STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Ridge Skilled Nursing & Rehabilitation	**1108 Birch Street , Douglas, Wyoming, 82633**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 6/15/26 through 6/18/26. Also reviewed in the course of the survey was complaint intake #3031172. The following common abbreviations are used throughout this document: DON: Director of Nursing BIMS: Brief Interview for Mental Status MA-C: Medication Assistant Certified MDS: Minimum Data Set CNA: Certified Nursing Assistant RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time,	F0801	Qualified Dietary Staff: CFR(s): 483.60(a)(1)(2) The facility will ensure that there is a qualified dietary manager. Corrective Action: New dietary manager has been hired and will be enrolled and complete the dietary manager or equivalent course by 07/20/26 All residents have the potential to be affected. Systemic Change to prevent Recurrence: New dietary manager will have course completed by 07/20/26.	07/20/2026

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 reverse for further 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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F0801 SS = F	Continued from page 1 part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a	F0801	Continued from page 1 Completion date: 07/20/26 Responsible party: RDO will educate NHA on the importance of having of a dietary manager with appropriate education and certificate. QAPI: Dietary manager will bring results of class and test to QAPI. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0801 SS = F	Continued from page 2 nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, and policy review, the facility failed to ensure the dietary manager met the required qualifications. The census was 49. The findings were: 1. Interview with the administrator on 6/15/26 at 12:25 PM revealed the facility did not have a dietary manager. Further interview confirmed the facility had a contract dietitian who did not work full-time in the facility. 2. Review of the policy titled "Dietary Services-Staffing" last revised 5/26 showed "3...If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility will designate a person to serve as the director of food and nutrition services who:...i. A certified dietary manager; ii. A certified food service manager;..."	F0801		07/20/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812	Food Procurement, store/prepare/serve-sanitary CFR(s): 483.60(i)(1)(2) The facility will ensure a sanitary environment in 1 of 1 kitchen, and will ensure that there is not outdated food in nourishment refrigerators. Regarding Hand hygiene/proper glove practice in a dietary setting Corrective Action: Dietary staff was educated in proper glove changing and hand washing techniques.	07/20/2026

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F0812 SS = F	Continued from page 3 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, review of facility policy, and review of the 2022 FDA Food Code, the facility failed to ensure a sanitary environment in 1 of 1 kitchen, and failed to ensure outdated food was disposed of in 1 of 2 nourishment refrigerators. The census was 49. The findings were: Regarding sanitary environment 1. Observation on 6/17/26 beginning at 10:08 AM showed cook #1 donned gloves and performed various tasks in the kitchen; she placed frozen garlic bread on a sheet pan, entered the walk in refrigerator and exited with 2 containers that she took to the dish room, cleaned a thermometer, removed lasagna from the oven and checked the temperature, removed the vegetables from the stove and took the temperature, tested the sanitizer bucket, wiped down the counters, placed pans in the steam table, placed bread into the oven, placed lasagna into the steam table, checked the bread in the oven by lifting a piece up with gloved left hand, pureed lasagna and placed into a container, removed garlic bread out from oven and placed into containers wearing gloves and used a spatula and gloved hand to touch bread. She threw the parchment away, took the pans to the dish room, dished out vegetables, and used a gloved hand to remove vegetables out of the container and pureed, then covered the vegetables and put them into the oven. She made gravy and mashed potatoes, removed the pureed vegetables from the oven and placed them into the steam table, and took the temperature of all foods in the steam table. At 11:16 the cook doffed her gloves, washed her hands, and donned new gloves. She then set up the service area, removed chips out from boxes in the dry storage room, looked through the meal cards, and began plating food to send to Hall 3. She used gloved hands to place bread on plates, and touched	F0812	Continued from page 3 All residents have the potential to be affected. Systemic Change to prevent Recurrence: Dietary staff will be enrolled in and completed serve safe classes for proper and safe food handling techniques. Completion date: 07/20/26 Responsible party: NHA or designee will educate staff in proper hand hygiene as well as facility enrollment of staff in proper serve safe class. QAPI: Dietary staff/manager will update NHA weekly on progress of class. Audit of glove technique and hand washing will be performed 3 times a week for 12 weeks. Results of audit will be brought to QAPI for 3 months. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance. Regarding outdated food Corrective Action: The facility removed outdated food immediately. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Dietary department implementation will include: AM dietary aide to be responsible for stocking nursing and C wing fridge and snacks as well as checking and removing items that have reached their use by date. PM aide will be responsible for checking that areas above are still stocked and restock if needed. PM aide will also check dates in fridges. Completion date: 07/20/26 Responsible party: NHA or designee will educate dietary staff to ensure that fridges are stocked and items are discarded by use by date. Dietary manager or designee will perform weekly audits to ensure compliance.	07/20/2026

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F0812 SS = F	Continued from page 4 the lasagna with her left hand when she cut it. At 12:21 PM she washed her hands and donned new gloves, placed a pan of lasagna in the steam table, opened a can of soup and cooked it in the microwave, and continued with tray service. At 1:11 PM she cleaned the thermometer, took the temperature of the test tray and touched the bread and vegetables with her left, gloved hand when she temped the food. 2. Observation on 6/17/26 at 10:08 AM showed dietary aide #1 donned gloves and prepared various tasks in the kitchen; she mixed drinks in pitchers, lifted the garbage can lid with gloved hands and threw garbage away, and prepared coffee. She removed a coffee filter and scooped coffee grounds into the filter. She washed coffee carafes in the sink, and lifted the lid of the trash can. At 10:27 AM she doffed her gloves, washed her hands, and donned new gloves. She made labels for drink containers, placed coffee grounds in the filter, and carried a carafe of coffee to the dining room. At 10:36 AM she washed her hands and donned new gloves, filled carafes with hot water, and wiped the counters. At 11:03 AM she doffed gloves, washed her hands. donned new gloves, and set up a container of ice and a scoop by the drink station. Without changing gloves, she placed cookies onto plates. 3. Interview on 6/17/2026 at 1:26 PM with the administrator revealed she expected dietary staff only touched food with gloved hands when at the service line. She stated if they left the service line they should take the gloves off and put new ones back on when they returned to the line. She stated they should use a tong or clean gloves to pick up bread and cookies. 4. According to the 2022 FDA Food Code showed "2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS,	F0812	Continued from page 4 QAPI: Audit of food/snacks will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Audits will be brought to QAPI each month for 3 months or until resolved. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0812 SS = F	Continued from page 5 eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands." Regarding outdated food 1. Observation on 6/17/26 at 5:25 PM showed 4 cups of yogurt with a "use by" date of 6/12/26 in the Hall 3 nourishment refrigerator. 2. Interview with the administrator. on 6/17/26 at 5:29 PM revealed the refrigerator contained food for residents' consumption. 3. Review of the policy titled "Date Marking for Food Safety" last revised 5/26 showed "...5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest...7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, and document accordingly..."	F0812		07/20/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F0584	Safe/clean/comfortable/homelike environment CFR(s): 483.10(1)(1)-(7) The facility will ensure that comfortable and safe temperatures levels between the temperature range of 71-81 degrees F. Corrective Action: Facilities manager increased temperature on Kitchen thermostat to help increase the ambient temperature in the dining room. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Outside plumbing company was contacted to investigate varying differences in ambient temperatures in the dining room. Education to Facility Manager. Task added to TELS system.	07/20/2026

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F0584 SS = E	Continued from page 6 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and policy review, the facility failed to ensure comfortable and safe temperature levels between the temperature range of 71 to 81 degrees F, in 1 of 2 dining areas (main dining room). The census was 49. The findings were: 1. Interview with Resident #35 on 6/15/26 at 4:11 PM revealed the temperature was sometimes cold, especially in the dining room. S/he revealed the facility ran the air conditioner all the time in the dining room. 2. Interview with Resident #2 on 6/15/26 at 4:02 PM revealed the dining room was cold and facility staff had to provide something on his/her shoulders during meals. 3. Interview with 6 residents during the resident council meeting on 6/16/26 at 10:29 AM revealed the dining room and hallways were always cold.	F0584	Continued from page 6 Completion date: 07/20/26 Responsible party: Facilities manager will ensure that outside vendor completes the desired/recommended changes to level out the ambient temperature to the appropriate and safe temperature. QAPI: Audit of room temperature will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Audit results will be brought to QAPI each month for the next 3 months. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0584 SS = E	Continued from page 7 4. Observation on 6/15/26 at 5:07 PM showed the main dining room felt cold in temperature. Observation showed 9 residents in the dining room at that time, 1 was wearing a coat, 1 had a blanket wrapped around his/her shoulders, and 2 residents had blankets on their laps. 5. Observation on 6/17/26 at 10 AM showed the dining room felt much colder than the area outside the dining room. 6. Observation on 6/17/26 at 1:22 PM showed the temperature in the main dining room, near the kitchen, registered at 68.6 degrees Fahrenheit. 7. Observation with the maintenance director on 6/18/26 at 10:31 AM showed the main dining room had 66.8 degrees Fahrenheit temperature on the surface of the table height closest to the kitchen. Further observation showed the long table, where residents were performing activities, showed a table surface temperature of 70 degrees Fahrenheit and the air vent closest to the kitchen showed air temperature of 46 degrees Fahrenheit, blowing into the dining room. Interview with the maintenance director at that time confirmed the temperature was colder than 71 degrees Fahrenheit. 8. Review of the facility policy titled "Safe and Homelike Environment" last revised on 5/2026 showed "...7. The facility will maintain comfortable and safe temperature levels. a. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit..."	F0584		07/20/2026
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance,	F0692	F0692: Nutrition/hydration Status Maintenance CFR (s): 483.25(g)(1)-(3) The facility will ensure that residents maintain acceptable parameters of nutritional status. #1 Corrective Action: Resident #40’s food preferences/dislikes and acceptable alternatives were re-verified. Care plan, meal ticket/tray card were	07/20/2026

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F0692 SS = D	Continued from page 8 unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 2 of 4 sample residents (#33, #40) reviewed for weight loss. The findings were: 1. Review of the quarterly MDS assessment dated 4/25/26 showed resident #40 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact and had diagnoses which included malnutrition, vitamin D deficiency, anemia, cancer, history of a stroke, and hemiplegia, or hemiparesis. Further review showed the resident required set up and clean up assistance with eating. Review of the nutritional care plan last revised on 6/9/26 showed the resident was at risk for nutritional deficits secondary to weakness and a history of a stroke. Further review showed interventions which included honoring food preferences, providing house supplements twice per day, diet and snacks as prescribed, and assisting with meals as needed. Review of the quarterly nutrition evaluation dated 4/24/26 and timed 10:46 AM showed the resident disliked pork, ham, salads, and beets. Further review showed the "Resident Interview" section included "...B. [Resident] has received a copy of the menu and the alternative menu. [Resident] states that [his/her] appetite is ok ... ambulates with a wheelchair but prefers to stay in [his/her] room for meals...." The following concerns were identified: a. Observation on 6/15/26 at 6:06 PM showed the resident was in his/her bed and the residents meal tray was on the bedside table. Further observation showed braised pork, scalloped potatoes, peas, and a dinner roll, which was untouched. Review of the meal intake record for 6/15/26 showed at 5 PM the resident was documented as consuming 0 to 25 percent of his/her meal. Interview with the resident at that time revealed "I don't eat pork, it's bad on	F0692	Continued from page 8 reconciled and communicated as appropriate to e nsure consistency. Meal observations were initiated to validate tray accuracy, in-room meal service, intake follow-up, and alternate meal offering when intake is poor or disliked items are served. RD/dietitian reviewed resident's weight/intake trends and interventions, with provider/resident notification completed as appropriate. All resident's have the potential to be affected. Systemic Change to prevent Recurrence: Activities/designee will complete daily meal choice rounds with residents using the daily and always-available menus. Preferences or alternate requests will be communicated to the dietary department prior to meal service to support resident choice and meal acceptance. Staff were educated on honoring resident food preferences/dislikes, offering alternatives for refused/disliked meal items, in-room tray set-up and follow-up, reporting/documenting poor meal/supplement intake or refusals, and ensuring diet orders, care plans, and meal tickets accurately reflect resident-specific needs. Nursing leadership, Dietary manager/designee, RD/dietitian, MDS/care plan staff, and direct-care staff as applicable were re-educated on strengthening weekly Nutrition-at-Risk review to include validation of intake trends, preferences/dislikes, supplement concerns, meal assistance needs, care plan/meal ticket accuracy, and follow-through of assigned interventions. Completion date: 07/20/26 Responsible party: NHA or designee QAPI: Audits will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Results of the audits will be reviewed in QAPI for the next 3 months. Administrator oversees the QAPI process and will ultimately ensure sustained compliance. #2 Corrective Action: Resident #33 care plan and tasks	07/20/2026

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F0692 SS = D	Continued from page 9 my stomach, they know I don't eat pork, but they bring it anyway." Further interview revealed the resident was never offered an alternative ahead of time. Continued observation showed an unidentified staff member provided the resident two "Uncrustables" sandwiches as a meal replacement. b. Review of the resident's meal intakes from 5/20/26 through 6/17/26 showed meals were documented 83 times. Further review showed the resident consumed 0 percent to 25 percent 25 times, consumed 26 percent to 50 percent 36 times, consumed 51 percent to 75 percent 16 times, consumed 76 to 100 percent 5 times, and refused 2 times. Further review showed no evidence alternative meals were offered or provided. c. Review of the resident's weight history showed on 12/6/25, the resident weighed 185.1 pounds and on 6/15/26, the resident weighed 160.2 pounds, which was a 13.45 percent Loss. Further review showed on 5/11/26, the resident weighed 177.8 pounds and on 6/15/26, the resident weighed 160.2 pounds, which was a 9.9 percent loss. d. Interview with the administrator on 6/17/26 at 1:32 PM revealed the dietary staff should have been aware the resident didn't eat pork. Further interview revealed the dietary staff should have been aware of the resident's dislikes, preferences, nutrition assessment requests, and documented care plan interventions. 2. Review of the quarterly MDS assessment dated 3/19/26 showed resident #33 had a brief interview for mental status (BIMS) score of 7 out 15, which indicated severe cognitive impairment, and diagnoses which included renal insufficiency, diabetes mellitus, non-Alzheimer's dementia, and malnutrition. Further review showed the resident required supervision or touching assistance with eating and had experienced a weight loss of 5 percent or more in the last month or 10 percent or more in the last 6 months, which was not physician prescribed. Review of the significant change MDS assessment dated 12/17/25 showed the resident required supervision or touching assistance with eating and had weight loss of 5 percent or more in the last month or loss 10 percent or more in the last 6 months which was not physician prescribed. Review of the nutritional care plan last revised on 6/17/26 showed the resident was at risk for nutritional deficits secondary to cognitive and age-related deficits. Further review showed interventions which included the resident receiving a	F0692	Continued from page 9 were updated to encourage to take resident to dining room for meals as she will allow. Resident was reassessed for level of assistance needed, preference/dislikes. DON educated nursing, CNAs, MA-Cs, dietary, and managers on identifying residents at nutritional risk, honoring preferences/dislikes, room tray setup/cleanup, cueing/feeding assistance, accurate intake documentation, offering alternatives for intake less than 50%, supplement offering/refusal, reporting repeated poor intake or refusals, and care plan/tray card accuracy. Systemic Change to prevent Recurrence: As stated in the corrective action for resident #33, DON educated nursing, CNA's, MA-C's, dietary, and managers to identify residents at risk for nutritional deficits, meal tray delivery, set up and follow up. Completion date: 07/20/26 Responsible party: DON or designee QAPI: Audits will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Results of the audits will be reviewed in QAPI for the next 3 months. Administrator oversees the QAPI process and will ultimately ensure sustained compliance.	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2026

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F0692 SS = D	Continued from page 10 house supplement twice per day to help with weight loss and provide assistance with meals as needed. Review of a physician progress note dated 6/12/26 and time 8:45 AM showed a 10 percent weight loss was identified in December 2025 and physical therapy, occupational therapy, and speech therapy were ordered to address functional decline and dysphagia. Further review showed the resident was started on Lasix (diuretic therapy) 20 milligrams (mg) on 1/13/26 to manage bilateral lower extremity edema and the resident received supplements twice daily, a fortified diet, and weekly weights. Review of the resident's weight history showed on 11/9/25, the resident weighed 139.2 pounds (lbs). and on 5/4/26, the resident weighed 119.5 lbs. which was a 14.15 percent weight loss. The following concerns were identified: a. Observation on 6/15/26 at 1:36 PM showed the resident was in his/her room in a recliner and the resident's meal tray was on the bedside table, with the cover still on. Review of the meal intake record for 6/15/26 showed at 1 PM the resident was documented as consuming 0 percent to 25 percent of his/her meal. b. Observation on 6/16/26 at 8:59 AM showed the resident was in bed and his/her meal tray was uncovered on the bedside table. Further observation showed the meal had not been eaten and no verbal cues or physical assistance was offered or provided. Observation on 6/16/26 at 9:03 AM showed the resident's meal remained un-eaten. MA-C #1 entered the resident's room to provide medications and then left the room. No verbal cues or physical assistance was offered or provided. Interview with the MA-C at that time revealed she did not provide or offer the resident's nutritional supplement because the resident "doesn't like it." Review of the meal intake record for 6/16/26 showed at 11:46 AM the resident was documented as consuming 26 percent to 50 percent of his/her meal. c. Observation on 6/16/26 at 11:26 AM showed an unidentified staff member entered the resident's room with a meal tray, placed it on the bedside table, and left the room. No verbal cues or physical assistance was offered or provided. Review of the meal intake record for 6/16/26 showed at 1 PM the resident was documented as consuming 0 percent to 25 percent of his/her meal. d. Continuous observation on 6/17/26 from 3:15 PM to 5:49 PM showed the resident was in his/her room, in the recliner and the door was closed. The resident's lunch tray remained on the bedside table.	F0692		07/20/2026

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F0692 SS = D	Continued from page 11 No verbal cues or physical assistance was offered or provided. At 5:49 PM an unidentified staff member entered the resident's room with his/her dinner tray and moved the lunch tray from the bedside table to another table inside the room. The staff member exited the room and closed the door. No verbal cues or physical assistance was offered or provided. Review of the meal intake record for 6/17/26 showed at 1 PM the resident was documented as consuming 26 percent to 50 percent of his/her meal. e. Review of the resident's meal intakes from 5/19/26 through 6/17/26 showed meals were documented 87 times. Further review showed the resident consumed 0 percent to 25 percent 20 times, consumed 26 percent to 50 percent 39 times, consumed 51 percent to 75 percent 14 times, consumed 76 percent to 100 percent 8 times, refused meals 5 times, and was marked not applicable 1 time. Further review showed no evidence alternative meals were offered or provided. 3. Interview with the dietitian on 6/18/26 at 10:03 AM revealed he expected staff to offer alternatives or assistance if a resident consumed less than 50% and staff should be going back to residents to offer something different or offer a supplement, when they pick up the meal trays. Further interview revealed residents should be offered their supplements every time it was ordered and staff should notify administration if a resident didn't like a supplement they were ordered. 4. Interview with the administrator on 6/17/26 at 1:32 PM revealed the facility had an always available menu and certain items rotated on the list. She revealed residents should be able to request additional items after all meals were served and if a resident did not eat the meal, the expectation was for staff to offer an alternative meal that is comparable in nutritional value. 5. Review of the policy titled "Nutritional Management" last revised on 5/2026 showed "...Compliance Guidelines: 1. A systemic approach is used to optimize each resident's nutritional status: a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information. c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary..."	F0692		07/20/2026

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F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure residents received appropriate treatment and services to attain their highest practicable physical, mental, and psychosocial well-being for 1 of 3 sample residents (#29) reviewed for dementia care. The findings were: 1. Review of the comprehensive MDS assessment dated 3/30/26 showed resident #29 had severe cognitive impairment and had diagnoses which included Alzheimer's dementia, non Alzheimer's dementia, Down syndrome, seizure disorder, anxiety, depression, and bipolar disorder. Further review showed the resident was independent with ambulation. Review of the care plan initiated on 3/24/26 and last updated 6/7/26 showed the resident was at risk for adjustment/psychosocial issues secondary to the need for skilled nursing facility cares, change in routine, and relied on others to assist with activities of daily living. Care plan interventions included daily opportunities for social contact and to encourage him/her to participate in activities of his/her choice. The following concerns were identified: a. Interview with resident #2 on 6/15/26 at 4:02 PM revealed s/he felt at times, there wasn't enough staff to monitor all residents. Observation during the interview showed resident #29 entered resident #2's room uninvited. Resident #2 told resident #29 to "get out" twice before resident #29 left. No staff intervention was provided. b. Interview with resident #35 on 6/15/26 at 4:11 PM revealed resident #29 wandered into rooms without being invited and it made resident #35 feel like s/he didn't have any privacy. c. Observation on 6/15/26 at 4:24 PM showed resident #29 entered resident #27's room without an invitation. Resident #27 asked resident #29 to leave 3 times before s/he left. Resident #29 returned to the room at 4:29 PM and resident #27 asked him/her to leave again. No staff intervention was	F0744	Treatment/Service for Dementia CFR(s): 483.40(b)(3) The facility will ensure that residents receive appropriate treatment and attain their highest practicable physical, mental, psychosocial well-being. Corrective Action: Resident #29's care plan was updated with more individualized activities to assist in redirection and reduce boredom. All residents with cognitive deficits have the potential to be affected. Systemic Change to prevent Recurrence: Activities staff educated on providing more individualized activities. Staff will be educated on proper techniques in redirecting residents. Completion date: 07/20/26 Responsible party: NHA or designee to educate staff and activities department QAPI: Audits will be completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Results of audits will be brought to QAPI for the next 3 months. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0744 SS = D	Continued from page 13 provided. d. Observation on 6/16/26 at 11:09 AM showed resident #29 wandered into the room of resident #46. Resident #46 told resident #29 to leave 3 times before the resident left the room. e. Interview with 6 residents during the resident council meeting on 6/16/26 at 10:53 AM revealed resident #29 wandered into residents' rooms and took food out of cupboards and clothing out of closets. Further interview revealed the residents were scared when resident #29 wandered into their rooms. f. Interview with resident #7 on 6/18/26 at 10:31 AM revealed residents wandered in and out of his/her room. g. Interview with resident #24 on 6/18/26 at 10:34 AM revealed residents wandered in his/her room and rummaged through the cupboards. Further interview revealed s/he had told staff during his/her care plan meeting, and s/he would not have that happen in his/her home. h. Interview with resident #9 on 6/18/26 at 11:35 AM revealed resident #29 had wandered into his/her room and s/he told the resident to go to the nurses' station. 2. Interview with the administrator on 6/18/26 at 12:04 PM revealed staff were expected to redirect wandering residents if they were found in another resident's room. Further interview revealed if staff didn't see a wandering resident enter another resident's room, the resident would be expected to call for help. 3. Interview with the regional director of operations on 6/18/26 at 12:12 PM revealed staff were expected to monitor residents who had wandered into another resident's room. Further interview revealed residents chose if they wanted their door closed to prevent wandering. 4. Review of the policy titled "Dementia Care" last revised 5/26 showed "...It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychological well-being."	F0744		07/20/2026

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F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure proper storage of medications for 1 of 7 sample residents (#46) reviewed for medication administration. The findings were: 1. Review of the quarterly MDS assessment dated 5/7/26 showed resident #46 had a BIMS score of 14 out of 15, which indicated intact cognition, and diagnoses which included anxiety disorder, depression, psychotic disorder, and schizophrenia. Review of the admission MDS assessment dated 3/24/26 showed resident #29 had short-term and long-term memory impairment and decisions regarding tasks of daily life indicated "Moderately impaired-decisions poor; cues/supervision required." Further review showed the resident had diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, and down syndrome. The following concerns were identified:	F0761	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) The facility will ensure proper storage of medications. Corrective Action: All bedside medications were removed. All residents have the potential to be affected. Systemic Change to prevent Recurrence: Residents who request bed side self-administration will be evaluated for safety and a bed side locked box for in room disbursement. Staff will be educated to not leave medications at bedside unless resident is deemed safe and lock-box is in place. Completion date: 07/20/26 Responsible party:. DON or designee QAPI: Audits will completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Results of audits will be brought to QAPI for 3 months. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0761 SS = D	Continued from page 15 a. Observation on 6/16/26 at 11:09 AM showed resident #29 wandered into the room of resident #46, uninvited. Resident #46 asked resident #29 to leave three times before resident #29 left the room. b. Observation on 6/18/26 at 8:30 AM showed MA-C #1 entered resident #46's room to administer medications. At that time, a bottle of fluticasone propionate was observed on the counter near the resident's sink. Interview the MA-C at that time revealed the resident was approved to self-administer the nasal spray and was permitted to store it in his/her room. c. Review of the medical record showed no evidence resident #46 had been assessed to self-administer or store medications. d. Interview with the DON on 6/18/26 at 9:25 AM revealed the medication should have been stored in a drawer or lockbox to prevent wandering residents from obtaining the medication. e. Interview with the DON during the exit conference on 6/18/26 at 4 PM confirmed resident #46 did not have an assessment to self-administer or store medications in his/her room. 2. Review of the policy titled "Resident Self-Administration of Medication" last revised on 5/2026 showed "...6. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in containers dispensed by the provider pharmacy..."	F0761		07/20/2026
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F0806	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) The facility will ensure to provide food that accommodates the resident's intolerance, and preferences. Corrective Action: Resident #44 for offered meals from the alternative menu to replace the meal he did not like.	07/20/2026

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F0806 SS = D	Continued from page 16 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to provide food that accommodated the resident's intolerances, and preferences for 1 of 2 sample residents (#40) reviewed for meal preferences. The findings were: 1. Review of the quarterly MDS assessment dated 4/25/26 showed resident #40 had a BIMS score of 15 out 15, which indicated the resident was cognitively intact and had diagnoses which included malnutrition, vitamin D deficiency, anemia, cancer, history of a stroke, and hemiplegia, or hemiparesis. Further review showed the resident required set up and clean up assistance with eating. Review of the nutritional care plan last revised on 6/9/26 showed the resident was at risk for nutritional deficits secondary to weakness and a history of a stroke. Further review showed interventions which included honoring food preferences, providing house supplements twice per day, diet and snacks as prescribed, and assisting with meals as needed. Review of the quarterly nutrition evaluation dated 4/24/26 and timed 10:46 AM showed the resident disliked pork, ham, salads, and beets. Further review showed the "Resident Interview" section included "...B. [Resident] has received a copy of the menu and the alternative menu. [Resident] states that [his/her] appetite is ok ... ambulates with a wheelchair but prefers to stay in [his/her] room for meals...." The following concerns were identified: a. Observation on 6/15/26 at 6:06 PM showed the resident was in his/her bed and the residents meal tray was on the bedside table. Further observation showed braised pork, scalloped potatoes, peas, and a dinner roll, which was untouched. Review of the meal intake record for 6/15/26 showed at 5 PM the resident was documented as consuming 0 to 25 percent of his/her meal. Interview with the resident at that time revealed "I don't eat pork, it's bad on my stomach, they know I don't eat pork, but they bring it anyway." Further interview revealed the resident was never offered an alternative ahead of time. Continued observation showed an unidentified staff member provided the resident two "Uncrustables" sandwiches as a meal replacement.	F0806	Continued from page 16 All residents have the potential to be affected. Systemic Change to prevent Recurrence: Activities department or designee will visit with residents each day to review current menu and offer alternative menu choices. These choices will be brought to the kitchen for updated menu options if needed. Kitchen staff will also be educated on meal replacement options and being nutritional in value. Completion date: 07/20/26 Responsible party: NHA or designee QAPI: Audit of menu choice sheets will completed 5 days a week for 4 weeks, 3 days a week for 4 weeks, and weekly for 4 weeks. Results of audits will be brought to QAPI for 3 months. Administrator oversees the QAPI process and is ultimately responsible for corrective actions and sustained compliance.	07/20/2026

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F0806 SS = D	Continued from page 17 2. Interview with the administrator on 6/17/26 at 1:32 PM revealed the facility had an always available menu and certain items rotated on the list. She revealed residents should have been able to request additional items after all meals were served and if a resident did not eat the meal, the expectation was for staff to offer an alternative meal that was comparable in nutritional value. Further interview revealed the dietary staff should have been aware the resident didn't eat pork, aware of the his/her dislikes, preferences, nutrition assessment requests, and documented care plan interventions.	F0806		07/20/2026