STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Healthcare Center	2939 S. Peach Avenue Fresno, CA 93725

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of practice according to the facility's policies and procedures (P&P) titled, Weight Assessment and Intervention, Nutrition (Impaired)/Unplanned Weight - Clinical Protocol, Change in a Resident's Condition or Status, Care Planning - Interdisciplinary Team, Administering Medication, and Enteral Nutrition, for four of eight sampled residents (Resident 1, 6, 7, and 8) when Resident 1, 6, 7, and 8 had unplanned weight loss from 4/20/26 to 5/25/26 and:The facility did not accurately obtain the weights of Resident 1, 6, 7 and 8 from 4/20/26 to 5/25/26.The facility did not complete a CIC (Change in Condition-a tool for staff to communicate important information with the resident's Responsible Party [RP-a person designated to make medical decisions for the resident] and Medical Doctor [MD] when there is change in the resident's health status) form and notify the RP and MD of the documented weight loss for Resident 1, 6, 7 and 8.The facility did not conduct an IDT (Interdisciplinary Team-a group of staff members consisting of physicians, nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) meeting to discuss the cause of the documented weight loss and develop a care plan to address the weight loss for Resident 1, 6, 7 and 8.The 4/2026 and 5/2026 Medication Administration Record (MAR) did not indicate when the administration of Resident 1 and 7's TF (Tube Feeding-the delivery of liquid nutrients, fluids, and medications directly into the stomach or intestines through a flexible tube) was turned off as ordered by the MD and as recommended by the Registered Dietitian (RD). These failures resulted in a documented and not validated unplanned weight loss for Resident 1, 6, 7, and 8 and had the potential to lead to malnutrition and health deterioration.Findings: During a concurrent observation and interview on 5/26/26 at 2:15 p.m. with Resident 1 in Resident 1's room, Resident 1 was in bed with TF [brand name] 1.5 connected to Resident 1's gastrostomy (an artificial opening into the stomach through the abdominal wall used for feeding and administering medication) infusing (the continuous introduction of fluids, medications, or nutrients directly into the body) at 40 ml/hr (milliliters per hour-unit of measurement). Resident 1 was nonverbal (unable to speak) and could only move his right arm. During a concurrent observation and interview on 5/6/26 at 2:20 p.m. with Resident 8 in Resident 8's room, Resident 8 was sitting on the side of the bed. Resident 8 was Spanish speaking only. Resident 8 stated he was unable to walk and used a wheelchair for mobility (to get from one place to another). During a review of Resident 1's admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other patient information), dated 5/27/26, the AR indicated Resident 1 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Hemiplegia (a medical condition characterized by paralysis of one side of the body) affecting right dominant side, Convulsions (sudden, involuntary, and violent contractions of the muscles that cause the body to shake uncontrollably), Dysphagia (difficulty swallowing), Gastrostomy, and Injury at C4 level (the fourth bone in the neck). During a review of Resident 1's Minimum Data Set (MDS-process for clinical assessment of all residents of long term care nursing facilities), dated 4/1/26, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS-an (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment of a resident's ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 0 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent (helper does all the effort) with transfer from bed to chair and dependent with dressing and personal hygiene (habits to maintain cleanliness such as bathing and toileting). During a review of Resident 6's AR, dated 5/27/26, the AR indicated Resident 6 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Hemiplegia, Hemiparesis, Unspecified Psychosis (a clinical classification used when a patient experiences a disconnect from reality but the symptoms do not fit the criteria for a specific disorder, and drug use or physical illness have been ruled out), Dysphagia, and Gastrostomy. During a review of Resident 6's MDS, dated 4/9/26, the MDS indicated, Resident 6's BIMS score was 0. The MDS indicated Resident 6 was dependent with transfer from bed to chair and dependent with dressing and personal hygiene. During a review of Resident 7's AR, dated 5/27/26, the AR indicated Resident 7 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Convulsions, Gastrostomy, Extrapyramidal and Movement Disorder (a physical condition causing involuntary movements, muscle rigidity, and changes in posture or motor control), and Rhabdomyolysis (a serious and potentially life-threatening medical condition where damaged skeletal muscle tissue breaks down rapidly).During a review of Resident 7's MDS, dated 4/17/26, the MDS indicated, Resident 7's BIMS score was 0. The MDS indicated Resident 7 was dependent with transfer from bed to chair and dependent with dressing and personal hygiene. During a review of Resident 8's AR, dated 5/28/26, the AR indicated Resident 8 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Nontraumatic Intracerebral Hemorrhage (bleeding directly into the brain tissue not caused by injury), Hemiplegia and Hemiparesis (a medical condition characterized by weakness on one side of the body). During a review of Resident 8's MDS, dated 3/9/26, the MDS indicated, Resident 8's BIMS score was 11. The MDS indicated Resident 8 required supervision (verbal cues and/or touching, steadying and/or contact guard assistance provided as resident completes activity) with transfer from bed to chair and with dressing and personal hygiene. During a concurrent interview and record review on 5/26/26 at 12:54 p.m. with the Director of Nursing (DON), the Weekly Weight (WW), dated 4/20/26 to 5/25/26 was reviewed. The WW indicated Resident 1 weighed 141 lbs (pounds-unit of measurement) on 4/27/26, 96 lbs on 5/4/26, 96 lbs on 5/18/26, and 99.2 lbs on 5/18/26. The DON stated Resident 1 was weighed with a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility) with a scale attached. The WW indicated Resident 6 weighed 120 lbs on 4/20/26, 120 lbs on 4/27/26, 122.1 lbs on 5/4/26, 122.1 lbs on 5/11/26, 103.8 lbs on 5/18/26, and 104.2 lbs on 5/25/26. The DON stated Resident 6 was weighed with a Hoyer lift. The WW indicated Resident 7 weighed 101.2 lbs on 4/20/25, 99.2 lbs on 4/27/26, 100.2 lbs on 5/4/26, 101 lbs on 5/11/26, and 97 lbs on 5/18/26. The DON stated Resident 7 was weighed with a Hoyer lift. The WW indicated Resident 8 weighed 220.1 lbs on 4/20/25, 221.4 lbs on 4/27/26, 209.2 lbs on 5/4/26, 223 lbs on 5/11/26, 209 lbs on 5/18/26, and 210.2 on 5/25/26. The DON stated Resident 8 was weighed with a standing scale. The DON stated Resident 1, 6, 7, and 8 were on weekly weight monitor because they had significant weight loss. The DON stated the RD was concerned that Resident 1, 6, 7 and 8's weight may not be accurate, and when the DON investigated the concern, the DON learned that the Restorative Nursing Assistants (RNAs) were not consistently weighing the residents with the same device each time, the RNAs were not weighing the residents consistently at the same time each time and the RNAs were not ensuring the residents were wearing the same clothes each time. The DON stated the facility had a Hoyer lift with a scale to weigh the residents and a standing scale to weigh the residents. The DON stated the Hoyer lift was calibrated (to adjust, evaluate, or mark a measuring device to ensure accuracy and precision) on 4/30/26. During a concurrent interview and record review on 5/26/26 at 1:30 p.m. with the DON, the invoice (cost for services provided) from [name of company], dated 4/30/26 was reviewed. The invoice indicated, Calibrate (2) Hoyer lifts + (1) wheelchair. (1) Health floor scale tested good. (1) Hoyer lift scale tested (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nausea or diarrhea to explain the rapid weight loss. The RD stated a 45 lbs weight loss in one week was severe (a loss of more than 5 % [percent-unit of measurement] body weight in one month, 7.5 % in three months and 10 % in six months) and considered a change in condition. The RD stated the ADON confirmed that Resident 1's weight was 96 lbs on 5/6/26 and the ADON was instructed to notify Resident 1's MD. During an interview on 5/27/26 at 10:15 a.m. with the ADON, the ADON stated she confirmed with the RD that Resident 1 was 96 lbs on 5/6/26. The ADON stated Resident 1's RP and MD were not notified of the weight loss on 5/6/26. The ADON stated the IDT did not conduct a meeting for the weight loss neither nor was a CIC form completed. The ADON stated it was her responsibility to complete the CIC form, notify Resident 1's RP and MD of the weight loss and conduct an IDT meeting and she did not do that. During a concurrent interview and record review on 5/27/26 at 10:30 a.m. with the RD, Resident 1's Nutrition/Dietary Note (NDN), dated 3/22/26 was reviewed. The RD stated on 3/22/26 the previous RD decreased Resident 1's TF [brand name] 1.5 to 35 ml/hr for weight gain. The NDN indicated Resident 1 was 155.6 lbs on 3/6/26, 155 lbs on 12/10/25, 150 lbs on 9/3/25. with a weight gain of 5.6 lbs (3.7 %) in six months. The RD stated the 3/22/26 recommendation was based on 17 kcal/kg (kilocalories per kilogram - unit of measurement) with BMI (Body Mass Index-a screening tool that uses height and weight to estimate body fat) of 29.4. The RD stated Resident 1's 91.8 lbs was the accurate weight and the previous RD based the nutritional recommendation for being overweight at 155 lbs. The RD stated Resident 1 was underweight and was not getting enough nutrient from the TF. The RD stated Resident 1 required 35-40 kcal/kg. The RD stated 35-40 kcal/kg was the underweight recommendation. The RD stated at 91 lbs, Resident 1 will need TF at 60 ml/hr for 20 hours. The RD stated it will provide 1800 calories (units of energy used to measure the amount of potential energy stored in food and beverages) and 70 g (grams - unit of measurement) of protein (an essential nutrient for building and repairing tissues, supporting immune function, and regulating hormones). The RD stated 912 ml of water from the TF formula and water flush at 50 ml/hr for 20 hours will provide 1,912 ml of total water. The RD stated Resident 1's TF will need to be gradually increased to avoid adverse effects (an unwanted, undesirable, and potentially harmful response to a treatment or medication). During a concurrent interview and record review at 5/27/26 at 10:45 a.m. with the RD, Resident 1's Order Summary Report (OSR), dated 4/24/26, was reviewed. The OSR indicated, Enteral Feed Order. [brand name] 1.5 kcal at 40 ml/hour x (for) 20 hours, providing 800 ml/1200 kcal, 51 g Protein, 608 water (ON at 1200 noon until total amount of feeding completed). The RD stated, On at 1200 noon until total amount of feeding completed, was vague and needed clarification. The RD stated it was standard practice to administer TF for 20 hours per day (24 hours) with the remaining four hours to allow for bowel rest, medication administration, and time for ADLs (Activities of Daily Living such as bathing, showering, and hygiene). During a review of Resident 1's MAR, dated 4/1/26 - 4/30/26, the MAR indicated, [brand name] 1.5 kcal at 35 ml/hour x 20 hours, providing 700 ml/1050 kcal (ON at 1200 noon until total amount of feeding completed). The MAR indicated there was no off time (the time TF should be turned off). During a review of Resident 1's MAR, dated 5/1/26 - 5/31/26, the MAR indicated, [brand name] 1.5 kcal at 40 ml/hour x 20 hours, providing 800 ml/1200 kcal, 51 g Protein, 608 water (ON at 1200 noon until total amount of feeding completed). The MAR indicated there was no off time (the time TF should be turned off).During a review of Resident 7,'s MAR, dated 4/1/26 - 4/30/26, the MAR indicated, [brand name] 1.5 kcal at 55 ml/hour x 20 hours (1100 ml/1650 kcal). ON at 12:00 PM until total amount of feeding completed). The MAR indicated there was no off time (the time TF should be turned off). During a review of Resident 7,'s MAR, dated 5/1/26 - 5/31/26, the MAR indicated, [brand name] 1.5 kcal at 50 ml/hour x 20 hrs/day (Provides 1500 kcal, 64 g Protein, 760 ml water). ON at 12:00 PM until total amount of feeding completed). The MAR indicated there was no off time (the time TF should be turned off). During a concurrent observation and interview on 5/27/26 at 11:09 a.m. with RN 1 in Resident 1's room, Resident 1's TF was observed. RN 1 stated she was assigned to Resident 1. RN 1 stated Resident 1's TF was [brand name] 1.5 at 40 ml/hr x 20 hours. The TF was observed to be (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disconnected from Resident 1 and the TF pump (a medical device used to deliver fluids such as medications, nutrients, and blood into the body) was turned off. RN 1 stated all TF pumps were turned off at 8:00 a.m. and will be turned back on at 12:00 p.m. RN 1 stated the TF pumps were turned off at 8:00 a.m. to administer medication and to allow the stomach to rest. When RN 1 was asked to provide documentation of when the TF pump was turned off, RN 1 stated there was no documentation in the MAR to indicate the TF pump was turned off. RN 1 stated it was standard practice to accurately document the administration of the TF according to the RD's recommendations and MD's orders. During an interview on 5/27/26 at 11:56 a.m. with LVN 1, LVN 1 stated she was assigned to Resident 1 on 5/4/26. LVN 1 stated the DON or the ADON enters the residents' weight in the EMR. LVN 1 stated no one informed her Resident 1 had weight loss. LVN 1 stated she became aware of Resident 1's weight loss when she saw Resident 1 was on alert charting (targeted, short-term documentation triggered by a change in a patient's condition) in the EMR. LVN 1 stated she did not complete a CIC or notify Resident 1's RP and MD of the weight loss on 5/4/26. LVN 1 stated the ADON or the DON may have completed the CIC for Resident 1 on 5/4/26 and notified Resident 1's RP and MD but she was uncertain (not sure). LVN 1 stated the residents' weights were managed by the ADON, DON and RN Supervisor and when there was a weight change, the resident was put on alert charting. LVN 1 stated weight changes were considered a CIC and a CIC form should be completed to notify the Resident's RP and MD. LVN 1 stated Resident 1 was on TF at 40 ml/hr. LVN 1 stated the TF pump should be turned off 8:00 a.m. and restarted at 12:00 p.m. LVN 1 stated the MAR should indicate when the TF was turned off and when it was turned on to indicate the RD's recommendation and MD orders were followed correctly. LVN 1 stated complete and accurate documentation of medication administration was standard practice. During an interview on 5/27/26 at 12:14 p.m. with the ADON, the ADON stated when there was a change in condition (CIC-a change in a resident's health care status), the facility was required to notify the resident's Responsible Party (RP-the person designated to make medical decisions for the resident), MD and complete a CIC form (a tool for staff to communicate important information with the resident's RP and MD). The ADON stated it was standard practice to notify the RP, MD, conduct an Interdisciplinary Team (IDT-a group of staff members consisting of physicians, nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff). meeting and develop a care plan for the resident when there was a CIC. The ADON stated a 45 lbs weight loss in one week was considered a CIC. The ADON stated inaccurate weights, incomplete and inaccurate documentation of medication administration, not completing a CIC form, not notifying the RP and MD, not conducting an IDT meeting, and not developing a care plan when there was a condition was unacceptable. During an interview on 5/27/26 at 12:20 p.m. with the Administrator (ADM), the ADM stated the DON or the ADON should have informed the Charge Nurse (CN) when there was a CIC so the CN could have assessed Resident 1, 6, 7 and 8 immediately. The ADM stated an IDT meeting should be conducted for Resident 1, 6, 7 and 8 and it was not. The ADM stated a 45 lbs weight loss in one week was considered a CIC. The ADM stated the purpose of conducting an IDT meeting when there was significant weight loss was to investigate the root cause of the weight loss and develop a care plan to address the weight loss. The ADM stated inaccurate weights, incomplete and inaccurate documentation of medication administration, not completing a CIC form, not notifying the RP and MD, not conducting an IDT meeting, and not developing a care plan when there was a change in condition was unacceptable. During an interview on 5/27/26 at 3:31 p.m. with the MD, the MD stated he was informed of Resident 1's weight loss one to two weeks ago. The MD stated a loss of 45 lbs in one week was impossible and stated the weight must be inaccurate. The MD stated he saw Resident 1 beginning of May 2026 and there was no change during the assessment compared to Resident 1's current status and Resident 1 was stable. The MD stated 91 lbs was more accurate for Resident 1 and not 141 lbs, but 91 lbs was considered underweight and he would refer Resident 1 to the RD for nutritional consultation. The MD stated it was standard of practice to notify the MD when there was a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	professional reference review from Journal of Parental and Enteral Nutrition, titled, ASPEN (American Society for Parenteral and Enteral Nutrition) Safe Practices for Enteral Nutrition Therapy, volume 41, number 1, dated 1/15/17, the professional reference review indicated, Enteral nutrition (EN) is a valuable clinical intervention for patients of all ages in a variety of care settings. Along with its many outcome benefits come the potential for adverse effects. These safety issues are the result of clinical complications and of process-related errors.Section 1. Assessment and Recommendations: .b. Physical exam includes GI function assessment and existing access devices as well as nutrition focused physical findings. Physical exam. Along with weight status, nutrition-focused physical exam findings should include assessment of skin integrity, fluid accumulation or deficit, muscle and fat loss, and functional status. Handgrip strength is a predictive indicator of postoperative complications, hospital length of stay and read mission, and physical status. Physical therapists may offer a valuable assessment of physical function. Muscle function correlates well and reacts quickly to changes in nutrition status. In pediatric patients, developmental status and risk of aspiration with oral intake should be evaluated. d. Administration method and rate. i. Document the method of administration (continuous, bolus, intermittent feedings). ii. Clearly define the volume and/or rate of EN administration for each method of administration. Section 6. The administration of EN therapy is a step in the process with significant potential for error. Errors can stem from incomplete evaluation of a patient's tolerance for enteral feeding that increases the risk for aspiration or GI complications. Enteral misconnections, poor positioning, pump misadventures, and contamination can all lead to less than optimal patient outcomes . During a professional reference review from American Academy of Family Physician Journal, titled, Evaluating and Treating Unintentional Weight Loss in the Elderly, volume 65, number 4, dated 2/15/2002, the professional reference review indicated, Elderly patients with unintentional weight loss are at higher risk for infection, depression, and death. Involuntary weight loss can lead to muscle wasting .depression and an increased rate of disease complications. Various studies demonstrated a strong correlation between weight loss and morbidity and mortality. One study showed that nursing home patients had a significantly higher mortality rate in the six months after losing 10 percent of their body weight, irrespective of diagnoses or cause of death. In another study, institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year . During a professional reference review retrieved from https://aspenjournals.onlinelibrary.[NAME].com/doi/abs/10.1177/0884533611405794 titled, Enteral Nutrition for Older Adults in Nursing Facilities, dated 5/16/11, the professional reference review indicated, Older adults who reside in nursing facilities tend to be frail and to have multiple comorbidities, increased risk of unintended weight loss, and protein energy malnutrition. Approximately 5.8% of nursing facility residents in the United States receive enteral feedings. The prevalence is higher for residents with cognitive impairment, ranging from 18% to 34%. In cognitively impaired residents, the majority of tube feeding placements occur in the acute care setting and result in significant use of additional healthcare resources and high postinsertion mortality rates within 60 days of insertion. Nursing facilities must abide by state and federal regulations and undergo stringent survey evaluation while balancing complex decisions related to initial placement of feeding tubes. Informed choice, resident-centered care decisions, and the role of advanced directives are essential in the decision-making process. In nursing facilities, it is often the registered dietitian who alerts the healthcare team to determine whether a feeding tube is appropriate. Once a tube is placed, healthcare practitioners must make careful decisions related to ordering, administering, and monitoring enteral nutrition (EN) delivery; adequacy of nutritional content; tolerance to feedings; monitoring for potential complications; and the possibility of return to oral feeding or, conversely, the decision to discontinue feedings. Further evidence-based research is neede

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Grace Healthcare Center	2939 S. Peach Avenue Fresno, CA 93725

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status for four of eight sampled residents (Resident 1, 6, 7 and 8) when Resident 1, 6, and 7 required enteral feeding (a method of supplying nutrition directly into the stomach or intestines through a flexible tube) and Resident 8 required regular, mechanical soft texture (a texture-modified eating plan for individuals with difficulty chewing or swallowing), regular consistency (thin liquids such as water) diet and staff did not administer nutrition in accordance with policies and procedures and professional standards of practice. This failure resulted in a documented unplanned weight loss of 45 pounds (lbs-unit of measurement) for Resident 1 from 4/27/26 to 5/4/26, a documented 18.3 lbs weight loss for Resident 6 from 5/11/26 to 5/18/26, documented 4 lbs weight loss from 5/11/26 to 5/18/26 for Resident 7, and documented 12 lbs weight loss from 4/27/26 to 5/4/26 for Resident 8.Findings:During a concurrent interview and record review on 5/26/26 at 12:54 p.m. with the Director of Nursing (DON), the Weekly Weight (WW), dated 4/20/26 to 5/25/26 was reviewed. The WW indicated Resident 1 weighed 141 lbs on 4/27/26, 96 lbs on 5/4/26, 96 lbs on 5/18/26, and 99.2 lbs on 5/18/26. The DON stated Resident 1 was weighed with a Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility) with a scale attached. The WW indicated Resident 6 weighed 120 lbs on 4/20/26, 120 lbs on 4/27/26, 122.1 lbs on 5/4/26, 122.1 lbs on 5/11/26, 103.8 lbs on 5/18/26, and 104.2 lbs on 5/25/26. The DON stated Resident 6 was weighed with a Hoyer lift. The WW indicated Resident 7 weighed 101.2 lbs on 4/20/25, 99.2 lbs on 4/27/26, 100.2 lbs on 5/4/26, 101 lbs on 5/11/26, and 97 lbs on 5/18/26. The DON stated Resident 7 was weighed with a Hoyer lift. The WW indicated Resident 8 weighed 220.1 lbs on 4/20/25, 221.4 lbs on 4/27/26, 209.2 lbs on 5/4/26, 223 lbs on 5/11/26, 209 lbs on 5/18/26, and 210.2 lbs on 5/25/26. The DON stated Resident 8 was weighed with a standing scale. The DON stated Resident 1, 6, 7, and 8 were on weekly weight monitor because they had significant weight loss (a loss of 5 % [percent-unit of measurement] body weight in one month, 7.5 % in three months and 10 % in six months). During a review of Resident 1's admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other patient information), dated 5/27/26, the AR indicated Resident 1 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Hemiplegia (a medical condition characterized by paralysis of one side of the body) affecting right dominant side, Convulsions (sudden, involuntary, and violent contractions of the muscles that cause the body to shake uncontrollably), Dysphagia (difficulty swallowing), Gastrostomy, and Injury at C4 level (the fourth bone in the neck). During a review of Resident 1's Minimum Data Set (MDS-process for clinical assessment of all residents of long term care nursing facilities), dated 4/1/26, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS-an assessment of a resident's ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 0 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent (helper does all the effort) with transfer from bed to chair and dependent with personal hygiene (habits to maintain cleanliness such as bathing, dressing and toileting). The MDS indicated Resident 1 was 156 lbs and was not on a physician-prescribed weight gain or loss regimen.During an interview on 5/26/26 at 1:55 p.m. with the Registered Dietitian (RD), the RD stated she started working with the facility in April of 2026. The RD stated the previous RD was only available through telehealth (the use of digital information and communication technologies such as computers, smartphones, and video conferencing to access healthcare services remotely). The RD stated observing the resident and talking to the resident in person was an important aspect of ensuring accurate nutritional assessments (the gathering of information) and recommendations. The RD stated Resident 1 weighed 141 lbs on 4/29/26 and 96 lbs on 5/6/26. The (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RD stated a loss of 45 lbs in one week was severe weight loss (a loss of more than 5 % body weight in one month, 7.5 % in three months and 10 % in six months). The RD stated the Assistant Director of Nursing (ADON) confirmed Resident was 96 lbs on 5/6/26. The RD stated she instructed the ADON to notify Resident 1's Medical Doctor (MD) immediately. During a concurrent observation and interview on 5/27/26 at 9:44 a.m. with Certified Nursing Assistant (CNA) 8, Registered Nurse (RN) 3 and the RD in Resident 1's room, Resident 1 was in bed with Tube Feeding (TF) [brand name] 1.5 connected to Resident 1's gastrostomy (an artificial opening into the stomach through the abdominal wall used for feeding and administering medication) infusing (the continuous introduction of fluids, medications, or nutrients directly into the body) at 40 ml/hr (milliliters per hour-unit of measurement). Resident 1 was nonverbal (unable to speak) and immobile (unable to get from one place to another). CNA 8 and RN 3 assisted Resident 1 on to the Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility) to be weighed. When Resident 1's gown was lifted for observation, Resident 1's rib cages and knee caps were visible. Resident 1 appeared to be thin with no body fat. The scale indicated Resident 1 was 91.8 lbs. The RD stated 91.8 lbs was consistent with Resident 1's appearance. During a concurrent interview and record review on 5/27/26 at 10:30 a.m. with the RD, Resident 1's Nutrition/Dietary Note (NDN), dated 3/22/26 was reviewed. The NDN indicated Resident 1 was 61 inches tall, 155.6 lbs on 3/6/26, 155 lbs on 2/5/26, 151 lbs on 12/10/25, 150 lbs on 9/3/25, gain 4.6 lbs (3 %) in three months, gain 5.6 lbs (3.7 %) in six months. The NDN indicated Resident 1's BMI (Body Mass Index-a screening tool that uses height and weight to estimate body fat; 18.5 is considered underweight, 18.5-24.9 is considered healthy weight, 25.0-29.9 is considered overweight, and 30.0 or higher is considered Obesity) was 29.4 indicating Resident 1 was overweight. The RD stated on 3/22/26 the previous RD decreased Resident 1's TF [brand name] 1.5 to 35 ml/hr for weight gain. The RD stated the 3/22/26 recommendation was based on 17 kcal/kg (kilocalories per kilogram-unit of measurement). The RD stated Resident 1's weight of 91.8 lbs on 5/27/26 was the accurate weight and the previous RD based the nutritional recommendation for being overweight at 155 lbs. The RD stated Resident 1 was underweight and was not getting enough nutrients from the TF. The RD stated 35-40 kcal/kg was the underweight recommendation. The RD stated at 91 lbs, Resident 1 will need TF at 60 ml/hr for 20 hours. The RD stated it will provide 1800 calories (units of energy used to measure the amount of potential energy stored in food and beverages) and 70 g (grams-unit of measurement) of protein (an essential nutrient for building and repairing tissues, supporting immune function, and regulating hormones). The RD stated 912 ml of water from the TF formula and water flush at 50 ml/hr for 20 hours will provide 1,912 ml of total water. The RD stated Resident 1's TF will need to be gradually increased to avoid adverse effects (an unwanted, undesirable, and potentially harmful response to a treatment or medication). During a record review of Resident 1's NDN, dated 4/29/26, the NDN indicated, On 4/25/26, TF rate was increased from 35 to 40 ml/hour per RD recommendation. BMI continues overweight and current weight remains within desired body weight range of 140 # (pounds) +- 5 #. RD recommends to continue TF as ordered; RD will monitor weekly weights and adjust plan of care as needed. During a record review of Resident 1's NDN, dated 4/24/26, the NDN indicated, Resident returned back from [name of acute care hospital] with replaced G-tube [gastrointestinal tube] on 4/21/26. Presents with significant weight loss of 12 #/7.7 % x 1 month, possibly in part d/t RD's recommendation on 3/22/26 to decrease tube feeding from [brand name] 1.5 40 ml/hr to 35 ml/hr. Weight loss was intentional and desired and resident is now within desired body wight range of 140+/- 5 #. RD recommends weight maintenance with no significant changes. During a review of Resident 6's AR, dated 5/27/26, the AR indicated Resident 6 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Hemiplegia, Hemiparesis, Unspecified Psychosis (a clinical classification used when a patient experiences a disconnect from reality but the symptoms do not fit the criteria for a specific disorder, and drug use or physical illness have been ruled out), Dysphagia, and Gastrostomy. During a review of Resident 6's MDS, dated 4/9/26, the MDS indicated, Resident 6's BIMS score was 0. The MDS indicated Resident (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6 was dependent with transfer from bed to chair and dependent with personal hygiene. The MDS indicated Resident 6 was 106 lbs and was not on a physician-prescribed weight gain or loss regimen. During a concurrent interview and record review on 5/27/26 at 11:31 a.m. with the RD, Resident 6's NDN, dated 5/20/26 was reviewed. The NDN indicated Resident 6 was on TF [brand name] 1.5 at 237 ml every 4 hours (2133 kcal, 91 g protein, 1080 ml free water). Free water flush 90 ml water before and 90 ml water after each bolus (a single, concentrated mass of a substance) feeding (2160 ml water total). The RD stated Resident 6 presented with a severe weight loss of 18.3 lbs between 5/11/26 and 5/19/26 (14.9 % weight loss) possibly due to an error on the scale or the Hoyer lift being recalibrated recently. The RD stated on 5/20/26 the nursing staff re-weighed Resident 6 and he was 105.6 lbs. similar to the weight on 5/19/26 of 103.8 lbs. The RD stated Resident 6's ideal body weight (IDBW) was 106 lbs and his usual body weight was 120-130 lbs. During a record review of Resident 6's NDN, dated 4/29/26, the NDN indicated, RD Consult: TF Review. Diet: NPO (nothing by mouth), TF: [brand name] 1.5 237 ml 5xday via bolus (6 AM, 10 AM, 2 PM, 6 PM, 10 PM) (1185 ml/1778 kcal, 76 g protein, 901 ml water) with free water flush 100 ml water before and 100 ml water after each bolus feeding (T [total]: 1901 ml). Assessment: On 4/26/26, RD recommended to add an additional bolus feeding of [brand name] 1.5 120 ml at 12 AM (120 ml/180 kcal, 8 g protein, 91 ml water) with 50 ml free water flush before/after each bolus feeding (100 ml). However, RN Supervisor consulted RD on 4/29/26, asking if the tube feeding order could be changed so that all boluses are 237 ml. [brand name] 1.5 237 ml 6x/day would add 255 kcal/16 g protein, providing a daily total of 2133 kcal, 91 g protein, which would be in excess of estimated nutritional needs (39 kcal/kg, 1.7 g/kg protein, 39 ml/kg fluid) but may be appropriate given recent weight loss. Intervention: 1. D/c (discontinue current TF order. 2. Start [brand name] 1.5 235 ml q (every) 4 hours (provides 2133 kcal, 91 g protein, 1080 ml free water). 3. Start free water flush 90 ml water before and 90 ml water after each bolus feeding (2160 ml water total). 4. Continue weekly weight monitoring. During a record review of Resident 6's NDN, dated 4/26/26, the NDN indicated, Weight Review. Diet: NPO (nothing by mouth), TF: [brand name] 1.5 237 ml 5xday via bolus (6 AM, 10 AM, 2 PM, 6 PM, 10 PM) (1185 ml/1778 kcal, 76 g protein, 901 ml water) with free water flush 100 ml water before and 100 ml water after each bolus feeding (T [total]: 1901 ml). Patient with significant weight loss x 49 days. Unavoidable weight loss s/p recent hospitalization for hematuria [the presence of red blood cells in the urine]. TF was changed on 3/22/26 as per TD d/u progressive weight gain. TF provides 33 kcal/kg/d, 1.39 g protein kg/d, 35 ml fluid/kg/d. Tolerating TF without N/V/D [nausea, vomiting, diarrhea] or residuals. Recommend: 1. Add additional bolus of feeding of [brand name] 1.5 120 ml at 12 a.m. [120 ml/180 kcal, 8 g protein, 91 ml water] with 50 ml free water flush before/after each bolus feeding [100 ml]. 2. Weekly weights x 4 weeks. During a record review of Resident 6's NDN, dated 4/24/26, the NDN indicated, TF Review. Diet: NPO (nothing by mouth), TF: [brand name] 1.5 237 ml 5xday via bolus (6 AM, 10 AM, 2 PM, 6 PM, 10 PM) (1185 ml/1778 kcal, 76 g protein, 901 ml water) with free water flush 100 ml water before and 100 ml water after each bolus feeding (T [total]: 1901 ml). No weight available as patient was transferred to hospital on 4/6/26 d/t hematuria. Patient came back with a diagnosis of UTI (urinary tract infection) and was treated with ATB (antibiotics). TF was changed on 3/23/26 as per RD recs (recommendation) d/t progressive weight gain. Tolerating TF without N/V/D or residuals. Recommend f/u (follow up) on weight. During a review of Resident 7's AR, dated 5/27/26, the AR indicated Resident 7 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Convulsions, Gastrostomy, Extrapyramidal and Movement Disorder (a physical condition causing involuntary movements, muscle rigidity, and changes in posture or motor control), and Rhabdomyolysis (a serious and potentially life-threatening medical condition where damaged skeletal muscle tissue breaks down rapidly). During a review of Resident 7's MDS, dated 4/17/26, the MDS indicated, Resident 7's BIMS score was 0. The MDS indicated Resident 7 was dependent with transfer from bed to chair and dependent with personal hygiene. The MDS indicated Resident 7 was 106 lbs and was not on a physician-prescribed weight gain or loss regimen. During a concurrent interview and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review on 5/27/26 at 11:40 a.m. with the RD, Resident 7's NDN, dated 5/20/26 was reviewed. The NDN indicated Resident 7 was 66 inches tall, 97 lbs on 5/19/26, 99.2 lbs on 4/29/26, 101.2 lbs on 4/23/26, 105.6 lbs on 4/14/26, 117 lbs on 3/15/26, 116 lbs on 2/5/26, 119 lbs on 1/6/26, and 116 lbs on 12/1/25. The NDN indicated Resident 7 had a BMI of 15.7. The NDN indicated Resident 7 was on TF [brand name] 1.5 at 65 ml/hr x 20 hours (1300 ml, 1050 kcal, 83 g protein, 988 ml water) FWF (Free water flush): 55 ml/hr x 20 hours (2097 ml total water). The RD stated Resident 7 had a 15 lbs weight loss in 3 months (12.9 % weight loss indicating severe weight loss) and 26 lbs in six months (19.2 % weight loss indicating severe weight loss). During a record review of Resident 7's NDN, dated 4/26/26, the NDN indicated Resident 7 was on TF [brand name] 1.5 at 65 ml/hr x 20 hours (1300 ml/1950 kcal, 83 g protein, 988 ml water) with free water flush of 55 ml/hr x 20 hours (total from formula and flush of 2088 ml). The NDN indicated, Trigger for significant weight loss x 9 days/x 40 days/x 3 months/x 6 months. Unavoidable weight loss s/p [status post] acute encephalopathy [sudden, temporary brain dysfunction], s/p CRF [chronic renal function- the progressive and irreversible decline of the kidneys' ability to filter blood, remove waste products, and maintain fluid and chemical balances in the body], s/p sepsis/infection [the body's extreme, life-threatening reaction to an infection], COPD [chronic obstructive pulmonary disease- . It is a progressive, long-term lung disease that makes it hard to breathe by restricting airflow into and out of the lungs]. TF provides approximately 42 kcal/kg/d, 1.8 g protein/kg/d, 45 ml fluid/kg/d. Tolerating TF without N/V/D or residuals. TF was increased on 4/23/26. During a review of Resident 8's AR, dated 5/28/26, the AR indicated Resident 8 was a [AGE] year old male resident admitted on [DATE] with a diagnosis of Nontraumatic Intracerebral Hemorrhage (bleeding directly into the brain tissue not caused by injury), Hemiplegia and Hemiparesis (a medical condition characterized by weakness on one side of the body). During a review of Resident 8's MDS, dated 3/9/26, the MDS indicated, Resident 8's BIMS score was 11. The MDS indicated Resident 8 required supervision (verbal cues and/or touching, steadying and/or contact guard assistance provided as resident completes activity) with transfer from bed to chair and with personal hygiene. The MDS indicated Resident 8 was 228 lbs and was not on a physician-prescribed weight gain or loss regimen. During a record review of Resident 8's NDN, dated 5/20/26, the indicated Resident 8 was on a regular diet, mechanical soft texture, regular consistency. The NDN indicated, PO (by mouth) intake remains 75-100 % at every meal in the last 14 days. The NDN indicated, Resident report that he has noticed that he has lost weight in his legs and would not like to lose any more weight. During a record review of Resident 8's NDN, dated 4/11/26, the NDN indicated, indicated Resident 8 was on a regular diet, mechanical soft texture, thin liquids and consumed 76-100 %. The NDN indicated, Noted patient is on Metformin (a medication used to treat and lower and blood sugar levels) for DM (Diabetes Mellitus), which can contribute to the weight loss. Patient is also on a diuretic (medication that help the body eliminate excess salt and water through increased urination) for HTN (hypertension-high blood pressure). Weight loss is desirable/beneficial to decrease risks of morbid/mortality associated with elevated BMI. Weekly weight were ordered. During an interview on 5/27/26 at 12:14 p.m. with the ADON, the ADON stated when there was a change in condition (CIC-a change in a resident's health care status), the facility was required to notify the resident's Responsible Party (RP-the person designated to make medical decisions for the resident), MD and complete a CIC form (a tool for staff to communicate important information with the resident's RP and MD). The ADON stated it was standard practice to notify the RP, MD, conduct an Interdisciplinary Team (IDT-a group of staff members consisting of physicians, nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff). meeting and develop a care plan for the resident when there was a CIC. The ADON stated a 45 lbs weight loss in one week was considered a CIC. The ADON stated inaccurate weights, incomplete and inaccurate documentation of medication administration, not completing a CIC form, not notifying the RP and MD, not conducting an IDT meeting, and not developing a care plan when there was a condition was unacceptable. During an (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 5/27/26 at 12:20 p.m. with the Administrator (ADM), the ADM stated the DON or the ADON should have informed the Charge Nurse (CN) when there was a CIC so the CN could have assessed Resident 1, 6, 7 and 8 immediately. The ADM stated an IDT meeting should be conducted for Resident 1, 6, 7 and 8 and it was not. The ADM stated a 45 lbs weight loss in one week was considered a CIC. The ADM stated the purpose of conducting an IDT meeting when there was significant weight loss was to investigate the root cause of the weight loss and develop a care plan to address the weight loss. The ADM stated inaccurate weights, incomplete and inaccurate documentation of medication administration, not completing a CIC form, not notifying the RP and MD, not conducting an IDT meeting, and not developing a care plan when there was a change in condition was unacceptable. During an interview on 5/27/26 at 3:31 p.m. with the MD, the MD stated he was informed of Resident 1's weight loss one to two weeks ago. The MD stated a loss of 45 lbs in one week was impossible and stated the weight must be inaccurate. The MD stated he saw Resident 1 at the beginning of May 2026 and there was no change during the assessment compared to Resident 1's current status and Resident 1 was stable. The MD stated 91 lbs was more accurate for Resident 1 and not 141 lbs, but 91 lbs was considered underweight and he would refer Resident 1 to the RD for nutritional consultation. The MD stated it was standard of practice to notify the MD when there was a CIC, follow the RD's recommendation, and administer TF as ordered. The MD stated documentation should be complete and accurate to reflect the care provided. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention, dated 3/2022, the P&P indicated, Policy Statement: Resident weights are monitored for undesirable and unintended weight loss or gain. Policy Interpretation and Implementation: Weight Assessment. 3. Any weight change of 5 % or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietitian in writing. 5. The threshold for significant unplanned and undesired wight loss will be based on the following criteria [where percentage of body weight loss = (usual wight - actual weight)/(usual weight) x 100]: a. 1 month - 5 % weight loss is significant; greater than 5 % weight loss is significant; greater than 5 % is severe. b. 3 months - 7.5 % weight loss is significant; greater than 7.5 % is severe. c. 6 months - 10 % weight loss is significant; greater than 10 % is severe. Evaluation: . The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, wight loss or increasing the weight loss. Interventions: .2. Interventions for undesired weight gain consider resident preferences and right. A weight loss regimen will not be initiated for a cognitively capable resident without his/her approval and involvement. During a review of the facility's P&P titled, Nutrition (Impaired)/Unplanned Weight - Clinical Protocol, dated 9/2017, the P&P indicated, Assessment and Recognition: 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. Cause Identification: .2. For individuals with recent or rapid weight gain or loss [for example, more than a pound a day], the staff will review for possible fluid and electrolyte imbalance as a cause. Treatment/Management: 1. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. Monitoring: 1. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting. During a review of the facility's P&P titled, Enteral Nutrition, dated 11/2018, the P&P indicated, Policy Statement: Adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation: .2. The reaccommodation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice. 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian. During a professional reference review from Journal of Parental and Enteral Nutrition, titled, ASPEN (American Society for Parenteral and Enteral Nutrition) Safe Practices for Enteral Nutrition Therapy, volume 41, number 1, dated 1/15/17, the professional reference review indicated, Enteral nutrition (EN) is a valuable clinical intervention for patients of all (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ages in a variety of care settings. Along with its many outcome benefits come the potential for adverse effects. These safety issues are the result of clinical complications and of process-related errors.Section 1. Assessment and Recommendations: .b. Physical exam includes GI function assessment and existing access devices as well as nutrition focused physical findings. Physical exam. Along with weight status, nutrition-focused physical exam findings should include assessment of skin integrity, fluid accumulation or deficit, muscle and fat loss, and functional status. Handgrip strength is a predictive indicator of postoperative complications, hospital length of stay and read mission, and physical status. Physical therapists may offer a valuable assessment of physical function. Muscle function correlates well and reacts quickly to changes in nutrition status. In pediatric patients, developmental status and risk of aspiration with oral intake should be evaluated. d. Administration method and rate. i. Document the method of administration (continuous, bolus, intermittent feedings). ii. Clearly define the volume and/or rate of EN administration for each method of administration. Section 6. The administration of EN therapy is a step in the process with significant potential for error. Errors can stem from incomplete evaluation of a patient's tolerance for enteral feeding that increases the risk for aspiration or GI complications. Enteral misconnections, poor positioning, pump misadventures, and contamination can all lead to less than optimal patient outcomes . During a professional reference review from American Academy of Family Physician Journal volume 65, number 4, dated 2/15/02, indicated, Elderly patients with unintentional weight loss are at higher risk for infection, depression, and death. Involuntary weight loss can lead to muscle wasting .depression and an increased rate of disease complications. Various studies demonstrated a strong correlation between weight loss and morbidity and mortality. One study showed that nursing home patients had a significantly higher mortality rate in the six months after losing 10 percent of their body weight, irrespective of diagnoses or cause of death. In another study, institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year . During a professional reference review from Journal of Nutritional Disorders & Therapy, titled, Nutritional Dietary Recommendations for Acute Ischemic Stroke and their Outcomes, volume 13, issue 3, dated 6/29/23, the professional reference review indicated, Nutritional intake is a key component of stroke care that can influence the recovery and outcome of acute ischemic stroke patients. An early screening and assessment of dysphagia and nutritional status is recommended for all stroke patients. Adequate hydration energy protein micronutrients fatty acids intake should be ensured while avoiding foods that can increase the risk of recurrent stroke or aspiration pneumonia. Dietary modifications may be needed depending on the patient's comorbidities swallowing ability preferences needs. A multidisciplinary approach involves physicians, nurse, dietitian speech-language pathologists pharmacists caregivers is essential for providing optimal nutritional care for stroke patients. Ensure adequate energy and protein intake to prevent or treat malnutrition, which is common in stroke patients and can impair recovery and increase mortality. The recommended energy intake ranges from 25 to 35 kcal/kg/day, and the recommended protein intake ranges from 1.2 to 1.5 g/kg/day. Provide oral nutritional supplements or enteral nutrition (tube feeding) if oral intake is insufficient or unsafe due to dysphagia or reduced appetite. Enteral nutrition should be initiated within 24 to 48 hours after stroke onset if oral intake is less than 50% of the estimated needs. Monitor fluid and electrolyte balance to prevent dehydration or overhydration, which can worsen cerebral edema or increase blood pressure. The recommended fluid intake ranges from 30 to 40 ml/kg/day, depending on the patient's condition and urine output.