the residents were given snacks three times per day but had been an issue since she was employed by the facility 2 ½ weeks ago. The DM stated she was told by the kitchen staff we do maybe 5 sandwiches. The DM stated where she worked previously, she was trained to have a set menu for snacks to determine how many snacks to make and prepare. The DM stated snacks with labels were for residents who had specific physician orders for a specific snack which were supplements or sometimes a sandwich. The DM stated The Dietician came last week and talks to some residents and then leaves. I've asked him about solutions to the snack problem and asked about a snack menu and he just sent me a list of what to use for puree. I didn't fix it because I am not a dietician. We're trying to get a new meal system in place to alleviate the guess work. The DM stated, the facility was well-stocked and house shakes were available but had noticed at least 6 of them (house shakes) were coming back, unopened. The DM stated she had not been told about residents not receiving snacks and did not have control of what went on after the snacks left the kitchen. The DM stated the kitchen staff dropped off the snacks at the nurse's station and the nurses delivered the snacks to the residents. During an interview on 6/11/25 at 5:48 p.m., Medication Aide A stated snacks were offered at least 3 times per day and some of the snacks were delivered with labels with the resident's name on them. Medication Aide A stated the snacks used to have all the resident's names on them but not anymore. Medication Aide A stated the labels with the resident names stopped about 9 or 10 months ago. Medication Aide A stated snacks labeled with a resident's name were for those residents who had a specific order for a specific snack or supplement. Medication Aide stated the CNA staff were responsible for delivering snacks, but she helped when the CNA staff were busy. Medication Aide A stated she did not document on the MAR/TAR for a snack given per physician orders, maybe the nurse, I really don't know. During an interview on 6/11/25 at 6:08 p.m., the Interim DON stated the residents received snacks three times a day and were delivered by the kitchen staff to the nurse's station. The Interim DON stated the problem was that there were some residents who will walk to the snacks and help themselves and have walked to other nurse's stations and help themselves. The Interim DON stated, of the three units, the snacks for the memory care unit were kept locked behind the nurse's station. The Interim DON stated the labeled snacks with resident names were for those residents with specific physician's orders. The Interim DON stated the CNA staff were responsible for distributing the snacks, but the nurses helped when CNA staff were busy. The Interim DON stated we have to document on the TAR the order like bedtime snack or health shake or offer nutrition for those snacks that have a doctor's order and was not aware there were not enough snacks. During an interview on 6/11/25 at 6:33 p.m., the [NAME] stated snacks were delivered to the nurse's station three times per day. The [NAME] stated the Dietary Aide assembled the snacks, and the DM printed out the labels for those residents who had to have a certain snack. The [NAME] stated he did not know the reason why only certain residents had their names on a snack. During an interview on 6/12/25 at 8:58 a.m., Dietary Aide L stated, kitchen staff were instructed by the DM not to give out snacks unless the resident had an order for it, and the other residents were not supposed to get snacks. Dietary Aide L stated the DM had observed the snacks being assembled and was told they were getting too much. Dietary Aide L stated the facility had an abundance of snacks, so it was not for a lack of supplies. Dietary Aide L stated there was no set menu for snacks, except for the snacks that were labeled for those residents with a specific order. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 6/12/25 at 10:07 a.m., the Registered Dietician stated he visited the facility twice a month and performed nutritional assessments, reviewed weight discrepancies and reviewed dietary assessments for new admissions. The Registered Dietician stated in his experience, obviously if there are orders for snacks, those have to be given, but I feel like all of the residents should be offered a snack at some point of the day. The Registered Dietician stated he did not provide the facility with a snack menu, and it was up to the DM to offer snack options and to curate a snack preference list. The Registered Dietician stated he was not aware of snacks not being offered at the facility. During a follow-up interview on 6/12/25 at 10:22 a.m., the DM stated, snacks were delivered to the nurse's station and the nurses should be giving the snacks to the residents. The DM stated, nursing should be keeping track of where and how the snacks were being distributed. The DM stated, we just set the tray out for snacks this morning and they are still sitting at the nurse's station. They get snacks three times a day here, but the other places I have worked at only offered snacks twice a day. They (the residents) eat a lot. A snack policy was requested on 6/12/25 at 10:22 a.m. from the DM, but was not provided at the time of exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 3 residents (Residents #1, #3 and #5) reviewed for accuracy of medical records: 1. The facility failed to ensure Resident #1's prescribed high protein snack order was documented on the TAR as ordered by the physician. 2. The facility failed to ensure Resident #3's prescribed health shake snack order was documented on the TAR as ordered by the physician. 3. The facility failed to ensure Resident #5s prescribed snack order and health shake was documented on the TAR as ordered by the physician. These failures could affect residents whose records are maintained by the facility and could place the residents at risk for errors in care and treatment. The findings included: 1. Record review of Resident #1's face sheet dated 6/11/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy (loss of muscle mass), diabetes with ketoacidosis (condition characterized by high blood glucose levels and elevated levels of ketones in the blood or urine), adult failure to thrive, and limitation of activities due to disability. Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, received a therapeutic diet, and received dialysis treatments (a medical treatment that performs the essential functions of the kidneys when they are no longer able to work effectively). Record review of Resident #1's Order Summary Report dated 6/11/25 revealed the following: - One High Protein Snack at HS in the evening for One High Protein Snack at HS with order date 11/24/24 and no end date Record review of Resident #1's MAR/TAR Schedule for June 2025 revealed the residents order to receive one high protein snack at HS was not included on the schedule therefore there was no documentation the resident was receiving the high protein snack. Record review of Resident #1's Dietary Profile dated 12/20/24 revealed the resident received a liberal renal diet with large protein portions, regular texture and 1 high protein snack daily (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's comprehensive care plan with revision date 1/22/25 revealed the resident was lactose intolerant, had a behavior problem related to obsessive/compulsive tendency about diet/foods, and had a nutritional problem related to dietary restrictions and preferences, with interventions that included to provide and serve diet as ordered. 2. Record review of Resident #3's face sheet dated 6/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included protein-calorie malnutrition, muscle weakness, feeding difficulties, muscle wasting and atrophy, Vitamin D deficiency, fatigue, and irritable bowel syndrome. Record review of Resident #3's most recent MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and required supervision with eating. Record review of Resident #3's Order Summary Report dated 6/11/25 revealed the following: - Chopped Meats texture, Regular/Thin consistency, Health shakes HS, Sandwiches TID for snack with order date 10/22/24 and no end date. Record review of Resident #3's MAR/TAR Schedule for June 2025 revealed the residents order to receive health shakes at bedtime was not included on the schedule therefore there was no documentation the resident was receiving the health shakes. Record review of Resident #3's Dietary Profile dated 11/12/24 revealed the resident received a regular diet, regular texture with cut up meats, and the resident's intake had decreased due to cognitive decline. Record review of Resident #3's comprehensive care plan with revision date 2/21/25 revealed the resident received a regular diet, regular texture with cut up meats and regular/thin liquids, and had a potential nutritional problem related to poor eating habits and had unplanned/unexpected weight loss with interventions that included to administer medications as ordered, and to give the resident supplements as ordered. 3. Record review of Resident #5's face sheet dated 6/11/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dysphagia-oropharyngeal phase (problems with chewing or tongue control and delayed swallow reflex), muscle weakness, iron deficiency anemia, Vitamin D deficiency, symptoms and signs concerning food and fluid intake, muscle wasting and atrophy (muscle tissue deterioration caused by inactivity), deficiency of other vitamins, weakness, and fatigue. Record review of Resident #5's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with eating, and required a mechanically altered diet. Record review of Resident #5's Order Summary Report dated 6/11/25 revealed the following: - Regular diet Mechanical Soft texture, Regular/Thin consistency, Request 1 sandwich with meal at lunch and supper. Prefers food in bowls and metal spoon. Health Shake with snacks TID with order date 10/2/24 and no end date. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Offer snack every night A = Accepted, R = Refused every night shift with order date 3/28/25 and no end date. Record review of Resident #5's MAR/TAR Schedule for June 2025 revealed the residents order to offer a snack every night and to mark A for accepted or R for refused was documented with a check mark, and the Health Shake with snacks TID was not documented in the MAR/TAR schedule. Record review of Resident #5's comprehensive care plan with revision date 3/20/25 revealed the resident had an ADL self-care performance deficit related to fatigue, limited mobility, limited range of motion, musculoskeletal impairment and pain with interventions that included, when eating, the resident was to be provided with finger goods when the resident had difficulty using utensils. Resident #5's comprehensive care plan revealed the resident had a swallowing disorder and interventions included to follow diet as prescribed. Record review of Resident #5's Dietary Profile dated 3/6/25 revealed the resident received a regular diet, cut up meats, House Shakes TID, House Snack TID, and required partial assistance with eating. During an observation and interview on 6/11/25 at 3:20 p.m., Resident #5 stated she received snacks, and was given a milkshake about a week ago, but I won't take it because I don't want to gain weight. Resident #5 was observed sitting up in the dining room with two cups of water, one cup with a soft drink, one pack of crackers and one wrapped cream filled cake with the resident's name and House Snack, Morning Snack on the label. Resident #5 stated when there were agency staff working, they did not know where to find her and did not get a snack at all. During an interview on 6/11/25 at 3:32 p.m., LVN J stated when a physician's order was transcribed into a resident's electronic record, the order should pre-populate into the MAR/TAR. LVN J stated, those orders could only be transcribed by a nurse and therefore should be documented on the MAR/TAR by a nurse. LVN J stated, any orders taken from the physician was usually tasked to the nurse. During an interview on 6/11/25 at 3:49 p.m., RN K stated she worked in the facility through an agency and recalled Resident #3 had an order for a house shake that was to be offered only if the resident's appetite was low. RN K stated she had 17 residents on her caseload and only Resident #3 had an order for a milk shake. RN K stated she did not recall Resident #5's house shake order being on the MAR/TAR. During an observation and interview on 6/11/25 at 4:06 p.m., Resident #1 stated he had not been getting snacks and stated it had been a long time since he had been offered a snack. Resident #1 stated he was not offered a high protein snack at night. During an interview on 6/11/25 at 5:48 p.m., Medication Aide A stated snacks were offered at least 3 times per day and some of the snacks were delivered with labels with the resident's name on them. Medication Aide A stated she did not document on the MAR/TAR for a snack given per physician orders, maybe the nurse, I really don't know. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/25 at 6:08 p.m., the Interim DON stated the residents received snacks three times a day and were delivered by the kitchen staff to the nurse's station. The Interim DON stated the labeled snacks with resident names were for those residents with specific physician's orders. The Interim DON stated, we have to document on the TAR the order like bedtime snack or health shake or offer nutrition for those snacks that have a doctor's order and was not aware there were not enough snacks. The DON stated, in the case of Resident #5, if the nurse documented a check mark on the MAR/TAR, instead of marking A for accepted or R for refused, it would be assumed the resident accepted the snack, but admitted the computer system used to generate the MAR/TAR was new to her. The DON stated, if the resident had refused the snack, it would have prompted the nurse to document it. In theory that's the way it's supposed to work. The MAR/TAR should reflect the physician's orders. If it isn't documented we could miss a lot of things, like labs, orders for snacks. Only the nurses can document following or completing doctor's orders. If the resident starts to lose weight, that would be a red flag. A request for a facility policy regarding clinical records documentation was requested from the DON on 6/11/25 at 6:08 p.m. but was not provided at the time of exit.