

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Hawthorne Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 11630 South Grevillea Ave. Hawthorne, CA 90250	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906 Based on interview and record review, the facility failed to: 1. Update the careplan for one of four sampled residents (Resident 79) after the resident self-removed his indwelling catheter (a flexible tube inserted into the bladder to continuously drain urine into a drainage bag) on two occasions. This failure had the potential to cause complications such as urinary tract infections (UTI - an infection in the bladder/urinary tract), bleeding, and/or pain with urination. Findings: During a review of Resident 79's Admission Record, the Admission Record indicated the facility admitted Resident 79 on 11/15/2024 and readmitted on [DATE], with diagnoses that included benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal and can slow or block the flow of urine from the bladder), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life). During a review of the Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 79 usually had the ability to express ideas and wants, and usually had the ability to understand others. The MDS also indicated Resident 79 was independent with self-care and mobility (walking). During a review of Resident 79's Progress Notes, dated 1/13/2025 , the Progress Notes indicated Resident 79 self-removed his catheter. During a review of Resident 79's Progress Notes, dated 1/18/2025, the Progress Notes indicated Resident 79 self-removed his catheter. During a review of Resident 79's Care Plan focusing on the Indwelling Catheter, initiated on 11/21/2024 and revised on 11/26/2024, the care plan indicated a goal for Resident 79 included, The resident will be/remain free from catheter-related trauma . (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555677	Facility ID: 555677 If continuation sheet Page 1 of 9

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 79's Order Summary Report dated 1/23/2025, the report indicated to change Foley (indwelling) catheter per schedule Q (every) month, as needed for leaking, occlusion, dislodgement . During a concurrent interview and record review on 1/23/2025 at 3:55 p.m. with Registered Nurse (RN) 1, Progress Notes, dated 1/13/2025 and 1/18/2025 were reviewed. RN 1 stated the physician was notified on 1/13/2025 of the catheter dislodgement. There should have been a revision of the care plan to address that the resident pulled the catheter out and monitoring to prevent it happening again. When it happened again on 1/18/2025, the physician was notified, but no care plan revision was done. The physician ordered the catheter to be re-inserted. There should have been monitoring for bleeding and low urine output. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised November 2018, the P&P indicated C. In addition, the comprehensive care plan will also be reviewed and revised at the following times: i. Onset of new problems; ii. Change of condition; During a review of the facility's P&P titled, Indwelling Catheter, with revised date: 9/1/2014, the P&P indicated, Update the resident's Care Plan as necessary.		

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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** 49131 Based on interview and record review, the facility failed to: 1. Obtain blood pressure readings to determine if three of three sampled residents (Resident 36, Resident 65 and Resident 75) have orthostatic hypotension (a form of low blood pressure that happens when standing after lying down or sitting). This deficient practice had the potential for Resident, 36, 65, and 75 to experience a delay in interventions if they were positive for orthostatic hypotension. Findings: a. During a review of Resident 36's Admission Record (Face Sheet), it indicated Resident 36 was readmitted on [DATE] with diagnoses that included failure to thrive (someone who is not developing and growing normally), muscle weakness, muscle wasting (loss of muscle mass and strength), and hypotension (low blood pressure). During a review of Resident 36's Minimum Data Set ([MDS]- a resident assessment tool), dated 10/20/2024, the MDS indicated Resident 36 had severe cognitive impairment (ability to reason, understand, remember, judge, and learn). During a review of Resident 36's Care Plan, dated 10/21/2024, it indicated that Resident 36 was at risk for decreased cardiac output (the amount of blood the heart pumps in one minute), and the intervention included to alert the provider if orthostatic blood pressure was positive. During a review of Resident 36's Order Summary Report, it indicated Resident 36 to have orthostatic blood pressure monitored every Saturday during the day shift. During a review of Resident 36's Blood Pressure Summary, dated 01/2025, Resident 36 had the following blood pressure recorded: 1/4/2025 8:06 a.m. 98/63 lying 1/4/2025 2:00 p.m. 101/64 lying 1/4/2025 3:35 p.m. 105/64 1/4/2025 4:29 p.m. 105/64 standing 1/11/2025 9:49 a.m. 97/62 lying 1/11/2025 1:06 p.m. 102/58 lying 1/11/2025 4:10 p.m. 123/71 lying (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/11/2025 4:28 p.m. 116/59 1/11/2025 4:51 p.m. 116/59 sitting 1/18/2025 2:47 a.m. 101/55 1/18/2025 9:41 a.m. 99/58 lying 1/18/2025 12:16 p.m. 105/64 lying 1/18/2025 4:36 p.m. 116/74 sitting b. During a review of Resident 65's Admission Record (Face Sheet), it indicated Resident 65 was admitted on [DATE] with diagnoses that included muscle weakness, unsteadiness on feet, and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 65's Care Plan, dated 5/10/2024, it indicated that Resident 65 had ineffective peripheral tissue perfusion (delivery of oxygen to body's arms and legs), and the intervention included to alert the provider if orthostatic blood pressure was positive. During a review of Resident 65's Order Summary Report, it indicated Resident 65 to have orthostatic blood pressure monitored every Saturday during the day shift. During a review of Resident 65's Blood Pressure Summary, dated 01/2025, Resident 65 had the following blood pressure recorded: 1/4/2025 11:54 a.m. 112/69 sitting 1/4/2025 2:30 p.m. 114/75 lying 1/11/2025 8:10 a.m. 105/68 sitting 1/11/2025 8:11 a.m. 105/68 sitting 1/11/2025 11:24 p.m. 112/72 lying 1/18/2025 8:57 a.m. 117/63 sitting 1/18/2025 12:33 p.m. 110/65 lying During an interview on 1/23/2025 at 11:04 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated orthostatic blood pressures are taken as ordered by the physician on the specified day and shift. LVN 1 stated the process of taking orthostatic blood pressure was to take a blood pressure when the resident was lying down and then having them sit up, wait 3-5 minutes and take another blood pressure reading. If the resident could stand, they would also take one with the resident standing. LVN 1 stated the orthostatic blood pressure needs to be taken in the order of lying, sitting and standing because they are measuring a change in blood pressure when getting up. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/23/2025 at 11:15 a.m. with LVN 1, Resident 36 and 65's Blood Pressure Summary were reviewed for 1/4/2025, 1/11/2025, and 1/18/2025. LVN 1 stated based on the times the blood pressure readings were taken and the position the residents were in, a true orthostatic blood pressure reading was not taken on the ordered days. LVN 1 stated it was important to have orthostatic blood pressure be taken correctly so staff can see if there was a change and if so, would need to alert the doctors so they can provide interventions. During a review of the facility's policy and procedure, titled Orthostatic Hypotension, dated 1/1/2012, it indicated orthostatic vital signs would be taken and recorded when ordered by the physician. The procedure for taking orthostatic blood pressure starts with the resident lying down and taking a set of blood pressure, then the resident would either sit or stand and have another blood pressure taken again after 3 minutes. If there was a drop in systolic blood pressure of 20 millimeters of mercury (mm Hg) or a 10 mmHg drop in your diastolic blood pressure within three minutes of standing up, the resident has orthostatic hypotension. 47042 b. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was initially admitted to the facility on [DATE] and last readmitted [DATE]. Resident 75's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), unspecified psychosis ((a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy) and Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment). During a review of Resident 75's history and physical (H&P), dated 12/14/2024, the H&P indicated Resident 75 did not have the capacity to understand and make decisions. During a review of Resident 75's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 12/20/2024, the MDS indicated Resident 75 needed maximal assistance on staff for activities of daily living (ADLs) such as toileting, dressing, showering, and positioning. During a concurrent interview and record review on 1/23/2025 at 3:00 p.m. with Director of Nursing (DON), Resident 75's Medication Administration Record (MAR), dated December 2024 and January 2025 were reviewed. The MAR indicated monitor orthostatic blood pressure every week on Saturday for anti-psychotic medication use. Take and record BP lying, sitting and standing if able to do so. Notify MD if noted decline of 20 mmHg or more in SBP or a 10 mmHg in DBP. MAR showed on 12/14/24, 12/21/24, 12/28/24, 1/4/25, 1/11/25 and 1/18/25 only SBP was recorded. DON stated the order showed to take and record orthostatic BP every Saturday, which included parameters to notify the doctor for SBP and DBP. DON stated the record only showed the SBP. DON stated that was not the correct way of documenting BP's. DON stated there would be no way to determine if there was a trend in the DBP and to notify the doctor. DON stated it was important to follow the doctor orders and document correctly. DON stated the resident could potentially lead to dizziness, falls or other health issues. During a review of the facility's policy and procedure, titled Orthostatic Hypotension, dated 1/1/2012, it indicated orthostatic vital signs would be taken and recorded when ordered by the physician.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906 Based on observation and interview, the facility failed to: 1. Complete a change of condition after Resident 79 self-removed his indwelling catheter (a flexible tube inserted into the bladder to continuously drain urine into a drainage bag), for the second time. This failure resulted in Resident 79 not having a detailed explanation of what occurred and if the physician and responsible party was notified. Findings: During a review of the admission record, the admission record indicated Resident 79 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included benign prostatic hyperplasia (a condition in which the prostate gland is larger than normal and can slow or block the flow of urine from the bladder), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life). During a review of the Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 79 usually had the ability to express ideas and wants, and usually had the ability to understand others. The MDS also indicated Resident 79 was independent with self-care and mobility (walking). During a review of Resident 79's Progress Notes, dated 1/18/2025, the Progress Notes indicated Resident 79 self-removed his catheter. During a review of the Change in Condition Evaluation form, dated 1/13/2025, the Change in Condition indicated Resident 79 had abdominal pain due to foley catheter removal. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification, revised April 2015, the P&P indicated VI. Documentation D. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the Twenty-Four-Hour report. During a concurrent interview and record review on 1/23/2025 at 3:45 PM with Registered Nurse (RN) 1, Resident 79's Progress Notes, dated 1/18/2025 were reviewed. RN 1 stated the physician and responsible party were notified per the notes, but the Change in Condition form was not completed. RN 1 stated that a resident removing their catheter should have a Change in Condition form completed be completed per facility protocol.		

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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** 49906 Based on observation, record review, and interview, the facility failed to: 1. Provide a smoking apron to Resident 17 for one of one saampled resident (Resident 17) as indicated on his care plan. This deficiency had the potential for the resident to burn himself. Findings: During a review of the admission record, the admission record indicated Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement of the body), schizophrenia (a mental illness that can affect thoughts, mood, and behavior), and nicotine dependence (a highly addictive substance found in tobacco usually consumed through smoking cigarettes or using e-cigarettes). During a review of the Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 17 had the ability to express ideas and wants and had the ability to understand others. The MDS also indicated Resident 17 normally used a wheelchair for mobility. During a concurrent observation and interview on 1/22/2025 at 2:30 PM, Resident 17 was observed in the designated smoking area smoking a cigarette without a smoking apron on. Observed one smoking apron hanging on a hook near him. When asked if he ever wears the apron, he stated I have been here five years and I have never worn that vest. Why would I now? During an Interview on 1/22/2025 at 2:40 PM, with Smoking Aide (SA), SA stated she offers the smoking apron to older, frail people who she feels would need it to be safe, and that there is no one like that right now. She denied being informed of residents who should wear it. During a concurrent interview and record review on 1/23/2025 at 10:30 AM with the Director of Nursing (DON), Resident 17's care plan for tobacco use, initiated 2/18/2022, was reviewed. The care plan indicated Resident 17 would wear a smoking apron while smoking. The DON stated the SA is responsible for offering the apron. If the resident refuses, the SA should let us know. The DON also stated that the apron is there for residents' safety, so they do not burn themselves or their clothes. When asked how the SA would know who needs a vest, the DON stated that she would look into it. During a review of the facility's policy and procedure (P&P) titled, Smoking Residents, revised 7/27/2023, the P&P indicated: (8) The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906 Based on observation and interview, the facility failed to: 1. Label a bottle of ClearLax (a medication used to treat occasional constipation), with the date opened. This failure had the potential to result in residents being administered expired medication that may be less effective, potentially leading to inadequate bowel movement relief. Findings: During an observation on [DATE] at 08:15 AM, Licensed Vocational Nurse (LVN) 1 administered medication from an opened bottle of ClearLax that was not labeled with the date it was opened. During an interview on [DATE] at 2:15 PM with LVN 1, LVN 1 stated, That bottle should have been labeled when it was first opened to know when to remove it from the cart after 30 days. Without knowing how long ago it was opened, there is no way to know if it would possibly be effective. Residents could be constipated if it does not work anymore. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated [DATE], the P&P indicated, When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47042 Based on observation, interview, and record review, the facility failed to: 1. Ensure the correct sized serving scoop was used for 29 of 29 residents on mechanical soft diets. This deficient practice had the potential for resident to receive the wrong caloric intake when not following the menu, resulting in decreased nutritional intake and weight loss. Findings: During an observation on 1/23/2025 at 12:00 p.m. in the kitchen, during serving of the lunch trays, [NAME] 1 (Cook 1) scooped the mechanical soft roast beef onto resident's plates using scoop size number 12 (one-third of a cup). During a review of Cooks Spreadsheet - Winter Menus, dated 1/23/2025, indicated ground roast beef for lunch required the use of scoop number 10 (three-eighths of a cup). During a review of facility list of residents on mechanical soft diets, dated 1/24/2025, indicated there were 29 residents on mechanical soft diets. During an interview on 1/23/2025 at 12:20 p.m. with [NAME] 1, [NAME] 1 stated that the number 12 scoop was used to serve the mechanical soft meat. [NAME] 1 stated the wrong scoop that was used was smaller than what the menu showed. [NAME] 1 stated the menu shows the number 10 scoop which is larger should have been used. [NAME] 1 stated it was important to use the right size scoop, it could possibly cause the resident to get less food and have weight loss. During an interview on 1/23/2025 at 12:35 p.m., with Dietary Supervisor (DS), DS stated cook 1 used the wrong size scoop for the mechanical soft meat. DS stated the scoop number 10 should have been used, it was a larger scoop than the one that was used. The DS stated that using the incorrect scoop size meant the residents could not get enough food and potentially have weight loss. During an interview on 1/24/2025 at 9:00 a.m., with Registered Dietician (RD), RD stated the menu showed which scoop size to be used and should be followed. RD stated not using the correct size scoop has the potential to affect the health of the resident by receiving less intake and potential weight loss. During a review of the facility's policy and procedure (P&P) titled, Menus, dated April 2014, the P&P indicated, food served should adhere to the written menu.		