STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145197	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their storage of medication policy by having opened, used, expired medication for four of four residents (R87, R19, R105 and R95) reviewed for medication storage. Findings include: On [DATE] at 9:52am, during a medication cart audit with V6 (Nurse), R87's Insulin Glargine Kwik Pen listed the open date of [DATE] and expiration date of [DATE] written on it. R19's Insulin Aspart Kwik Pen listed the open date of [DATE] and expiration date of [DATE] written on it.V6 said, R87's and R19's insulin were opened, used and expired. V6 said, insulin is good for twenty-eight to thirty days after opening. V6 said, R87's and R19's insulin were expired. Expired medication should not be on the medication cart.R87 was diagnosed with type two Diabetes Mellitus. R87's physician order sheet documents: Insulin Glargine Kwik Pen. Status: Discontinued. R19 was diagnosed with type two Diabetes Mellitus. R19's physician order sheet documents active orders as of [DATE]: Insulin Aspart Injection Solution: Inject per sliding scale.On [DATE] at 10:02am, during a medication cart audit with V7 (Nurse), R105's insulin lispro listed the opened date of [DATE] and expiration date of [DATE] written on it. R95's Xalatan Ophthalmic Solution listed an opened dated [DATE] and expiration date of [DATE] written on it. V7 said, R105's eye drops are open, used and expired. V7 said, expired medication should not be on the medication care.R105 was diagnosed with type two Diabetes Mellitus. R105 's physician order sheet documents:Insulin Lispro Solution. Status: Discontinued. R95's physician order dated [DATE] Xalatan Ophthalmic Solution instill in right eye in the morning.Storage of Medications Policy no date: All expired medication will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. Certain medication or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, once opened require an expiration date shorter than the manufactures' expiration date to insure medication purity and potency.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow its food service and sanitation policies by not ensuring milk was maintained at a temperature of at least 45 degrees Fahrenheit during meal service, failing to discard outdated bread observed with a green substance, failing to ensure the sanitizing solution was maintained at the appropriate concentration, and failing to use clean water when cleaning food carts. This deficient practice had the potential to affect all 118 residents who receive food prepared by the facility kitchen. Findings include:On 1/13/2026 at 10:29a.m. during the tour of the kitchen, there was no hand soap for hand washing, hand sanitizer was requested, V18 (Dietary Supervisor) did not present any hand sanitizer. V26 (Dietary Staff) said he informed someone from housekeeping at 9:30am that the hand soap was out, V26 said he do not know the name of the male staff that he informed. V18 said there should be hand soap available for hand washing at all times. V25 (Dietary staff) was observed cleaning the food carts with a white towel, placing the towel in the red bucket then removing the towel to continue cleaning the carts. V18 identified the bucket to be the sanitizing bucket. The bucket was filled with dirty water dark in color. The bucket was tested with the quaternary ammonium strip, the strip read 100 ppm, V18 said the concentration should be at least 200 ppm for sanitizing. During observation of dry food storage, assisted by V18, there was flying insects observed in the dry food storage room, observed by V18 (landing on white gallon stored metal on shelf). There were 2 large packages of dinner rolls with best used by date of 1/9/2026 observed with green substance one them, they were stored on the bread rack with the non-expired bread. There was a large package of hamburger buns observed with a black flying insect inside the bag of hamburger buns. V18 said the dinner rolls was expired and should have been thrown away, V18 observed the flying insect in the bag and removed it. V18 said she keep the dented cans on a shelf with non-dented cans, V18 said the staff would know not to use the dented cans by asking her first before using the canned foods.1/13/26 12:23pm during lunch services the milk was observed to be stored in a black tub/container, there were no ice noted in the tub, V26 (Dietary staff) was asked to touch the milk to feel for coldness, V26 said the milk was not cool, surveyor touched the milk, it was no cool to touch. V26 said there was no ice in the black tub to keep the milk cool. V26 said the practice is to place the milk in the freezer before serving it for lunch. V18 was summoned to complete a temperature on the milk, the milk was observed to be at 60 degrees Fahrenheit, V18 said the milk should be maintained at 40 degrees Fahrenheit, V18 walked away, V18 did not remove the milk at that time. V1 (Administrator) was summoned to inform him of the observation. The facility does have residents with feeding tubes that does not eat food served from the facility kitchen. Facility policy and procedures titled storage labeling and dating denotes products inventory must be labeled, dated rotated and discarded properly according to federal and guidelines. Items that have exceeded the manufactures expiration date or UB (use by) date should be discarded.Facility policy titled cold storage areas denotes in-part cold food and beverages should be stored under safe and sanitary conditions.Facility policy for storing-food storage denotes in-part food should be stored and prepared in a clean, safe, sanitary manner that complies with state and federal guidelines. Purpose to minimize contamination and bacteria. There should be separate area designated area for damaged food items to be returned to vender for credit. Dented cans should be returned to the vendor upon delivery or stored in a separate area until picked up by the vendor.Facility policy food and beverage temperature control denotes food temperature are maintained during serving times. Purpose to ensure residents receive safe food served at acceptable temperatures. Temperature food log denotes cold holding reference for milk is less than 45 degrees Fahrenheit.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their care plan policy and ensure that the care plan accurately reflects the resident advance directives to not be resuscitated, and failed to obtain a physician order and document R111's code status in her electronic medical record this affects two of three residents (R46 and R111) reviewed for advanced directives. Findings Include:1.R46's physician order sheet dated [DATE] denotes do not resuscitate. R46's Illinois Department of Public Health uniform practitioner order for life sustaining treatment (POLST) form dated [DATE] denotes no CPR: do not resuscitate (DNAR), signed by R46's agent under power of attorney and provider. R46's face sheet denotes R46 has a guardian the name is the same as the noted on the POLST form. R46's care plan for advanced directive, initiated date of [DATE], revision on [DATE] denotes I am a full code, attempt resuscitation CPR, including intubation and mechanical ventilation. Honor choice of resident and family surrogate, legal guardian or POA- dated [DATE]. Perform CPR if and when the resident stops breathing- dated [DATE]. Facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that includes measurable objectives and time frames to meet a resident medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. On [DATE] at 11:35am V23 (Care Plan Coordinator) said care plans should be updated quarterly and when there's a change. V23 said the care plan for advance directives should be updates as soon as the resident or power of attorney make changes from full code to Do not resuscitate. Facility comprehensive care plan policy effective date [DATE] denotes in-part to develop a comprehensive care plan that directs the care team and incorporate the residents goals preference and services that are to be furnished to attain the residents highest practicable physical, mental and psychosocial well-being. Advance Directive Policy dated [DATE] documents: To ensure that all residents and/or resident representative and informed concerning the right to accept or refuse medical or surgical treatment, at the resident's option, formulate an advance directive. A written physician's order is required in response to the resident's Advanced Directive(s) Physician's orders shall be specific and address each Advance Directive. 2.R111's face sheet under advance directive was blank. No code status was documented. R111's physician order sheet, active orders as of [DATE] did not document a code status. On [DATE] at 1:25pm, V2 (Director of Nursing) said, a resident's code status must be visible on the face sheet and in miscellaneous. V2 said, the resident's code status must be documented in two places in the resident's electronic record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect a resident from a resident-to-resident physical assault when R120 pushed R106 to the floor. This affected two (R106, R120) of four residents reviewed for physical abuse. Findings Include: R120's Minimum Data Set/MDS date 12/22/25 shows BIMS score of 15.On 1/13/26 at 11:52am R120 observed alert to person, place, time and situation. R120 said a male resident came to his room looking her his roommate (R34). R120 said he told the resident that he could not come in the room. R120 said he got out his bed and pushed the resident down to the floor. R120 said the resident was standing at the doorway when he pushed the resident to the floor. R120 said he don't know who the male resident was that he pushed to the floor. R120 said his roommate cannot have other residents visit him and that the residents can visit R34 in the dining room.R34 identified R106 as the resident that was pushed down by R120.On 1/13/2026 at 12:08pm R106 was observed sitting on his rollator near nurse station. R106 was alert to person, place and situation. R106 said he was up pretty late last night. He went to smoke. He went to sit in the dining room and he may have gone for another smoke break. R106 explained he was in the dinging room watching video on his phone, during that time, R34 asked him if he (R106) could help him with his phone. R106 said he told R34, yes. R106 said R34 left the dining room maybe to get his phone. R106 said he was waiting in the dining room for R34, R106 explained when R34 did not return, he went to R34's room to see if he was okay and still needed his help with the cell phone. R106 said R120 pushed him to the floor. R106 said he was in the hallway and not inside the room. R106 said R120 was telling him that he could not come inside the room when he (R120) approached him (R106) and pushed him. R106 said he fell onto the floor on his back. R106 said the nurse picked him up from the floor. R106 said he just returned from the hospital. R106 said he wanted to press charges against R120 for pushing him down. R106 said he's tired of being pushed around by other residents. R106 explained there was an incident where a resident threw coffee on him and when he defended himself, he was told that only R106 was on camera. R106 said he went to the hospital to get checked out because his back was hurting. R106 said he feels safe in the facility, but he does want to press charges. R106 said he did not hit R120. R106 was agreeable that surveyor inform the administrator (V1). On 1/13/26 at 1:48pm V1 (Administrator) said he was made aware today around 5:30am by the Nurse that R106 fell after being pushed by R120. V1 said he doesn't recall who the Nurse was that informed him. V1 said R120 has a right to his privacy. V1 was made aware that R120 stated that R106 was coming to visit R34 and not R120, and that R120 also stated that R34 could not have visitors in his room, and that R34 has to visit with residents in the dining room. V1 explained that R106 shouldn't be visiting residents in early morning hours. V1 said his expectation is that R120 notify the Nurse if he's having issues with residents and not push other residents to the floor. V1 said at this time he has not reported the is incident to the department he was waiting for R106 to return from the hospital and now that R106 has returned, and R106 said he wants to make a police report, he will now report this incident to the state surveying agency. V1 said he has not reviewed the video surveillance to determine what happened during that incident. V1 said he has 5 days to complete his investigation. On 1/15/26 at 3:36pm request was made to V1 to review the facility video surveillance, V1 said No. V1 said R120 admitted to pushing R106 to the floor when R106 was standing in the doorway of his room, R106 fell to the floor in the hallway. V1 demonstrated where R106 landed on the floor outside of room XXX.On 1/15/26 at 1:27pm V28 (Licensed Practical Nurse/LPN) said she was made aware by another Nurse that R106 was pushed on the floor by R120. V28 said she assessed R106 and R106 complained of pain to his back. V28 said R106 was assisted off the floor using a mechanical lift. V28 said she notified the administrator, the family and the physician. V28 said she was given orders to send R106 to the hospital for evaluation because R106 complained that his entire body hurt. V28 said she offered (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R106 pain medication but R106 was focused on wanting to press charges on R120 for pushing him down. V28 said R106 continuously made the statement that he wanted to press charges on R120.R106's emergency room records dated 01/13/2026 denotes chief complaint patient presents with a fall. [AGE] year-old male with past medical history of seizures, hypertension, COPD, schizophrenia coming in today for evaluation of back pain after he was pushed by another resident of his nursing home and fell onto his back. He states that he has pain all the way from his neck down into his feet. He denies any numbness, weakness, tingling anywhere in his body. He denies any saddle anesthesia, urinary retention, bowel incontinence, bowel retention. R106 after visit summary shows diagnosis of acute midline thoracic pain.Facility abuse policy dated 11/28/16 denotes in-part this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or including anguish to a resident. The resident right for people living in the long-term care facility denotes You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally or sexually.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their practice to ensure that the Minimum Data Set assessment is accurately coded for four of four residents (R2, R46, R106, R116) reviewed for accuracy of MDS assessments. Findings include: 1. On 1/14/25 at 3:24pm V2 (Director of Nursing) said R46 was assess for hospice service and was not eligible for hospice services. V2 said R46 has never received hospice care while a resident at the facility. R46's Minimum Data Set/MDS section O for special services K1 for hospice dated 11/20/25 and 9/22/2025 shows X for hospice care performed while a resident at this facility. On 1/15/26 at 2:12pm, V21 (MDS Coordinator) said staff should ensure to code the MDS accurately to reflect the care for R46. 2. On 1/14/26 at 3:29pm, V16 (Restorative Nurse) said R116 is currently receiving restorative programing services 15 minutes a day, daily for range of motion to upper and lower extremity and bed mobility. Review of R116's MDS dated [DATE] section O for Restorative Nursing Programs for passive range of motion zero is documented for number of days for restoratives services performed. On 1/15/26 at 2:12pm V21 (MDS Coordinator) said staff should ensure to code the MDS accurately to reflect the care for R116. 3. R106's face sheet shows diagnosis of bipolar disorder, major depression disorder, schizoaffective disorder and anxiety disorder. R106's annual MDS assessment dated [DATE] section A1500 for Preadmission Screening and Resident Review (PASRR) no is documented for Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. On 1/15/26 at 2:12pm V21 (MDS Coordinator) said staff should ensure to code the MDS accurately to reflect the care for R106. 4. R2 who was admitted on [DATE] with a diagnosis of type II diabetes, chronic pain, anxiety disorder, vascular dementia, and schizoaffective disorder. R2's MDS section dated 10/17/25 documents under restorative programs a score of 0 which indicates none. R2's restorative task dated 10/30/24 documents: R2 has limited range of motion. Under description it documents Nursing rehab/restorative documents: R2 will participate in assisted range of motion flexion and extension, adduction and abduction to Bilateral upper and lower extremities. On 1/16/25 at 10:00AM, V16 (Restorative Nurse) said R2 has been receiving restoratives services since 2024. V16 said she recently started doing restorative section of MDS but did not complete R2's (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS assessment in October. V16 said R2 should have been coded for restorative services on October MDS because she was receiving services and is unsure why she was not coded accurately.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their incontinence care policy by not providing incontinence care for over two hours for a resident as requiring substantial/maximal assistance with incontinent care. This affects one of three residents (R124) reviewed for incontinence care. Findings include:R124's Minimal data set dated [DATE] section C (cognitive patterns) document a score of eleven which indicate moderate cognitive impairment. Section GG dated 11/8/25 documents: R124 requires substantial/maximal assistance with toileting (helper does more than half the effort. Helper lifts or holds truck or limbs and provides more that half the effort.) Section H (bowel and bladder) dated 10/29/25 urinary continence document always incontinent. On 1/13/26 at 1:13pm, R124 was observed on the sit to stand device with the back of his jogging pants wet. R124 had a strong smell of urine. R124's wheelchair cushion was observed wet. V10 (Certified Nursing Assistant/CNA) said, R124 was soiled and saturated with urine. V10 said, she was not R124's assigned CNA she was taking R124 to be showered. V13 (R124's Medical Power of Attorney) said, R124 is always left wet. Staff does not provide care.On 1/13/26 at 1:32pm, R124 said, he was last changed at 2:00am. V10 removed R124's adult brief. R124 brief was observed completely saturated with liquid consisted with urine and liquid dripping from R124's left hip.On 1/13/26 at 1:34pm, V9 (CNA) said, she was R124's assigned CNA. V9 said, she last provided incontinence care for R124 between 9am and 10am. V9 said, residents should be checked and changed every two hours and as needed.Incontinence Care Policy dated 11/28/12 documents: Incontinent resident will be checked periodically in accordance with the assessed incontinent episode or every two hours and provided perineal and genital care after each episode.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure supervision of a resident while smoking on the patio. The resident was identified as requiring supervision during smoking. This affected one of three residents (R22) reviewed for safe smoking monitoring. Findings include:R22 was admitted on [DATE] with a diagnosis of sickle cell, chronic obstructive pulmonary disease, type II diabetes, and major depressive disorder.R22's smoking safety risk dated 11/13/25 documents under smoking supervision recommendations documents: this resident requires supervision while smoking. Under the question does the resident display any of the following safety concerns? With nothing marked.On 1/13/26 at 1:34PM, R22 was observed in common dining. R102 was observed smoking on patio and upon reentering the patio assisted R22 to the outside patio and gave R22 a cigarette and lit the cigarette. R22 remained outside to smoke the cigarette. There were no staff on the patio monitoring or in the dining room watching from the window.On 1/14/26 at 12:42PM, V16(Social Service Director) said smoking assessments are conducted upon admission and quarterly. Residents are either assessed to be supervised or independent. If assessed to need supervision they would not be able to hold their own smoking materials and staff or family would hold materials for the resident. V16 was asked to review the list of smokers and said only two residents requiring supervision which did not include R22. V16 was asked if R22 requires supervision was not able to recall. V16 was shown R22 assessment and said based on that information R22 would require supervision with smoking. V16 was asked if R22 holds her own smoking materials and V16 said her boyfriend or family hold her smoking materials. V16 was unable to say why R22 requires supervision with smoking. V16 said she was aware of a situation yesterday that another resident was sharing smoking material with R22 but that staff were supervising. V16 said that staff should be supervising R22 when smoking based on the R22's assessment. V16 said resident should not be sharing smoking materials with other residents.On 1/14/26 at 1:57PM, R22 said staff told her that other residents cannot share smoking material with each other. R22 said she does not have her own smoking materials and will get them from staff or family. Smoking safety policy revised 10/24/22 documents: To provide a safe and healthy living environment with respect for the health and well being needs of each resident, staff member and visitor.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to follow its urinary care policy by not ensuring a resident's indwelling urinary catheter drainage bag was kept off the floor. This affected one of three residents (R72) reviewed for urinary catheter and infection control practices Findings include:Physician order dated 10/20/25 documents: Indwelling catheter for the diagnosis Neuromuscular Dysfunction of Bladder. R72's Minimal Data Set section H (bladder and bowel) dated 10/22/25 documents: indwelling catheter. On 1/14/2026 1:16 PM, R72 was observed sitting on the side of the bed eating his lunch with his indwelling catheter bag on the floor with the privacy bag not completely covering the top portion of the bag. On 1/14/26 at 1:17PM, V6 (Nurse) said, R72 indwelling catheter should not be on the floor. It should be attached to his bed frame. On 1/14/2026 at 1:25pm, V2 (Director of Nursing) said, indwelling bags should not be on the floor for infection control issue. Urinary Catheter Care dated 11/28/12 documents: To establish guidelines to reduce the risk of or prevent infection in resident with an indwelling catheter. Urinary drainage bags and tubing shall be positioned to prevent either from touching the floor directly.

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	145197	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Oak Lawn	9401 South Ridgeland Avenue Oak Lawn, IL 60453

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its weight assessment and intervention policy by not conducting a reweight within 24 hours after a significant weight loss was noted. This deficient practice affected one of three residents (R88) reviewed for nutrition and weight loss prevention. Findings include:R88 was admitted to the facility on [DATE] with a diagnosis of dysphasia, muscle wasting, major depressive disorder and adult failure to thrive. R88's weights documents: October weight 132.5 pounds, November weight 132.8 pounds, December weight 132 pounds and January (1/9/26) weight 120 pounds (comparison weight 12/10 9.1 % loss, 12 pounds). There were no other weights documented in R88's medical record until 1/16/26 which documents 118.5 pounds after request was made by surveyor. On 1/16/25 at 10:00AM, V16(Restorative Nurse) said they conduct weights monthly and review any changes. If there is a big difference between the weight from last month either loss or gain we will reweigh the resident. V16 did not have any other weights for R88. On 1/16/25 at 11:02AM, V22(Nurse Practitioner) said if there are any weight changes she will ask for a reweight to confirm that the weight is accurate. V22 said she would expect staff to reweigh the resident to ensure accuracy of weight and to determine if interventions need to be put in place. Facility weight assessment and intervention policy undated documents: 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, dietician, dining service or other members of the team within 24 hours. The threshold for significant unplanned and undesired weight loss shall be based on the following: one month significant loss of 5 % and severe loss greater than 5 %.