

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057778		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/07/2026	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE SOUTH HOLLAND				STREET ADDRESS, CITY, STATE, ZIP CODE 16300 WAUSAU STREET , SOUTH HOLLAND, Illinois, 60473			
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S0000	Initial Comments		S0000			02/20/2026	
	Annual Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	1 of 2						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)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						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow their Weight Assessment and Interventions Policy and Unintentional Weight Loss Policy. Specifically, the facility did not report poor appetite and decreased oral intake to the physician and dietician and failed to develop interventions to prevent further weight loss. Additionally, the facility failed to ensure that one resident who was identified as at risk for malnutrition and dependent on enteral nutrition, received his enteral feeding as ordered. The facility also failed to implement dietician recommendations and to evaluate interventions to promote weight gain. This affected three of three residents reviewed for prevention of weight loss and nutrition (R34, R46, and R9) These failures resulted in R34 experiencing severe weight loss of 9.1% over 9 days, R46 experiencing severe weight loss of 11.5% over one month, and R9 experiencing an unplanned weight loss of 20 pounds over approximately 10 months. 1. R9 was admitted to the facility on 4/30/25 with a diagnosis of chronic respiratory failure, anoxic brain damage, cardiac arrest, convulsions, type II diabetes, dysphagia, gastronomy and anemia. R9's admitting weight dated 4/30/25 documents 118 pounds. R9's weight summary documents: body max index 15.4 goal weight range 158-191 pounds. According to the Centers			S9999			

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S9999	Continued from page 2 for Disease control a body max index of 15.4 is underweight. On 2/6/26 at 9:26AM, R9's weight taken by V9 (Restorative aide) and V11 (Restorative aide) via mechanical lift. Weight scaled displayed zero prior to weight being taken. Weight measured at 98.6 pounds. On 2/5/26 at 4:35PM, R9 was observed in bed. R9's artificial feeding was hung dated 2/4/26 with pump on but not infusing. Pump displayed pump inactive pump has been idle for 10 minutes. On 2/6/26 at 8:46AM, R9 was observed in bed. R9's artificial feeding was hung dated 2/4/26 with pump on but not infusing. Pump displayed pump inactive pump has been idle for 10 minutes. On 2/6/26 at 9:26AM, R9's feeding pump displayed inactive pump has been idle for 10 minutes upon entering room with staff for weight observation. On 2/6/26/at 9:54AM, V3 (Nurse) was observed in R9's room. V3 said she was turning off R9's feeding because it is due to be turned off at 10:00am. V3 was asked to verify the amount of feeding administrated. Pump read 38 ml given that hour. V3 unsure why it only displayed 38ML. V3 said she does not need to do anything with the feeding but just needs to stop the feeding at 10:00AM. V3 turned off the feeding and left the room. On 2/6/26 at 11:27AM, V2 (Director of nursing, DON) showed surveyor a new bottle of artificial feeding 1.5 which contained 1000 milliliters (ML). V2 (DON) was asked to confirm the feeding bottle and feeding amount in R9's room. V2 confirmed that there was one bottle of jevity 1.5 hanging in the room dated 2/6/26 with about 800ml left in the bottle with no time documented. V2 said the overnight shift would have hung a new bottle on their shift the feeding was currently off due to the order stating to stop at 10:00AM. V2 said nursing staff are expected to ensure the full amount of feeding was provided to the resident prior to stopping the feeding at 10:00AM. It is expected that the nurse would check the feeding pump to ensure the full amount was given and if not that the feeding would continue until the full amount was given. Pump displayed total feed for the hour was 38ML and total daily was 774ML and water flushed was 750ML. R9's physician order sheet dated documents: two times a day Jevity 1.5 @ 80 ml/hour x 20 hours/day - Total 1600 ml daily off 10 am on 2 pm.		S9999				

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S9999	Continued from page 3 On 2/26/26 at 2:55PM, V13 (Dietician) said she would expect staff to be following the feeding orders and should continue the feeding until the resident has reached the total amount given. V13 said the resident not receiving all the required feeding can lead to weight loss, dehydration and potentially worsening of pressure sores. On 2/6/26 at 4:27PM, V18 (Medical Doctor/MD) said he would expect R9's feeding to be given as ordered and that the total amount of feeding would be given. R9's mini nutritional note dated 1/16/2026: R9 admitted on 4/30/25. No hospital stays this quarter. At risk of malnutrition due to body mass index (BMI). No edema or Gastrointestinal distress documented: Height: 68 inches weight: 101# (45.9 kg) BMI: 15.4 (underweight). Gradual, intentional weight gain is desirable. Per weight history, no clinically significant weight changes x 1, 3, or 6 months. Diet: NPO (nothing by mouth). NKFA (no known food allergies). Liquid protein 30 ml BID (twice daily). Estimated nutritional needs: 1606-1836 kcals (35-40 kcal/kg) 69- 92 g protein (1.5-2.0 g/kg) 1606-1836 ml fluid (1ml/kcal) TF (tube feeding): two times a day Jevity 1.5 @ 80 ml/hour x 20 hrs/day - Total 1600 ml daily off 10 am on 2 pm FWF (free water flush): every shift Flush GT (gastrostomy tube) with 250 ml of water Q4H (every 4 hours) via pump TF provides: 1600 ml total volume, 2400 kcals, 102 g protein, and 2716 ml total fluid (free water + flushes). Percent of estimated nutritional needs met: 131% kcals, 111% protein and 148% fluid. Recommendations: current TF order meets/exceeds estimated nutritional needs for healthy weight and wound healing. Add multivitamin (MVI/MIN) and Vitamin C for wound healing. R9's physician order sheet dated 2/6/26 does not document any orders for multivitamin (MVI/MIN) and Vitamin C. R9's medication administration record for January 2026 and February 2026 do not document any orders for multivitamin (MVI/MIN) and Vitamin C. On 2/6/26 at 4:27PM, V18 (MD) said he would expect dietician recommendations to be followed.		S9999				

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S9999	Continued from page 4 R9's weights document: 5/29/25 119 pounds; 6/6/25 120 pounds; 7/9/25 103 pounds, 7/28/25 105 pounds, 8/4/25 104 pounds, 9/9/25 100 pounds, 10/3/25 101 pounds, 11/4/25 100.5 pounds; 12/8/25 103 pounds, 1/5/26 101 pounds. No weight recorded for February. R9's dietician notes 12/15/25 documents: Gradual, intentional weight gain is desirable. Per weight history, weight loss of -14.9% , -18 Lb x 6 months. No clinically significant weight changes x 1 or 3 months. TF provides: 1600 ml total volume, 2400 kcals, 102 g protein, and 2716 ml total fluid (free water + flushes).% of estimated nutritional needs met: 128% kcals, 109% protein and 145% protein Recommendations: continue present management. R9's dietician notes 11/17/25 documents: Weight stability or gradual, intentional weight gain is desirable. Per weight history, unplanned weight loss of -8.0% , -8.7 pounds x 3 months and -15.1% , -18 pounds x 6 months. Weight stable x 1 month. TF provides: 1600 ml total volume, 2400 kcals, 102 g protein, and 2716 ml total fluid (free water + flushes).% of estimated nutritional needs met: 131% kcals, 112% protein and 149% fluid. Recommendations: Current TF/FWF meet/exceed estimated nutritional needs to support healthy weight and wound healing R9's dietician notes 10/14/25 documents: He is NPO and receives via G-tube Jevity 1.5 @ 80ml/hr x 20hrs with 250ml FWF q 4hrs. This provides 2400 kcals, 102 g protein, and 2716 ml total Weight (10/3) 101#, BMI of 15.4 is within underweight range. This provides 2400 kcals, 102 g protein, and 2716 ml total fluid (free water + flushes). No significant weight changes x 1 or 3 months. Gradual weight loss is desired for resident r/t (related to) malnutrition. Current feeding volume is adequate to meet 100% of kcal, 100% protein, and 111% fluid estimated needs. Continue present management. R9's dietician notes 9/15/25 document: TF: Jevity 1.5 @ 80mL/hr x 20hrs (ON 2pm; Off 10am) or until 1600mL total volume formula has infused w/ 250mL flushes q4h. TF formula was changed from Jevity 1.2 to Jevity 1.5 on 9/2 to support wt gain and wound healing. TF and flushes provide 2400kcal, 102g protein and 2716mL total fluid (1216mL via TF+ 1500mL flushes). This supports 100% kcal, 100% protein and 111% fluid estimated nutritional needs. No GI distress or TF intolerance noted. BMI of 15.5- underweight. Wt hx shows significant 7.4#(6.8%) wt loss x 1 month and significant 19#(15.7%) wt loss x 3 months. Wt loss		S9999				

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S9999	Continued from page 5 likely r/t Dx, wounds, fluid shifts and possible SE of Rx. Wt stability or intentional, gradual wt gain is desired. Estimated needs based on IBW for wt gain (70kg): 2100-2450kcal @ 30-35kcal/kg, 84-105g pro @ 1.2-1.5g/kg and 2100-2450mL @ 1.0mL/kcal. Refer RD as needed. Continue present management. R9's dietitian notes 7/21/25 document: R9's weight: 103# (46.8 kg) 7/21 wt. ht: 68 inches BMI: 15.7 (Underweight). Weight stability or gradual, intentional weight gain is desirable. Per wt hx, weight loss of -14.9% , -18 Lbs x 1 month and 12.7% , -15.0 pounds x 3 months. Last amount of weight lost in a short period of time, will monitor weekly weights. Recommendations: Weekly weights x 4 weeks. Increase TF to 80 ml/hr x 20 hours. TF will provide: 1600 ml total volume, 2400 kcals, 103 g protein and 1216 ml free water. R9's dietitian notes 6/19/25 document: Current wt: 120.8# (54.9 kg) ht: 68 inches BMI: 18.4 (underweight). Weight stability or gradual, intentional weight gain is desirable. Recommendations: Change TF to meet new facility guidelines. Jevity 1.5 @ 70 ml/hr x 20 H, ON at 2PM and OFF at 10 AM. Total volume 1400 ml. FWF per MD. TF will provide: 1400 ml total volume, 2100 kcals, 89 g protein, 1064 ml free water. On 2/6/26 at 5:00PM, V2 (DON) was asked what interventions the facility put in place following R9's weight loss to promote weight gain or healthy weight for R9. V2 said the facility adjusted R9's feeding in July by increasing the rate of the feeding from 70 ml to 80 ml an hour. V2 said they changed the type of artificial feeding as well from jevity 1.2 to jevity 1.5 for more calories. On 2/6/26 at 2:55PM, V13 (Dietician) said residents receiving tube feeding are seen monthly to monitor. R9 had weight loss from June to July. V13 said they increased the feeding from 70 ml an hour to 80 ml an hour and implemented weekly weights. V13 said she is unsure what caused the weight loss or if there was anything additional done to evaluate R9's weight loss. V 13 said R9 was receiving enough caloric and nutritional needs that would maintain weight. On 2/6/26 at 4:27PM, V18 (MD) said he is aware of R9's weight loss and said it could be possibly due to an absorption issue. V18 was asked how you confirm that it is an absorption issue, and not an underlying condition, or not providing the feeding as ordered. V18 said R9 would need to have further testing to confirm an absorption issue that would require a hospital stay. V18 said that there is no acute reason that R9 would			S9999			

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S9999	Continued from page 6 require hospitalization and that if the facility sent R9 to the Emergency room, they would probably send him right back. V18 said R9 does not have any diagnosis or conditions that would attribute to the sudden weight loss. V18 said R9 has not had any acute infections that would have caused weight loss. V18 said R9 has been stable but due to his wounds and tracheostomy status, he has a poor quality of life and would be appropriate for hospice. R9's artificial feeding order history documents: 4/30/25 – 6/19/25 Jevity 1.2 at 65ml an hour x 21 hours total 1365 ml daily; 6/21/25- 7/21/25 Jevity 1.5 @70 ml/hour x 20 hours/day - Total 1400 ml daily; 7/21/25 Jevity 1.5 @80 ml/hour x 20 hrs/day - Total 1600 ml daily. There were no other increases to the feeding documented. R9's care plan dated 5/2/25 documents: R9 requires enteral feedings as the primary source of nutrition that puts resident at risk for: Aspiration, Malnutrition, Dehydration, and Intolerance. Enteral feeding is related to: Dysphagia. Interventions: Diet: nothing by mouth (NPO); Elevate head of bed to prevent aspiration. Date Initiated: 05/02/2025; Enteral nutrition per physician order. Date Initiated: 05/02/2025; Monitor for complications including aspiration, diarrhea, respiratory infection, dehydration, abdominal pain, feeding tube displacement, nausea, vomiting, and abnormal lab values. Notify nurse or physician as indicated. Date Initiated: 05/02/2025; Monitor weights: Monthly per routine. Date Initiated: 05/02/2025. R9's mini nutritional assessment dated 5/2/25 documents malnourished; mini nutritional assessment dated 9/2/25 documents malnourished; mini nutritional assessment dated 10/14/25 documents malnourished; mini nutritional assessment dated 1/16/26 documents at risk for malnutrition. Facility policy titled Enteral Nutrition- tube feeding dated 2020 documents: Nursing staff will follow community enteral nutrition policies and guidelines. Monitoring of the residents actual intake and tolerance of tube feeding is important to ensure that nutritional goals are met and maintained. monitoring of the resident with a tube feeding is an interdisciplinary team effort and includes: enteral feeding delivered as ordered by physician; weights. Facility policy titled Unintentional Weight Loss dated 2020 documents: Unintentional weight loss can have serious implications for older adults. Studies indicate	S9999					

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S9999	Continued from page 7 unintentional weight loss can lead to malnutrition, poor wound healing, risk of pressure sores, decline in function and inability to fight infections. Unintentional weight loss can be rapid or sometimes slow an insidious. Its important that systems are in place to detect, assess and develop individualized plan of care for residents with weight loss. For individuals with unintentional weight loss. Monitoring is vital after plan of care implementation to assess progress on nutritional related goals. Goals may need to be modified and new interventions implemented based individual responses to current interventions, their weight and other factors related to their medical conditions. 2. On 2/6/26 at 9:30 AM, V7 (restorative director) stated that all newly admitted and re-admitted residents will have weights done weekly x 4 weeks. V7 stated that if the resident has +/- 5 pound weight change from previous weight, the restorative aides will automatically re-weigh the resident to verify the accuracy of the weight obtained. V7 stated that the re-weight is done immediately and only the re-weight is entered into the resident's electronic medical record. V7 stated that if there is a change in the resident's weight will be reviewed by V13 RD (registered dietitian). V7 stated that the facility has a NARs (nutrition at risk) meeting weekly that V13 attends and any nutritional concerns are discussed. The resident's nurse is responsible for notifying the physician of any weight loss. V7 stated that R34's weight on 2/1/26 was 179.5 pounds. On 2/6/26 at 2:48 PM, V13 RD stated that she has up to one month to evaluate residents' who have experienced changes in weight +/- 5 pounds. V13 stated that she was not notified of R34's 18-pound (9.1%) weight loss from 12/27 – 1/5. V13 stated that the nurse should have notified her of R34's weight loss on 1/5. V13 stated that weight fluctuations will be seen in residents with diagnosis of CHF (congestive heart failure). V13 reviewed R34's medications and stated that while R34 has a diagnosis of CHF he is not receiving any diuretic medication that could explain his weight loss. V13's RD note, dated 1/30/26, notes R34's current weight is 180.5 pounds on 1/5. Weight stability is desirable but anticipate weight fluctuating with diagnosis of CHF and fluid shifts. Per weight history, weight loss of 18 pounds, 9.1% x about 1 week, add weekly weight to monitor weight trends. Skin is intact, with no active wounds per wound rounds. R34 is on a no added salt diet, mechanical soft texture, thin consistency. Oral intakes of meals per POC (point of		S9999				

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S9999	Continued from page 8 care) documentation are good, consuming >51% of most meals. No reported issues chewing/swallowing current diet order. Recommendations: Weekly weight x 4 weeks to monitor weight trends. There is no documentation found in R34's medical record noting the physician or the registered dietitian was notified of R34's weight loss on 1/5/26. There is no documentation noting any interventions were implemented between 1/5 and 1/30 for weekly weight monitoring or the addition of nutrition supplements in R34's medical record. R34's weight documentation notes: R34's weight on 12/20/25 was 195.5 pounds; on 12/27/25 it was 198.5 pounds; and on 1/5/26 it was 180.5 pounds. R34's POS (physician order sheet), dated 1/5/26 – 2/6/26, does not note any orders for weekly weights or for nutritional supplements to prevent further weight loss. R34's medical record does not note weekly weights x 4 weeks were obtained on re-admission to the facility on 12/20/25. The nurse practitioner's note, dated 1/7/26, nor the physician's note, dated 1/20/26, note R34's weights were reviewed. 3. On 2/6/26 at 2:48 PM V13 RD stated that she was not made aware of any further weight loss for R46. V13 stated that R46's weight loss was 9.9 pounds (3.72%) from 12/17 – 1/5, which is not significant. V13 stated that gradual intentional weight loss would be 1–2-pound weight loss per week. V13 stated that weight fluctuations will be seen in residents on dialysis and those with diagnosis of CHF (congestive heart failure). V13 reviewed R46's medications and stated that while R46 has a diagnosis of CHF she is not receiving any diuretic medication that could explain their weight loss. V13 stated that she will monitor R46's weights because of the downward trend. On 2/6/26 at 3:05 PM, V23 (dialysis staff) presented R46's dialysis communication report for today. R46's post dialysis weight is noted to be 102.6 kg (kilograms) which is 226.2 pounds. R46 has had an 11.5% weight loss in one month, 1/5 to 2/6. R46's medical record notes on 1/23 R46's post dialysis weight was 109.8 kg or 242.1 pounds. On 1/28 R46's post weight was 107.4 kg or 236.8 pounds.			S9999			

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S9999	Continued from page 9 R46's pre-weight documentation on all dialysis communication reports, dated 1/7 through 2/6, is noted to be 255.6 pounds. R46's amount eaten documentation for the past 30 days was reviewed. There was documentation found for 80 out of 90 meal opportunities. R46 consumed 0-25% of meals on 4 occasions; 26-50% on 13 occasions; 51-75% on 13 occasions; 76-100% on 46 occasions; and refused meals on 4 occasions. V13's RD note, dated 1/9/26, notes R46 was admitted on 12/17/25. Current weight is 255.6 pounds on 1/5. Body mass index is 46.7 (obese). Gradual, intentional weight loss is desirable, but anticipate weight to fluctuate with fluid shifts. No clinically significant weight changes since admission. Skin is intact, no active wounds per wound rounds. No edema or GI distress documented. R46 is on a consistent carbohydrate/LCS (low concentrated sweets) diet, regular texture, thin consistency (milk with every meal). Nepro (supplement) 60 ml (milliliters) daily. Oral intakes vary per POC documentation, 0-100% of meals x 1 month. No reported issues chewing/swallowing with current diet order. Recommendations: continue present management. The facility's weight assessment and intervention policy, dated 2020, notes any weight change of 5% or more since the previous weight assessment shall be re-taken the next day to confirm. If the weight is verified, nursing will notify the appropriate designated individuals such as physician, registered dietitian, or other members of the interdisciplinary team within 24 hours. Verbal notification must be confirmed in writing. The registered dietitian will review the weight log each month to follow individual weight trends. The threshold for significant weight loss shall be based on the following criteria: one month – significant weight loss of 5%, severe loss > 5%; three months – significant weight loss of 7.5%, severe loss > 7.5%; and six months – significant weight loss of 10% severe loss > 10%. (B) 2 of 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		S9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057778		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/07/2026	
NAME OF PROVIDER OR SUPPLIER ELEVATE CARE SOUTH HOLLAND				STREET ADDRESS, CITY, STATE, ZIP CODE 16300 WAUSAU STREET , SOUTH HOLLAND, Illinois, 60473			
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S9999	Continued from page 10 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. These requirements were not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to follow its Pain Management Policy. The facility did not assess a resident with new-onset pain, failed to document the new-onset pain, and did not ensure the resident's physician was notified or obtain an order for pain medication for one resident (R17) out of three reviewed for pain management in a sample of 44. As a result, R17 experienced psychosocial harm, enduring excruciating pain for more than 20 hours without pain medication. R17 self-reported a pain rating of 12–13 on a 1-to-10 scale. On 2/4/26 at 1:00 PM, this surveyor observed R17 to be		S9999				

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S9999	Continued from page 11 alert and oriented x 3. R17 stated that he was in pain. R17 stated that he has wounds on both heels. When asked to rate his pain on a scale of 1 to 10, R17 responded 12-13. When asked if R17 notified the nurse of his pain, R17 stated that staff think he is senile and don't do anything when he complains of pain to them. R17 appears to be restless, frustrated, his face is saddened/pained when speaking with this surveyor. R17 stated that he takes naproxen at home; it takes the edge off his pain, and he is able to function. On 2/4/26 at 1:05 PM, this surveyor made V3 (nurse) aware of R17's complaint of pain, 12-13 out of 10. V3 stated that V3 would address his pain right away. V3 checked R17's medication record. V3 stated that R17 did not have any medication ordered for pain and V3 would call R17's physician to obtain an order. There is no documentation found in R17's medical record noting R17's physician was notified on 2/4 for an order for pain medication. On 2/5/26 at 10:30 AM, R17 stated that he did not receive any medication for the pain the day before. When asked to rate his pain on a scale of 1 to 10, R17 responded 12-13. R17 appears even more restless, frustrated, his face is saddened/pained when speaking with this surveyor. On 2/5/26 at 10:30 AM, V4 (nurse) was informed of R17's complaint of pain. V4 immediately checked R17's medication record and stated that R17 does not have an order for pain medication, and she will call the physician right away to obtain orders. On 2/6/26 at 12:45 PM, R17 was observed to be calm, smiling, and relaxed. R17 stated that he received medication for pain, and he feels much better. R17's POS (physician order sheet), dated 2/5/26 at 10:40 AM, notes an order for naproxen sodium 220mg (milligrams) oral for pain. R17's MAR (medication administration record), dated February 2026, notes V4 administered naproxen tablet on 2/5 at 10:45 AM and on 2/6 at 8:39 AM. R17's care plan, initiated 1/8/26, notes R17 has potential for pain. Interventions include but not limited to administer analgesia as per orders, monitor R17's complaints of pain or requests for pain treatment and notify nurse, monitor signs and/or symptoms of non-verbal pain: vocalizations (silence), mood/behavior (changes, restless, squirmy), eyes, face (sad), body.		S9999				

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S9999	Continued from page 12 Notify physician of any complaints of pain. R17's care plan, initiated 1/12/26, notes R17 has arterial wounds on the left and right heels related to peripheral artery disease. Interventions include but not limited to pain management and assess for pain and administer pain medications as ordered, observe feedback and notify physician as necessary. The facility's pain management policy, revised 7/6/18, notes in part, when the resident is unable to describe pain, physical signs such as grimacing, body posturing, vital signs, and changes in behavior and mood will be used to determine the presence of pain. (B)		S9999				