STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515087	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Center	302 Cedar Ridge Road Sissonville, WV 25320

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and staff interview, the facility failed to manage pain in accordance with professional standards of practice. This deficient practice had the potential to affect one (1) of two (2) residents reviewed for the care area of pain. Resident Identifier: #14. Facility census: 117. Findings included:a) Resident #14 The facility's policy titled Pain Management with effective date 01/01/04 and revision date 03/24/25 stated that reasons for as needed (PRN) pain medications would be documented. Review of Resident #14's physician's orders showed the resident was receiving the following scheduled pain medications: -Morphine sulfate extended relief tablet, 10 mg, three (3) times a day for pain, ordered 01/18/26-Morphine sulfate extended relief tablet, 60 mg, two (2) tablets, three (3) times a day for pain, ordered 01/31/26 Resident #14 also had an order to document the pain level and non-pharmaceutical interventions for pain every shift. Pain was assessed on a score of 0-10, with 0 being no pain and 10 being the highest pain imaginable. Resident #14 was also ordered the following PRN pain medication on 12/16/25.: Morphine sulfate, 30 mg, every six (6) hours as needed for pain. Review of Resident #14's medication administration record (MAR) for February 2026 showed the resident received PRN morphine sulfate six (6) times in February. There was no documentation of the resident's pain level before administration of the medication. The medication was documented as effective in relieving the resident's pain. Resident #14 received PRN morphine sulfate on the following dates at the following times: -02/01/26 at 4:16 PM; pain assessments performed that day documented pain levels of 0.-02/10/26 at 1:13 PM; pain assessments performed that day documented a pain level of 0 for day shift and 1 for night shift.-02/11/26 at 11:15 AM; pain assessments performed that day documented a pain level of 0 for day shift and 1 for night shift.-02/12/26 at 11:27 PM; pain assessments performed that day documented pain levels of 0.-02/13/26 at 6:00 PM; pain assessments performed that day documented pain levels of 3. On 02/18/2026 at 9:03 AM, the Director of Nursing (DON) confirmed Resident #14's pain level had not been documented before administration of PRN pain medications. She stated she had revised the resident's MAR to include a place for the pain level and non-pharmacological interventions to be recorded before the medication administration. No further information was provided through the completion of the survey process.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and food tray temperatures, the facility failed to serve food to residents that was palatable and at an appetizing temperature. Based on resident interview and staff interview, the facility failed to ensure hot foods were served hot and cold foods were served cold. This failed practice was true for one (1) of one (1) hallways tested for food tray temperatures throughout the complaint survey process. Resident #35. Facility census: 117.Findings include: a) The facility was not taking and documenting all food temperatures prior to sending the food to the residents. The facility was also sending cold food out above the FDA Food Code temperature of 41 degrees Fahrenheit. The Healthcare Services Group policy 016 titled Food Preparation shows the following: All foods are prepared in accordance with the FDA Food Code. Cold foods at 41 degrees F or below and hot foods at 135 degrees F or above before it leaves the kitchen.This surveyor asked for a copy of the service line checklist dated 02/01/2026 - 02/15/2026 that shows the temperature of the food items that are prepared and what the temperatures are before the kitchen staff sends the food to the residents. They were all missing temperatures and there were eleven total cold food items that were documented at 42 degrees Fahrenheit before the items left the kitchen. b) Resident #91 stated during an interview on 02/16/2026 at 11:37 AM that food was not always hot when it was served to him.Resident #60 stated during an interview on 02/16/2026 at 1:29 PM, The food is not hot when I get it. Resident #9 stated during an interview on 02/16/2026 at 12:30 PM, The food sucks.At 12:58 pm, the dietary manager took the temperature of room [ROOM NUMBER]-A meal tray. The temps were as follows: Spaghetti w meat sauce 120.7 degrees FGreen Beans 112.1 degrees FVanilla ice cream 23.5 degrees F The hot foods are supposed to be 120 degrees F or above at point of service per the FDA food code. The cold foods are supposed to be at 41 degrees F or below before it leaves the kitchen. Per the FDA food code and the facilities policy & procedure this was not followed.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety. Additionally, the facility failed to follow the proper sanitation practices for the kitchen and the food preparation equipment. This practice had the potential to affect more than an isolated number of residents. Facility census: 117. Findings include: a) The Healthcare Services Group (HCSG) policy 019 titled Food storage: Cold Foods shows the following: All Time / Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. All foods will be stored wrapped or in a covered container, labeled and dated, and arranged in a manner to prevent cross contamination. The HCSG policy 027 titled Equipment shows the following: All foodservice equipment will be clean, sanitary, and in proper working order. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. All food contact equipment will be cleaned and sanitized after every use. All non-food contact equipment will be clean and free of debris. 02/16/2026 10:28 AM Initial walkthrough of the kitchen. Findings include: the inside of the ice machine had a pink colored sludge located on a white plastic part above the ice.There was a mildew smell around the outside of the ice machine.The hand washing sink in the dining room was soiled with food / liquid debris.There were two (2) containers of left over food sitting directly on the dish room floor.There was a push cart in the dish room that had one (1) bottle of unlabeled chemical without a lid on it. It also had wrapped disposable cutlery, soiled muffin pan, a roll of trash can liners and a box of food service gloves on it.There were two cleaning cloths that were sitting on counter tops in the kitchen and was not in a bucket of sanitized water.The dish machine was not working the previous evening on 02/15/2026 and the three compartment sink log was missing the water temperature and the sanitizer parts per million (PPM). When I asked employee #48 to make me a copy of this log at 10:50 AM, he wrote in the missing temperature and sanitizer PPM and initialed it. I asked him about this and he replied I did write it in, I was not trying to be sneaky, they just forgot to write it down yesterday.I also asked for a copy of the service line checklist dated 02/01/2026 - 02/15/2026 that shows the temperature of the food items that are prepared and what the temperatures are before the kitchen staff sends the food to the residents. They were all missing temperatures and there were eleven total cold food items that were documented at 42 degrees Fahrenheit before the items left the kitchen. The cleaning schedule was posted for 02/01 - 02/07/26 and was not filled in by any staff member. There was not one posted for last week or this week.The can opener was soiled with debris.The inside of the microwave was soiled.The toaster crumb tray was soiled with debris.The double convection ovens were soiled and need to be cleaned on the inside.The backup exhaust vent in the ceiling has debris hanging from it.The return air vent in the ceiling needs to be cleaned.There was one (1) oven rack sitting directly on the floor.The meat slicer was covered but was still soiled from the last time it was used.The mop bucket, broom and dust pan were sitting beside the bread rack in the kitchen.The bread on that rack was not dated.The is a tremendous amount of ice build up in the walk-in freezer.There was one (1) container of red gelatin not labeled or dated in the walk-in refrigerator.The walk-in refrigerator floor was soiled with debris and needed to be swept.There was a Ziploc bag with cut yellow squash that was not labeled or dated in the walk-in refrigerator.The dunnage rack and shelving units in the walk-in refrigerator was soiled with debris and needed to be cleaned.The knife rack was soiled with food splatter and dust.The trash can lid was soiled with food splatter.The fire extinguisher located beside the hand washing sink is very dirty with debris and dust.Two (2) clean stock pots were not stored upside down as they should have been.The ice scoop holder was dusty.At 11:25 AM, the refrigerator in the pantry was soiled with food / liquid spills.02/17/2026 at 9:35 AM this surveyor made a follow up visit to the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings include:The same cart was in the dish room with soiled and clean items both sitting together on it,One (1) oven rack was sitting directly on the floor again. 02/18/2026 at 10:18 AM The menu posting did not match the menu week at a glance, that was given to me for the week. At 10:25 Am, this surveyor asked employee #48 why it was changed? He said it was the resident choice meal of the month. I asked employee #48 for the menu substitution log and the policy. The menu substitution log did not reflect the menu change that the Registered Dietitian (RD) is supposed to approve, per the facility's policy. 02/18/2026 at 10:28 AM This surveyor asked employee #48 for the production sheets, diet guides and recipes for lunch today. 02/18/2026 at 12:33 PM The outside of the ice scoop holder is still dusty. The container housing the bread crumbs was open to air with the lid being off at this time.

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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 record review and staff interview, the facility failed to provide accurate and complete medical records for four (4) of 24 residents reviewed in the long-term care survey sample. Transfer assessments were not accurate for Residents #78 and #7. Tube feeding documentation was not accurate for Resident #47. Additionally, the activities assessment for Resident #21 was not completed by a qualified staff member. Resident Identifiers: #78, #7,#47, and #21. Facility census: 117.Findings included:a) Resident #78 On 02/18/26 at 3:30 PM, a review was completed for Resident #78. The review found the resident had been transferred to an acute care facility on 12/26/25. However, the transfer form had the incorrect date of 10/31/25. On 02/19/26 at 10:00 AM, the Corporate Registered Nurse (RN) #156 confirmed the transfer form had the incorrect date noted. b) Resident #7 On 02/18/26 at 4:30 PM, a review was completed for Resident #7. The review found the resident had been transferred to an acute care facility on 10/12/25. However, the transfer form had the incorrect date of 08/08/25. In addition, the resident was transferred to an acue care facility on 05/27/25. The transfer form had the incorrect date of 03/14/24. On 02/19/26 at 10:00 AM, the Corporate Registered Nurse (RN) #156 confirmed the transfer forms had the incorrect dates noted. c) Resident #21 Record review completed on 02.17/26 of Resident #21's Recreation Comprehensive Assessment, completed on 09/24/25 was signed off by Activity Director (AD)#1 who at the time had not completed or was not enrolled in the class required to be a qualified AD. Further record review of AD#1's Qualifications showed completion of the course on 01/29/26 During an interview with the facility Administrator on 02/17/26 at approximatly 2:00 PM who stated she was enrolled in the [NAME] it started in November of 2025 and was completed late January 2026. Another interview completed with AD#14 and AD#1 on 02/17/26 at 2:20 PM confirmed AD#1 completed activity assessment on Resident #21 before AD#1 was a qualified activity professional. d) Resident #47 Review of Resident #47's physician's orders showed an order written on 02/06/26 for the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube feeding, The resident was to receive Jevity tube feeding solution at 82 ml [milliliters] an hour for 20 hours, to total 1400 ml in 24 hours. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/24/26 at 9:30 AM, the Director of Nursing (DON) confirmed 82 ml of tube feeding for 20 hours equaled 1640 ml, not 1400 ml. The order was rewritten for Jevity tube feeding solution at 82 ml [milliliters] an hour for 20 hours, to total 1640 ml in 24 hours. Additionally, the Medication Administration Record (MAR) documented the resident received 1400 ml of tube feeding on day shift and 1400 cc of tube feeding on night shift. The DON stated this was a documentation error.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on record review and staff interview, the facility failed to complete the quarterly assessments for restraint usage for Resident #6. This was true for one (1) of one (1) residents reviewed under the care area of restraints. Resident Identifier: #6. Facility Census: 117. Findings Include: a) Resident #6 On 02/18/26 at 8:30 AM, a record review was completed for Resident #6. The review found the following physician's order dated 04/22/25, Restraint: Positioning device/belt to w/c (wheelchair) while up in w/c for dx (diagnosis) of Cerebral Palsy and involuntary movements of core/ trunk area. Release device/belt every 2 (two) hours for repositioning every 2 (two) hours for seat belt to chair. Also, the review found the last restraint evaluation/reduction was completed on 05/29/25. The evaluation/reducation should be completed quarterly. On 02/18/26 at 10:20 AM, the Administrator was notified and confirmed the evaluation was not completed quarterly. b) Policy On 02/18/26 at 9:45 AM, a review of the facility policy entitled, Restraints: Use of was completed. Under section 6, states, Patients with a restraint will be re-assessed monthly for three (3) months, then quarterly and with any significant change in condition or in accordance with state regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to develop a comprehensive care plan for one (1) of 24 residents reviewed in the long-term care survey sample. Resident identifiers: #3. Facility census: 117. Findings included: a) Resident #3 Review of Resident #3's medical records showed diagnoses of post-traumatic stress disorder (PTSD) and exposure to disaster, war and other hostilities were documented on 01/20/26. On 02/17/26, the following focus was initiated on the resident's comprehensive care plan: Resident reports past experience of trauma as evidenced by: Feeling upset when reminded of a stressful experience from the past related to PTSD. On 02/18/2026 at 11:27 AM, Corporate Nurse #156 confirmed Resident #3 had not been care planned for PTSD until 02/17/26. No further information was provided through the completion of the survey process.

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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. Based on record review and staff interviews th facilty failed to revise care plans related to one (1) on one(1) activities and PEG tube length. This failed practive was found true for two (2) of 24 residents care plans reviewed during the Long Term Care Survey Process. Resident identifiers: #50 and #47. Facility Census: 117Findings include: a) Resident #50 On 02/16/26 at 11:27 AM a Review of the participation record for Resident #50 showed most activities Provided were one-on-one activities. further record review of Resident #50's care plan revealed nothing in the care plan for Resident #50 to receive one (1) on (1) activities. Record review completed on 02/17/26 Revealed the one (1) on one (1) list provided from Activity Director (AD) #14 showed the resident was on the one (1) on one (1) program list to receive one (1) on one (1) activities. During an Interview with AD #14 on 02/17/26 at 3:40 PM she confirmed the one-on-one activities were not in the resident's care plan. b) Resident #47 Review of Resident #47's physician's order showed an order written on 02/06/26 to check the resident's Percutaneous Endoscopic Gastrostomy (PEG) tube for placement prior to each feeding, flush or medication administration by measuring the length of the tube. According to the order, the baseline length of the tube was 26 centimeters (cm). A PEG tube is placed into the stomach through the abdominal wall to provide long-term nutrition for patients with swallowing difficulties. Measuring the tube before use ensures that the tube has not been inadvertently dislodged from the stomach. Resident #47's comprehensive care plan gave the following intervention written on 12/10/25, Tube 22 cm at base [baseline]. On 02/19/2026 at 10:53 AM, the Director of Nursing confirmed 22 cm was an old PEG tube measurement. She confirmed the current PEG tube measurement was 26 cm. She stated Resident #47's comprehensive care plan had not been updated when the resident's PEG tube length had changed because the PEG tube had been replaced. No further information was provided through the completion of the survey process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, resident interview, and staff interview, the facility failed to follow a physician's order for oxygen settings for Resident #20. Facility census 117. a) Resident #20. Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with physician orders. Specifically, the facility failed to ensure oxygen was administered at the ordered rate. On 02/18/26 at 9:19 a.m., observation of Resident #20 revealed oxygen delivered via nasal cannula at 4 liters per minute. Record review of the physician's orders indicated an active order for oxygen at 2 liters per minute via nasal cannula. On 02/18/26 at 9:19 a.m., interview with Nurse #111 confirmed the oxygen was set at 4 liters per minute and verified the current physician order was for 2 liters per minute. An interview with the Director of Nursing (DON) indicated that any increase in oxygen flow rate would require documentation of a change in condition and updated physician orders. However, as of 9:40 a.m. on 02/18/26, review of the medical record did not reveal documentation of a change in condition or updated physician orders to support the increased oxygen setting. The facility's failure to administer oxygen in accordance with physician orders placed the resident at risk for adverse outcomes related to improper oxygen administration.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on record review and staff interview, the facility failed to ensure the posted daily nurse staffing information was accurate for one (1) of 20 days reviewed, resulting in incorrect staffing and census information being displayed. Facility Census: 117Findings include:Review of the facility's nurse staffing posting on 02/18/26 for staffing dated 07/06/25 showed the posted Hours Per Patient Day (HPPD): 2.19 and the posted facility census: 109 residentsDuring surveyor review, the facility administrator provided verified staffing documentation and census reports showing actual HPPD for 07/06/25 was 2.58 and actual facility census for 07/06/25 was 105 residentsDuring an interview the discrepancies were reviewed with the facility administrator On 02/19/26 at 11:00 AM when the administrator confirmed the staffing posting contained incorrect HPPD and census information.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation and staff interview the facility failed to ensure the residents received the proper portion sizes. This failed practice has the potential to affect more than an isolated number of residents and was a random opportunity for discovery found during the completion of the dining observation pathway during the long-term care survey process. Resident #44 and #91. Facility Census: 117. Findings include: a) The Healthcare Services Group policy 004 titled Menus shows the following: Menus will be planned in advance to meet the nutritional needs of the residents / patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Menu Cycles will include standardized recipes. Menu cycles will include nutrient analysis to ensure that all clients nutritional needs are met in accordance with the most recent edition of the Food and Nutrition Board, Institute of Medicine, National Academics, and the Dietary Guidelines for Americans, 2020 - 2025 edition. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. A menu substitution log will be maintained on file. 02/17/2026 at 12:30 PM this surveyor made a dining room observation, and Resident #44's tray ticket did not totally match what the kitchen sent out to her. She received a bowl of green bean salad that was regular consistency and she is on a Dysphagia advanced diet. The employee that was assisting Resident #44 discarded the green bean salad since it was not on her tray ticket. The recipe given to the surveyor by the Healthcare Services Group Director of Operations showed that the green bean salad should have been transferred to a food processor and chopped to pea size pieces before serving. She was also supposed to receive a half cup (4 oz) of applesauce for her dessert, and she only received 2 ounces of applesauce. The surveyor approached employee #48 and the Healthcare Services Group (HCSG) Director of Operations (DO) about this observation. The DO said that the green bean salad was sent by mistake. The surveyor asked Employee #48 how many ounces of applesauce the resident was served. The dietary account manager poured the applesauce into a two (2) ounce scoop and said, It seems only 2 ounces. The surveyor asked the manager and the Director to please give the remaining residents the 4-ounce serving, like the menu and diet guides called for, and to please give Resident #44 and any other residents that was in the dining room that may have received the smaller serving size the correct amount. The menu posting did not match the menu week at a glance, that was given to the surveyor for the week. At 10:25 Am, on 02/18/26 the surveyor asked Employee #48 why it was changed, and he said It was the resident choice meal of the month. The surveyor asked Employee #48 for the menu substitution log and the policy. The menu substitution log did not reflect the menu change that the Registered Dietitian (RD) is supposed to approve, per the facility's policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515087	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Center	302 Cedar Ridge Road Sissonville, WV 25320

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Resident #91 Resident #91's diet order, written on 11/20/25, was for a consistent carbohydrate diet, regular texture, thin liquids consistency, with double vegetable portions and large portions for breakfast. On 02/8/26 at 1:23 PM, Resident #91's diet tray ticket was reviewed. It did not specify for the resident to receive double vegetable portions. The resident had already finished his meal. Resident #91's meal and tray ticket were observed on 02/19/25 at 1:13 PM. The tray ticket did not specify for the resident to receive double vegetable portions. The resident had three (3) potato wedges, which was the amount received by the other residents in the facility. On 02/19/26 at 1:25 PM, the Dietary Manager stated orders for extra portions should be printed on the tray tickets so dietary staff are aware extra portions are to be given. He stated Resident #91 used to have instructions for extra portions on his tray tickets, but he doesn't know what happened that the tickets no longer say this.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, record review, resident interview, and staff interview, the facility failed to ensure that the resident's received a therapeutic diet for a renal diet and the 2 gram sodium diet. This failed practice was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifiers: #42, #56, #80, #78, #132, # 90, #98, #105 and #117 . Facility census: 117.Findings include: a) 02/18/2026 12:15 PM A review of Healthcare Services Group (HCSG) policy 008 titled Therapeutic Diets revealed Therapeutic diet is defined as a diet ordered by a physician, or delegated registered licensed dietitian, as part of the treatment for a disease or clinical condition. The purpose of the therapeutic diet is to eliminate or decrease specific nutrients in the diet, or to increase specific nutrients in the diet. All nine (9) residents that were on a Renal diet and / or the 2 gram sodium diet, did not receive low sodium marinara meat sauce for the lunch meal on 02/28/2026, as per the recipe and diet guide used by the facility, The tray ticket also showed that they should have received low sodium sauce. The dietary manager and the HCSG DO said that they did not have the low sodium sauce to give the residents on a renal and 2 gram sodium diet. At 2:27 PM, this surveyor asked the HCSG Director of operations (DO) for the policy on therapeutic diets. The facility did not follow this policy on this date for the nine (9) residents on a renal diet and the 2 gram sodium diet.