

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057869		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/02/2026	
NAME OF PROVIDER OR SUPPLIER PEARL OF MONTCLARE, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2833 NORTH NORDICA AVENUE , CHICAGO, Illinois, 60634			
(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			04/15/2026	
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5) 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. 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:		S9999			04/15/2026	

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 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a 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. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the low air loss mattresses were used in accordance with facility policy to promote effective pressure redistribution (inappropriate layering of multiple linens) for two residents (R2 and R4); and failed to ensure a resident (R5) with a acquired stage 4 pressure ulcer received wound care as ordered by the physician resulting in the development of a wound infection, requiring IV (intravenous) antibiotic therapy. These failures affected 3 of 3 residents (R2, R4 and R5) reviewed for pressure ulcers in the sample of 61. Findings include: R5 has a diagnosis which includes but not limited to reduced mobility, sepsis, other lack of coordination and non-ischemic myocardial injury. R5's Brief Interview for Mental Status (BIMS) dated 2/10/26 shows that R5 has a score of 7 which indicates that R5 has some cognitive impairments. On 3/30/26 at 10:12 am, Surveyor observed V2 (Director of Nursing, DON) administer R5's IV antibiotic's, identified as Vancomycin. During this interview V2 stated that the IV antibiotics was prescribed for R5's sacral wound infection.			S9999			04/15/2026

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S9999	Continued from page 2 On 03/21/25 at 9:06 am, Surveyor observed V8 (Registered Nurse, RN, Wound Care Nurse), V11 (Restorative Aide), and V10 (R5's Physician) perform wound care on R5's acquired stage 4 sacral wound that had 100 % necrotic tissue, foul odor, moderate serous drainage, and visible bone exposed. V10 stated that R5's wound had a foul odor and that R5 was receiving IV antibiotics for sacral wound infection. V10 was then observed performing bedside sharps debridement to R5's sacral wound removing necrotic tissue. On 4/1/26 at 10:00 am, V8 (Registered Nurse, RN, Wound Care Nurse) stated that she has been the wound care nurse for eight days at the facility. V8 explained that R5's sacral wound was a stage IV pressure ulcer with mild odor and drainage when V8 first observed R5's sacral wound. V8 then stated that R5 currently has wound care orders for sacral wound treatment every shift and IV antibiotics Vancomycin for his sacral wound infection. V8 stated that nurses should treat a residents wound per the physicians' orders on the residents' physicians' orders sheet (POS) and that empty boxes on the resident Treatment Administration Record (TAR) indicates that the nurse did not sign off on the wound care and the treatment was not performed. V8 further explained if a resident's treatment is not performed the wound can decline and it may cause an infection. V8 also stated that during the times of R5's missing signatures on his TAR that indicate that R5 did not have treatment rendered, V8 was not employed at the facility. On 4/1/26 at 10:30 am, V2 (Director of Nursing, DON) stated that pressure ulcers began at a stage 1 with un-blanchable redness. V2 then explained when R5's acquired sacral wound was first observed on 3/6/26, she observed R5's sacral wound as an unstageable pressure ulcer with necrotic tissue. V2 then explained that nurses follow the physicians' orders and Treatment Administration Record (TAR) to treat the residents' wounds. Surveyor and V2 reviewed R5's current TAR for R5's sacral wound treatment order with no documentation on 3/12/26, 3/14/26, 3/17/26 and 3/21/26. V2 explained that on 3/12/26, 3/14/26, 3/17/26 and 3/21/26 treatment was not rendered for R5's sacral wound and that if treatment is performed the nurse must document performing the treatment by signing the residents TAR. V2 then stated, "If a resident does not receive treatment as ordered by the physician there is a			S9999			04/15/2026

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S9999	Continued from page 3 potential for the wound to decline and potential for infection in which he (referring to R5) is currently being treated for." V2 then explained R5's sacral wound was first observed as a unstageable pressure ulcer wound on 3/6/26 and was able to be staged as a stage 4 on 3/24/26 with bone exposed. On 4/1/26 at 1:04 pm, V10 (R5's Wound Care Physician) stated that he has treated R5's sacral wound for the last 3 weeks and upon initial treatment of R5's acquired sacral wound, R5's sacral wound presented as a full thickness wound that was beyond the subcutaneous layer with necrotic tissue, moderate serous drainage and no signs of infection that V10 classified as an unstageable wound. V10 then explained that when a pressure ulcer wound initially develops there is non-blanchable erythema seen. V10 further explained when a wound is necrotic there is ischemia of the skin over a long period of time, and the capillaries become ischemic, the longer the pressure the more ischemic the tissue becomes. V10 then explained that he initially ordered R5's sacral wound with daily wound care with a "Santyl" dressing. V10 then explained Upon debridement of R5's sacral wound V10 prescribed and order for Dakin's treatment three times a day and ordered IV antibiotics due to concerns for osteomyelitis. V10 also explained that he ordered a x-ray of R5's sacral wound that was negative for osteomyelitis and that V10 then did perform a wound culture with R5's sacral wound because R5's primary care physician reviewed V10's wound care notes and ordered IV antibiotic's to treat R5 for sacral wound infection. V10 stated that if a residents wound care orders are not performed as ordered by the physician the residents wound can worsen, deteriorate, have an increase in bio infectious bacteria and develop a wound infection. On 04/01/26 at 12:00 pm, Surveyor requested R5's initial Wound Assessment Detail report for 3/6/26 when R5's acquired sacral wound was first observed by V2 and V2 stated that there was no documentation for R5's acquired sacral Wound Assessment Detail until 3/9/26. R5's Minimum Data Set (MDS) dated 2/10/26 shows that is at risk for pressure ulcers and does not currently have unhealed pressure ulcers. R5's Minimum Data Set (MDS) dated 3/26/26 shows	S9999				04/15/2026	

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S9999	Continued from page 4 that is at risk for pressure ulcers and has a stage 4 pressure ulcer. The facility's document presented by V3 (Infection Preventionist, IP, Assistant Director of Nursing, ADON, Registered Nurse, RN) shows that R5 is receiving IV (intravenous) Vancomycin 1500 mg (milligrams)/ ml (milliliter) q (every) 12 hours . R5's Physician Order Sheet (POS) active order as of 03/31/26 shows R5 has order for cleanse sacrum wound with NS (Normal Saline) and pack with moist ¼ strength Dakin's followed by dry 4x4 gauze than (then) a foam border silicone dressing every shift. Every shift for wound care. R5's Physician Order Sheet (POS) active order as of 03/31/26 shows R5 has order for Vancomycin HCL (hydrochloride) use 1500 mg (milligram) intravenously every 12 hours for wound infection until 04/08/2026 23:59 **Pharmacy to dose medication** R5's Treatment Administration Record (TAR) shows that R5 did not receive treatment to his sacral on 3/12/26, 3/14/26, 3/17/26 and 3/21/26. [According to V2 she initially found R5's wound on 3/6/26. However, no wound assessment was completed until 3/9/26. There are no treatment orders for R5's stage 1 on the TAR or POS.] R5's care plan dated 3/6/26 documents in part: "Focus: Alteration in skin integrity – Resident has pressure ulcer to sacrum. Intervention: Treat per MD (Medical Doctor) order." R5's Pressure Ulcer Risk Assessment dated 2/20/26, 2/27/26 and 3/25/26 shows that R5 is at risk for pressure ulcers. R5's Wound Assessment Detail dated 3/9/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 8.0cm (centimeter) by 6.0 cm by unknown depth, with necrotic hard, firm, adherent 100% without debridement. R5's Wound Assessment Detail dated 3/12/26 shows that R5 has facility acquired pressure ulcer	S9999				04/15/2026	

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S9999	Continued from page 5 identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 11.0cm (centimeter) by 7.5 cm by unknown depth, with necrotic hard, firm, adherent 50% , necrotic soft 50% with debridement. R5's Wound Assessment Detail dated 3/17/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 10.5cm (centimeter) by 7.5 cm by 2.0 cm with necrotic hard, firm, adherent 100% with debridement. R5's Wound Assessment Detail dated 3/24/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 10.5cm (centimeter) by 8.5 cm by 2.5 cm, with necrotic hard, firm, adherent 100% , with debridement. The facility's document dated March 2026 and titled "Wound Prevention and Healing" documents in part "Intent: To provide wound care treatments/services (using a multidisciplinary approach) based on evidence standards of care under the direction of a physician." The facility document dated March 2026 and titled "Wound Prevention Healing" documents in part: "Intent: To provide wound care treatments/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician ... 10. Wound Care and Treatment: a. Wound care treatments are provided within an individualized plan of care under the direction of a physician. 11. The Multidisciplinary Wound Care Team: 1. The Wound Care team is responsible for identifying problems, coordinating care, and promoting development of the team and the program." The facility document dated March 2026 and titled "Treatment/Services to Prevent/Heal pressure Injury" documents in part: "Intent: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preference, goal for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. Procedure: b. A resident with a pressure injury receives necessary treatment and services consistent with professional standards of			S9999			04/15/2026

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S9999	Continued from page 6 practice, that are aimed to promote healing, minimize complications and prevent the development of further pressure injury." R2's admission record diagnoses include but are not limited to cerebral infarction, heart failure, peripheral vascular disease, metabolic encephalopathy, hemiplegia and hemiparesis. R2's Minimum Data Set (MDS), dated 3/6/26, documents in part, "Section C. Brief Interview for Mental Status (BIMS) Score is blank. Section M. Skin Conditions: Risk of Pressure Ulcer/Injury documents, "resident at risk of developing pressure ulcers/injuries." On 3/30/26 at 11:30 am, R2 was in room lying on a low air loss mattress with multiple layers between R2 and the low air loss mattress. The layers observed under R2 consisted of a flat sheet, an incontinent pad and an incontinent brief. On 3/30/26 at 11:40 am, V18 License Practical Nurse (LPN) stated, "There are three layers under R2 and should only be one layer for circulation and wound prevention. Having multiple layers will constrict the flow of the air and defeat the purpose of the air loss mattress, which is to prevent skin breakdown." R2's Physician Orders Set dated 4/1/26 documents, in part, "Air loss mattress." R2's risk assessment dated 2/11/26 documents R2's Braden score is 16 which indicates at risk. R2's care plan dated 3/17/26 documents in part, "Focus: Alteration in skin integrity. Residents have a vascular wound of the right foot with necrotic tissue. Goal: Create an environment for healing. Intervention: Air loss mattress." R4's admission record diagnoses include but are not limited to reduced mobility, tracheostomy, hypertension, encephalopathy, seizures, hemiplegia and hemiparesis. R4's Minimum Data Set (MDS), dated 3/23/26, documents in part, "Section C. Brief Interview for Mental Status (BIMS) Score is blank. Section M. Skin Conditions: Risk of Pressure Ulcer/Injury documents, "resident at risk of developing pressure ulcers/injuries."			S9999			04/15/2026

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S9999	Continued from page 7 On 3/30/26 at 12:50 pm, R4 was lying on a low air loss mattress with multiple layers between R4 and the low air loss mattress. The layers observed under R4 consisted of a flat sheet; a flat sheet folded multiple times and an incontinent brief. On 3/30/26 at 12:53 pm, V8 Registered Nurse (Wound Care) stated, "There are 6 layers under R4 and there should only be one layer, a flat sheet under R4. All those layers defeat the purpose of the air loss mattress. That many layers are not preventing wounds and can develop wounds which defeat the purpose of the air loss mattress." R4's Physician Orders Set dated 3/27/26 documents, in part, "Air loss mattress." R4's risk assessment dated 3/28/26 documents R4's Braden score is 13 which indicates moderate risk. R4 care plan dated 3/20/26 documents, in part, "Focus: Actual Impairment to skin integrity skin tears to coccyx due to shearing. Healed as of 3/27/26 but with scar tissue. Intervention: Air loss mattress." On 4/1/26 at 12:07 pm, V2 Director of Nursing (DON) stated, "An air loss mattress should only have a flat sheet. The purpose of air loss mattress is for the air to circulate back and forth to help with the distribution to relieve pressure. Multiple layers don't allow the air to breathe and will defeat the purpose of having the air loss mattress. Facility's document titled, "Skin Management: Specialty Mattress" reviewed date 5/25, documents in part, Procedure: 1. As per manufacture guidelines, no more than 1 piece of linen will be placed between the mattress and the resident. Facility's policy/procedure document titled "Specialty Mattress" dated March 2026, documents, in part, "Intent: It is the policy of the facility to ensure it identifies and provides needed interventions including specialty mattresses to aid in the healing of skin impairments. Procedures: As per manufacture guidelines, no more than 1 piece of linen will be placed between the mattress and the resident."			S9999			04/15/2026

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S9999	Continued from page 8 The (undated) low air loss mattress Operation Manual documents, in part, "Installation Instructions: Step 2. You may place a thin cotton sheet over the quilted mattress top cover. Operation Instructions: Step 5. Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the patient. (B) 2 of 2 300.610a) 300.1010h) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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			S9999			04/15/2026

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S9999	Continued from page 9 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 requirements are not met as evidenced by: Findings include: Based on observation, interview and record review, the facility failed to ensure physician ordered high protein nutritional supplements were administered, failed to follow facility policies for nutritional assessments, monitor weights, monitor the effectiveness of interventions, and document meal intakes accurately for one of four residents (R23) reviewed for weight loss in a total sample of 61 residents. These deficient practices resulted in R23 sustaining a 7.5 percent significant weight loss from January 2026 through March 2026. The Electronic Health Record (EHR) documents, in part, R23's diagnoses include: Hypertensive Heart Disease, Hyperlipidemia, Gastro-Esophageal Reflux Disease and Constipation. The Medication Administration Record (MAR) for February and March 2026 did not show R23 was on any diuretics that would affect her weight. A Weight Summary documents R23's weights as follows: on 1/1/26, weight 99.6 pounds on 2/3/26, weight 92.8 pounds, a five percent significant weight loss in one month; and on 3/3/26, weight 92 pounds, a 7.5 percent significant weight loss in two months. R23 had no re-weights performed after a significant weight change as per facility policy. The Physician Order Sheet (POS) shows that an intervention for a high calorie drink to be increased from twice a day to three times a day was not added			S9999			04/15/2026

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S9999	Continued from page 10 until 2/10/26, one week after the five percent weight loss was identified. On 3/3/26, when R23 continued to lose weight, an intervention to increase a high calorie frozen dessert from once a day to two times a day was not ordered until 3/11/26, eight days after the weight loss. R23 is currently on a mechanical soft textured diet for improved nutrition. On 3/30/26 at 12:26 PM, R23 was sitting in bed with a lunch meal of grilled cheese which was cut in half, tomato soup and pasta salad. R23's meal ticket reads: lightly grilled, (cut in quarters) grilled cheese sandwich. R23 did not have a high calorie frozen dessert on her tray as ordered. The meal ticket did not indicate R23 should receive a high calorie frozen dessert. R23 ate less than half of the soup, less than half the grilled cheese sandwich and the pasta salad was untouched. R23 was having difficulty chewing the bread and stated, "tomato soup is salty and the grilled cheese is hard." R23 tapped the half sandwich on her plate as she described how hard it was. The sandwich was dark brown in color and hard. The sandwich was not lightly grilled and not cut into fourths as printed on her mechanical soft meal ticket. At 12:44pm, R23 was still chewing the food that was in her mouth originally. R23's "Nutrition – Amount Eaten" meal intake form dated 3/30/26 documents R23 ate 76-100 percent of her lunch meal even though it was observed that R23 ate less than half of her meal. On 3/31/26 at 12:36 PM, R23 was sitting up in the dining room with a lunch meal of chopped hot dog in a hot dog bun and steak fries. R23 did not have a high calorie frozen dessert on her tray as ordered. The hot dog bun was whole and dry and without any liquid to moisten it. R23 ate less than half the hot dog and none of the fries. R23 stated, "It's too hard to swallow the bread." The Meal Intake Form dated 3/31/26 showed that R23 ate 76-100 percent of her lunch meal even though it was observed that she ate less than half of her meal. On 3/31/26 at 1:17 PM, V23 (Director of Rehabilitation/Speech Therapist) indicated that R23 is on a mechanical soft diet due to broken teeth and difficulty chewing meat. When asked about R23's difficulty eating her mechanical textured lunch meals for the last two days, V23 stated, "She has never had issues with swallowing." V23 stated the standards for a mechanical soft diet is that meats			S9999			04/15/2026

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S9999	Continued from page 11 and foods should be ground up and cut into minced/ground pieces. V23 stated, "Grilled cheese should be cut into fourths with soft bread." On 3/31/26 at 12:42 PM, V12 (Traveling Supervisor) was in the 2nd floor dining room passing out High Calorie frozen nutritional desserts. R23 did not receive one. V12 said R23 does not get one. V12 stated that the frozen dessert would be printed on the meal tickets once the Director of Nursing or the nurse receives a physician order and then they notify the dietary department. On 3/31/26 at 12:48 PM, V14 (Director of Dining Services) stated the high calorie frozen dessert supplement is to help residents increase appetite and increase weight for those residents with significant weight loss, due to the higher calories. V14 looked at several meal tickets for R23 and confirmed the high calorie frozen dessert was not printed on R23's meal tickets because no one let V14 know of the change. V14 further confirmed that unless it was printed on the meal ticket, R23 would not receive it. Both V12 and V14 confirmed R23 has not received high calorie frozen desserts from the dietary department recently. R23's medical record shows that V27 (Dietitian) only performed two nutritional assessments for R23 despite the significant weight loss triggers. One assessment was dated 1/31/26 and the other was dated 3/1/26. Neither of these nutritional assessments documented: height, usual body weight and/or ideal body weight as per facility policy. R23's electronic record denotes that R23's weight was performed monthly despite triggering for significant weight changes in two consecutive months. On 4/1/26 at 9:29am, V4 (Restorative Nurse) stated that R23 has only been weighed monthly and that there was no order for weekly weights to be done. On 3/31/26 at 1:37 PM, V27 (Dietitian) stated, "Nutritional supplements get ordered for people that have poor oral intake. Primarily added to help those with gaining weight or to stop losing weight." V27 indicated that after R23 had significant weight losses, there were high calorie desserts with lunch and dinner ordered on 3/11/26. High calorie drink was added on 2/3/26. V27 did not know why it took			S9999			04/15/2026

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S9999	Continued from page 12 seven and eight days to put interventions into place after significant weight loss triggers. V27 stated, "I have not monitored (R23's) meals to see if she is eating and to see how her intake is. The staff do that and input the information into the computer. I did not monitor if (R23) was receiving the nutritional supplements." The inaccurate documentation for meal intakes was discussed. V27 stated that he would like to see dietary intake in the 75-100 percent (%) range. V27 stated, "When eating 50% and paired with drop in weight, I'll recommend more interventions." On 4/1/26 at 12:10pm, V27 said additional interventions which could have been added were: weekly weights; asking about food preferences; checking if the mechanically soft diet was texturally right; cueing the resident during meal time, and placing the resident in a high visible area for dining monitor intake more closely. V27 said he did not suggest any of these interventions for R23. V27 said a 7 pound weight loss would be considered a significant weight loss since it was greater than a five percent weight loss. According to V27, R23's usual body weight was below her ideal body weight and weekly weights should have been done. V27 stated "I will fess up to that. I should have communicated to the dietary department that a change was made in orders and a high protein frozen dessert was added. Especially because there is no way for our systems to communicate electronically." V27 indicated that he is newly certified and a newer dietitian for the facility. On 4/1/26 at 11:05 AM, V2 (DON – Director of Nursing) stated, "Dietitian recommendations are relayed to the doctor. Doctor gives the order. Once it's in the system, our (electronic system) does not communicate with the dietary electronic system. So, the dietitian aid should convey those orders or order changes to the dietary department." V2 said she meets with the dietitian and the dietitian aid weekly on Wednesdays to discuss any resident weight loss and any changes in diets. V2 stated that the dietitian aide will let the dietary department know of any changes. It was clarified with V2, three different people gave three different responses for how the facility notifies the dietary department of any changes in dietary orders. On 3/31/26, the dietary department indicated V2 (DON) would let them know. On 3/31/26, V27 (Dietitian) stated he would email the dietary department regarding the change; and now V2 said the Dietary Aide would notify the dietary department. V2 not aware of V27 emailing the dietary staff			S9999			04/15/2026

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S9999	Continued from page 13 "unless he changed the process". V2 said the facility policy is that any resident with a significant weight loss of five percent, 7.5 percent, or 10 percent should be on weekly weights times four weeks. V2 stated, "(R23) should have been weighed weekly to monitor her closely." On 4/1/26 at 12:49pm, V26 (Physician) stated he doesn't focus on the weight, but focus' on nourishment. R23 should be receiving the supplements as ordered to stay nourished and if they weren't, this would be a problem and the resident would continue to lose weight. With significant weight loss, V26 would expect weights to be done every two weeks and for the facility to be monitoring bloodwork. R23's current BMI (Body Mass Index) is documented in the progress notes dated 3/1/26 as 15.9 percent, which is low. R23's medical record denotes that she has not had any blood work performed since 2/16/26. R23's Nutrition Care Plan documents: Interventions: 1) Monitor/document/report to MD (Medical Doctor) for signs and symptoms of dysphagia, pocketing, choking, coughing, drooling. Holding food in mouth. Several attempts at swallowing, refusing to eat. 2) Provide and serve diet as ordered. 3) Provide and serve supplement as ordered. 4) RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). A facility policy with a review date of 3/20/26 and titled, "Physician Orders" documents: Intent: Facility has a process to ensure that all Physician Orders are documented appropriately. A facility policy with a review date of 5/15/25 and titled, "Nutrition/Hydration Status Maintenance" documents: Intent: it is the policy of the facility to provide Nutrition/Hydration Status Maintenance Services in accordance with State and Federal regulations. Procedure: 1. Nutritional assessments are completed on residents and include body mass index, usual body weight, height, weight, ideal body weight, and diagnosis.			S9999			04/15/2026

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S9999	Continued from page 14 A facility policy with a revised date of 12/15/25 and titled, "Weight Management" documents: Procedure: 3. Monitoring and Review: b. A re-weight will be obtained for any significant or unexpected weight change, including but not limited to: i. 5% change in one month, 7.5% in 3 months and 10% in 6 months. 4. Re-Weight Process: a. Re-weights will be obtained promptly to confirm accuracy. An undated facility policy titled, "Characteristics & Procedures for Consistency Modified Foods" documents: Policy: Mechanical Soft, Dysphagia and Puree Diets will be prepared to the food characteristics listed below. Ground; Mechanical Soft. Note 1: bite size pieces no larger than ½ inch. Note 2: Most entrees of this consistency are served with additional sauce or gravy to ensure adequate moisture is maintained. (B)	S9999				04/15/2026	