STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010637	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	1380 NORTH 27TH ROAD , OTTAWA, Illinois, 61350

(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
S0000	Initial Comments Annual Licensure Survey	S0000		08/28/2025
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.1210b)4) 300.1210d)3) 300.1850k) 300.2040d) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.Section 300.1210 General Requirements for Nursing and Personal Care 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a	S9999		

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

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S9999	Continued from page 1 means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1850 Other Resident Record Requirements This Section contains references to rules located in other Subparts that pertain to the content and maintenance of medical records. k) The resident's record shall include the physician's diet order and observations of the resident's response to the diet, as describe in Section 300.2040 of this Part. Section 300.2040 Diet Orders d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to identify a decrease in food intake and ensure nutritional status was maintained which resulted in unintentional weight loss for one of three residents (R8) reviewed for nutritional status in a sample of 31. This failure resulted in R8 having a severe weight loss of 17% (37 pounds) within 30 days. Findings include: R8 was admitted on 9/13/23 with diagnoses of Chronic Atrial Fibrillation, Chronic Kidney Disease Stage 3, Dysphagia, Oropharyngeal Phase, Senile Degeneration of the Brain and Dementia. The Minimum Data Set documents R8 was admitted with a Brief Interview for Mental Status (BIMS) score of 4.0 (severely cognitively impaired) and on 10/29/24, a BIMS could not be conducted due to cognitive impairment. R8's current Care Plan documents R8 has Activities of Daily Living (ADLs) self-care deficit related to her disease process and the following interventions were implemented: on 9/19/23, to provide finger-food when the resident has difficulty with utensils; on 2/27/24, R8 is able to feed self with supervision after set up	S9999		

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S9999	Continued from page 2 and to monitor for pocketing food; on 9/18/24, to weigh every month and notify physician for weight gain/loss greater than or equal to 5 percent (%) in 10 days or 10% in 6 months. R8 has a nutritional problem or potential nutritional problem related to aspiration, weight loss, dysphagia and a dysphagia advanced diet restriction and the following interventions were implemented: on 9/27/23, the Registered Dietician to evaluate and make diet recommendations; on 9/27/23, to monitor intake and record every meal; on 9/27/23, monitor for signs and symptoms of aspiration; on 7/24/24, to provide and serve supplements as ordered twice daily; and on 7/29/25, to weigh R8 daily, notify Registered Dietician of a weight loss greater than 5%. The Nutrition-Amount Eaten task dated 7/3/25 through 7/31/25 documents the percentage of food R8 has consumed at each meal. 34 of 84 (45%) meal intakes were documented; 17 of the 38 meal intakes were documented at 0%-25% consumed; and 14 of the 38 meal intakes were documented as 26%-50% consumed. The weight flowsheets documents R8 weighed 214 pounds on 6/2/25; 177 pounds on 7/9/25 (37-pound loss); and 169 pounds on 7/30/25 (45-pound loss). There was a 17.3% weight loss from 6/2/25 to 7/9/25. V2's (Director of Nursing) Progress Notes dated 7/10/25 documents R8 noted to have a significant weight loss from June to July of 2025. R8 physically does not appear of have a significant change in weight. R8 continues to have some difficulty with chewing and swallowing. R8 will be weighed weekly for the next 4 weeks. Manual scale and mechanical lift scale will be assessed to make sure that they are functioning properly by facility maintenance. V19's (Registered Dietician) noted dated 7/22/25 documents R8 was triggered for significant weight loss of 37 pounds and a 17.6% loss at 3 and 6 months. R8 was reweighed and weights were accurate. V25's (Advanced Nurse Practitioner) Progress Notes dated 7/24/25 documents V25 was "notified by nursing staff of resident with reports of weight loss of greater than 10 pounds in one month. Patient family is at bedside today, requesting discussion and review. Review of symptoms is obtained with the assistance of nurse caring for her at the bedside as patient is essentially non-verbal and with history of chronic dementia. Will get basic acute work up for physical decline, weakness, decreased appetite, daily weights and labs, UA (urinalysis) with culture as indicated."	S9999		

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S9999	Continued from page 3 On 7/29/25 at 11:10 AM, R8 was observed sitting in a reclining chair with eyes closed. R8 was dressed in what looked to be well-fitting clothes and appeared clean and kept. R8's Physician Orders dated 7/14/25 to 7/31/25 ordered weekly weights; 7/22/25 – 7/29/25 were to add a nutritional supplement with medication pass two times a day (6 med passes 0% consumed, 4 med passes 25% consumed, 1 med pass was documented as unknown consumption); on 7/28/25 blood work was ordered for a new onset of a deep tissue injury left heel; on 7/30/25, the nutritional supplement was increased to three times daily and daily weights were ordered; and no urinalysis was ordered or conducted. The Progress Note dated 7/26/25 documents R8 developed a Deep Tissue Injury (wound) on the left heel. On 7/31/25, a referral to the wound specialist and an antibiotic was ordered for treatment of the Deep Tissue Injury, as well as significant bruising with cellulitis of bilateral lower extremities. On 7/29/25 at 11:15 AM, V17 (R8's family member) stated the facility only weighed R8 once a month. V17 stated she could tell R8's clothes were too big and had lost weight. "I asked them to weigh (R8). She had lost 44 pounds in 6 weeks. They weighed her on two different scales both in a wheelchair and in the (mechanical lift). I had to bring it (weight loss) to their (facility staff) attention at a Care Plan meeting last week. They didn't even address it (weight loss). If I'm not here to feed her, I don't know if she gets fed or how much she eats. The food is not even palatable most of the time. It's cold by the time it gets here (to R8's room) and not fit to eat." On 7/31/25 at 1:45 PM, V2 (Director of Nursing) stated she had recently identified that intakes were not being recorded. V2 stated she thought R8's weight loss was a misreading and wanted to monitor her weight before initiating interventions. V2 stated she was not sure if increasing the med pass to three times a day would be beneficial because R8 was not consuming the drink twice daily as previously ordered. V2 agreed R8 was declining although 44 pounds was excessive in a small duration of time. On 8/1/25 at 2:00 PM, V1 (Administrator) verified the kitchen issues (quality of food) and R8's weight loss. "B"	S9999		

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S9999	Continued from page 4 Statement of Licensure Violations 2 of 2: 300.610a) 300.1210b)4) 300.2040b)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.2040 Diet Orders b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a	S9999		

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S9999	Continued from page 5 general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian. 2) The diet shall be served as ordered. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor high risk residents with swallowing difficulty and follow physician ordered therapeutic diets for two of 16 Residents (R41 and R46) reviewed for therapeutic diets in a sample of 31. This failure resulted in R41 choking and requiring hospitalization and R46 choking and requiring the Heimlich maneuver. Findings include: 1.R41's Physician Order Sheet/POS, dated 7/2/25, documents diagnoses including Dysphagia, Oral Phase, Barrett's Esophagus without Dysplasia, Hemiplegia affecting left side, Major Depressive Disorder, recurrent severe and Psychotic symptoms. The POS also documents Physicians Diet Order (dated 4/13/24) for a Regular diet, Regular texture and Regular consistency and no longer to have eggs and the diet order was discontinued on 6/3/25. On 6/3/25, a new diet for Regular diet, Dysphagia Puree texture, Regular consistency was ordered. R41's Minimum Data Set/MDS (Section C/Cognitive Patterns), assessment reference date of 6/10/25, documents a Brief Interview for Mental Status/BIMS score of 12, documenting mild cognitive impairment. R41's current Care Plan, undated, documents: that on 8/18/22, assistance with eating and meals, per set-up assistance as needed; has periods of forgetfulness and confusion with fluctuating BIMS scores; has no natural teeth; and has the potential for swallowing problems related to Barrett's Esophagus and Dysphagia and to monitor/document/report signs of pocketing, choking, swallowing or holding food in mouth (initiated 8/18/22) R41's Incident Report, dated 6/2/25, documents that on 6/2/25 at 6:15 pm, R41 was in the Facility dining room and "was lowered to the floor to do abdominal thrusts due to Resident choking on food, expelled after abdominal thrusts and back blows." The Report documents that R41 had complaints of abdominal pain. The Incident investigation documents: that R41 was eating dinner in the dining room and was found in distress due to	S9999		

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S9999	Continued from page 6 choking; R41 was blue and unable to talk; and tends to put large amounts of food in mouth and this was not the first time. The Facility local State Agency Reports, dated 6/1/25 through 8/1/25, did not document notification to the local State Agency for R41's 6/2/25 choking episode that resulted in R41 requiring hospitalization. R41's Nursing Progress Note, dated 6/2/25 at 7:17 pm, documents R41 was observed choking in the dining room, resident was blue and unable to talk. R41 was moved to the floor and eight "abdominal thrusts and five back blows" were performed and R41 expelled what appeared to be soggy bread. R41 complained of epigastric pain. R41 was transported to the local area hospital for evaluation and was tearful. R41's Nursing Progress Note, dated 6/2/25 at 11:11 pm, documents that the local area hospital was observing R41 for "overnight or maybe two days" for bleeding from an old surgical wound on abdomen. R41's Nursing Progress Note, dated 6/4/25 at 11:16 am, documents that the local area hospital was discharging R41 back to the Facility on 6/4/25 at 12:30 pm. R41's Nursing Progress Note, dated 6/4/25 at 4:03 pm, documents that R41 arrived back to the Facility from the local area hospital and R41's diet as pureed, thin liquids. R41's Nursing Progress Note, dated 6/4/25 at 12:53 pm, documents a late entry from V25 (R41's Advanced Practice Nurse/APN) that R41 was re-admitted back the Facility for a choking episode, the Heimlich was performed and R41 was kept for observation for Dysphagia and monitoring on an old surgical site that continues to drain. R41's Hospital History and Physical/H&P, dated 8/1/25, documents that R41's reason for visit to the Emergency Department on 6/2/25 after being found choking on an egg salad sandwich. R41 reported that R41 was eating an egg salad sandwich and started choking on the last bite. The H&P documents that R41 was "blue in the face and that staff were uncertain exactly how long R41 had been choking per Emergency Medical Services/EMS. Abdominal thrusts were performed for approximately 40 to 50 seconds and the foreign body was able to be dislodged from her airway." The H&P documents that R41 had a few choking episodes in the last few months. R41's H&P also documents that a Comminuted Tomography	S9999		

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S9999	Continued from page 7 Imaging Test (CT Scan) was performed of R41's Chest. The H&P documents that R41 had no evidence of foreign body in the airway, but given chest pain and abdominal pain status, the possibility of solid organ injury could not be ruled out. R41 reported pain in upper belly from the abdominal thrusts. The H&P documents a referral for Physical Therapy, Occupational Therapy and Speech Therapy and changed R41's diet to pureed with thin liquid through a straw, while sitting upright with chin tucks. The H&P documents CT scan results that R41 does likely have posttraumatic hematoma which resulted in R41 needing continued hospital observation. The Hospital H&P documents a Speech/Language Pathology Evaluation, dated 6/3/25 documents recommendations for R41's diet as mechanical soft and thin liquids, medications crushed in applesauce, sit upright 90 degrees and fully awake/alert, alternate solids and liquids and that R41 would benefit from continued skilled intervention. R41's Video Swallow Study results revealed R41 had severe Oral Pharyngeal Dysphagia, with delayed swallowing, reflex initiation and repeated vallecular residuals, though notably without penetration or aspiration. Given R41's bedbound status, R41 was placed on aspiration precautions. On 8/1/25 at 1:58 pm, R41 stated, "I was taking a bite of egg salad, then I started having trouble breathing. I do not have any teeth, and I was gumming my food when I was eating. Now they changed my diet to pureed because I choked. I have not gotten any therapy." On 7/30/25 at 2:20 PM, V20 (Dietary District Manager) stated, "The Facility does not have a policy for Dysphagia diets. The facility follows the National Dysphagia Diet Guidelines." V23 could not provide a copy of the National Dysphagia Diet Guidelines. V23 verified that a copy of the National Dysphagia Diet Guidelines was not available for Facility staff. On 8/1/25 at 12:41 pm, V24 (Speech and Language Therapist) stated, "I know that (R41) has had a couple of choking episodes. One was about a year ago on eggs, so we recommended that (R41) not be served eggs. (R41's) last choking episode at the beginning of June, was on an egg salad sandwich and (R46) should not have been served eggs. They had to perform the Heimlich on (R46) and R46 had to be sent to the hospital. Therapy did not evaluate (R41) after this choking episode; the family did not want a Speech Therapy evaluation so they just downgraded (R41's) diet as pureed. I have no Physical Therapy, Occupational Therapy or Speech Therapy notes or evaluations. The last time we saw (R41) was in April of 2024."	S9999		

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S9999	Continued from page 8 2.R46's Physician Order Sheet/POS, dated 5/17/24, documents R46 was admitted on 3/16/25 with diagnoses including Alzheimer's Disease, Dementia, Bipolar Disorder, Major Depressive Disorder, Dysphasia (Oral Pharyngeal Phase) and anxiety disorder. R46's POS also documents a Physician's diet order for a Dysphagia Advanced texture, Regular consistency, Lactose intolerant and "may only have soup as an option, if she does not like the meal." R46's current Care Plan documents: impaired cognitive function; oral/dental problems related to upper and lower partial; has poor health literacy and "always" requires assistance to understand medical/healthcare information; has potential nutritional problem, possible Aspiration Dysphagia, lactose intolerant (initiated on 09/05/2022); monitor/document/report any signs or symptoms of Dysphagia (pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat or appears concerned during meals); monitor/document, report signs/symptoms of aspiration/pneumonia: shortness of breath, choking, labored respirations, lung congestion (initiated: 05/21/2024); provide and serve diet as ordered. (Dysphagia Advance) lactose free milk, may have cheese, cranberry juice with each meal (initiated: 09/05/2022). R46's Physician Order, dated 5/17/24, documents a diet order of Dysphagia Advanced, Lactose Intolerant, may have soup as an option, if does not like meal. R46's Speech Therapy Evaluation and Plan of Treatment, dated 5/20/24, documents: R46 had a choking incident on thin water on 5/26/25; mild Oropharyngeal Dysphagia; increased difficulty with mastication of harder solids with decreased bolus formation and control due to missing teeth. R46's Progress Note, dated 7/24/25, documents that R46 had a choking incident during lunch and that the Heimlich maneuver was performed and was successful. R46's Physician was notified, and 15-minute observations were initiated. R46 remained alert and complained of no pain or discomfort throughout the day. R46's Progress Note, dated 7/25/25, documents that R46's diet was updated per V16 (R46's Power of Attorney/Daughter) to have no bread and to only have soup as an option if R46 does not like the meal. The Progress Note does not document a Physician or Speech Therapist review of initiating a new diet order.	S9999		

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S9999	Continued from page 9 V15's (Certified Nursing Assistant) Employee Action Form/Disciplinary Form, authored by V2 (Director of Nursing/DON), dated 7/24/25, documents "(R46) given and PB &J (Peanut Butter and Jelly) sandwich at lunch, began to have difficulty eating it and began to choke. R46 is on a Dysphagia Advanced diet. No physician order to have a PB & J sandwich. The Employee Action Form (Supervisors Concerns) documents that only Physicians or Speech Therapists are able to upgrade diets and if a resident requests something other than what is served it must clear their diet or be specialty on their diet. The Employee Action Form (Recommendation) documents to ask the nurse if in question about a diet or food choice for a resident on modified diet, do not assume a Resident is safe to eat something without confirmation (this is out of their understanding) and out of your scope as a Certified Nurse Aide/CNA. On 7/31/25 at 11:00 AM, V15 (CNA) stated, "Cheese ravioli was served (on 7/24/25) and (R46) did not want it. I was discussing with the dietary aide about what (R46's) substitute options were, and they offered (R46) a grilled cheese but (R46) had a dairy allergy so I told them I did not think (R46) could have it (grilled cheese), so they gave me a peanut butter and jelly sandwich to give to her. I continued to pass trays. I was at the serving table when I heard my name called and (R46) was blue. I gave her three to four good thrusts and she gasped. Nothing came out but she had a drink of water and was ok. She wanted to go to her room, but I would not move her until (V14 Agency Nurse) checked her out. Honestly, after this whole thing, I did some deep diving and educated myself on special diets. We (CNAs) are not educated enough on diets. There are many different levels that are difficult to understand. I did get a write up for serving the wrong food." On 7/30/25 at 12:40 PM, V16 (R46's daughter) stated, "Last week, they (Facility) called me and told me (R46) choked on a peanut butter and jelly sandwich and someone had to do the Heimlich. I must be here every day to make sure (R46) is attended to. (R46) is 98 years old with dementia and on a mechanical soft diet and needs to be watched. I had them change her diet order to only give Mom (R46) soup if she does not like the meal and no bread." On 7/30/25 at 2:20 PM, V20 (Dietary District Manager) stated, "The Facility does not have a policy for Dysphagia diets. The facility follows the National Dysphagia Diet Guidelines." V23 could not provide a copy of the National Dysphagia Diet Guidelines. V23	S9999		

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S9999	Continued from page 10 verified that a copy of the National Dysphagia Diet Guidelines was not available for Facility staff. On 8/1/25 at 12:41 pm, V24 (Speech and Language Therapist) stated, “I did not know anything about (R46) choking on a peanut butter and jelly sandwich. I think the family did not want a speech evaluation after (R46) choked, so I never saw (R46). (R46) was on a Dysphagia Advanced diet, which is more like mechanical soft, and it says soft bread is okay, but it does not say anything about peanut butter. I know that the Facility follows the National Dysphagia Diet, but I do not have any clear evidence or a copy of that. I am sure that I could maybe do an internet search on how to find it, but I do not have a copy of it to refer to, I definitely know that bread is okay to eat on a Dysphagia Advanced diet, but I cannot definitely say if a peanut butter sandwich is okay for (R46) to eat.” The Facility Therapeutic Diets Policy, revised 9/2017, documents: all Residents have a diet order, including regular, therapeutic and texture modification, that is prescribed by the attending physician in accordance with the applicable regulatory guidelines; therapeutic diet is defined by a Physician or Registered Dietician and the purpose of a therapeutic diet is to provide food that a Resident is able to eat; mechanically altered diet means the texture of the diet is altered; and diets are prepared in accordance with the guidelines in the approved Diet Manual and the individualized plan of care. The Facility Dining Service Agreement (Dining Services/Exhibit A), dated 11/25/24, documents: preparation of food to be served to Facility Residents/Patients on the premises of each Facility, including therapeutic diets for Residents/Patients including general meal planning. The Facility Diet and Nutrition Care Manual, dated 5/1/19, documents: Dysphagia diets should be customized for each individual with modifications made by the Registered Dietician, Speech/Language Therapist and/or Physician; a Physician's order is needed for each specific level of Dysphagia diet and thickness of liquid and for any changes in the consistency of foods or fluids; Level Three Dysphagia Advanced is defined (soft-solid, requires more chewing ability, easy to cut meats/meats/vegetables, regular texture with exception of hard/chunky food items, all foods in Level One and Level Two are allowed, requires some chewing ability and meats in soft/bite size pieces); Level One is defined (pureed/pudding like food, moist pudding like consistency without particles, easily swallowed diet	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010637	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	1380 NORTH 27TH ROAD , OTTAWA, Illinois, 61350

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S9999	Continued from page 11 with minimum chewing; Level Two is defined (cohesive/moist/semi-solid, requires some chewing ability, ground/minced meat with fork-mashable fruits/vegetables, moist ground soft textured meat/simple to chew, food forms easily into cohesive bolus, may include Level One diet foods and excludes moist bread products, crackers and other dry foods). The Facility Assisted Nutrition and Hydration Policy, revised 8/28/17, documents: Resident receiving assisted nutrition shall maintain acceptable parameters of nutritional status and shall be offered a therapeutic diet; should a Resident be at a point where oral intake is possible, the Resident shall be referred to skilled speech therapy and the Resident's Physician for orders concerning a therapeutic diet as appropriate; the Resident will be in a Restorative program and will be provided assistance as needed with eating, also as needed by the Resident; and Residents who progress in this manner to the point where oral intake is again possible will be assessed at least on a daily basis for swallowing status both during and after meals, respiratory status and effectiveness of interventions. The Facility Medical Orders Source Modifications Policy, dated 8/28/17 documents: to increase and ensure the continuity of medical orders required for the care of Residents at and prior to admission, throughout the stay of the Residents within the Facility and through the time of discharge from the Facility; pursuant to 42 CFR 483.30 from the following the Physician, Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner; and in the case of dietary orders, dietary orders may be received from the Physician, Dietician or qualified professional operating under the supervision of a Physician. The Facility Resident Exercise of Rights Policy, dated 5/24/23, documents: every Resident has the right to reside in the Facility and receive services in the Facility with reasonable accommodation of Resident needs and preferences unless to do so would endanger the health/safety of the Resident; provide assessment and monitoring to detect and remedy any unintentional or accident (as well as intentional) abridgment of the Resident rights to choices in any facet of their care or stay in the Facility. "A"	S9999		