STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145637	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Village of Chicago	4021 West Belmont Chicago, IL 60641

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 - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interviews and record reviews, the facility failed to follow their policy to ensure significant weight loss is prevented in the facility for one (R5) out of three residents reviewed for nutrition in a sample of 14. This failure resulted in R5 not receiving suggested supplements and experiencing severe weight loss.Findings include:On 05/06/2026 at 12:12 PM, surveyor reviewed R5's weights from 10/2025 to 04/2026.R5's weight documents in part:03/01/2026: 128.2 lbs.02/01/2026: 131.5 lbs.01/05/2026: 137.6 lbs.12/09/2025: 150 lbs.12/03/2025: 145.0 lbs.11/05/2025: 147.8 lbs.10/02/2025: 147.6 lbs.Based on documented weights, R5 has a 13.1% weight loss in a 6-month period from 10/2025 to 03/2026Based on documented weights, R5 has 9.3% weight loss in a 3-month period from 12/2025 to 02/2026.Based on documented weight, R5 has a 5.1% weight loss in a 1-month period from 12/2025 to 01/2026.On 05/06/2026 at 2:18 PM, V13 (Dietician) stated that when she gets an alert of any weight loss or changes, she looks into their diet, what they are consuming, and looks if we have any supplements. V13 stated that she is familiar with R5 and his weight loss. V13 stated that she talked to R5 and the power of attorney (POA) about adding supplements, to avoid further weight loss to help meet those needs. There are interventions we put in place to address the weight loss. The interventions for example were supplements and putting them in the dining room which encourages them to eat in the dining room. V19 stated that R5 did have significant weight loss. Supplements should have been ordered but I forgot to for some reason. Supplements can be ordered by herself or nurse. V13 verified significant weight loss with surveyor on R5's electronic health record.R5's progress note by V13 on 12/3/2025 documents in part: WEIGHT WARNING:Value: 145.0. Vital Date: 2025-12-03 10:36. -10.0% change [11.6%, 19.0]. BMI: 22 [Normal and WNL]BMI: 23.1 [Normal]. Diet: No Added Salt, regular, thin 1200ml Fluid restriction. He has a good appetite, and no medications impacting weight changes. Weight triggered due to 7/2 164 lbs. Family aware of weight changes. Doctor informed.R5's progress note by V13 on 12/31/2025 documents in part: R5 in agreement with supplements.R5's progress note by V13 on 1/5/2026 documents in part: Recommend offering (supplement) after meals.R5's progress note by V13 on 4/2/2026 documents in part: R5 has a significant weight loss over 180 days due to a decrease in appetite from a significant life change.Reviewed R5's full care plan. No documentation of weight loss with appropriate interventions.Reviewed R5's physician order sheet. No order for supplements such as (supplement). No medications ordered to improve appetite. No order for weekly weights.Facility's Weight Management policy (11/08/2025) documents in part: The registered dietician (RD) is responsible for monitoring all weight changes and documenting significant weight loss/gain. Significant weight loss/gain is defined as greater/less than 5% in one month, greater/less than 7.5% in 3 months or greater/less than 10% in one month. Residents noted to have significant weight changes should be placed on weekly weights until their weight stabilizes or until the weight loss is determined to be unavoidable by the Interdisciplinary Team. The RD will review and document those residents who have been placed on weekly weights. A follow up note will be completed a minimum of weekly until weight stabilization occurs. The RD is responsible for developing comprehensive care plans for those residents with significant weight changes and updating care plans with new interventions as needed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 proper sanitation and food storage practices as evidenced by a.) food not properly labeled, b.) food not properly stored, and c.) not practicing effective handwashing. These deficient practices have the potential to affect 52 residents receiving food prepared in the facility kitchen. Findings include: On 05/05/2026 at 9:39AM during initial kitchen tour with V4 (Dining Services Director) and V5 (Chef), the following food items were found in the walk-in cooler: 1 opened carton of eggs, no open date, no use by date, and not labeled with the food item.1 tray of sliced onions, green peppers, and red peppers wrapped in clear plastic wrap, no preparation date, no use by date, and not labeled with the food item.1 bowl of beef steak wrapped in clear plastic wrap, no preparation date, no use by date, and not labeled with food item.1 opened container of sliced limes wrapped in clear plastic wrap, with a use by date of 05/04/2026.1 opened container of potatoes cut in halves inside of a water solution, no use by date.On 05/05/2026 at 9:56AM the following items were found in the dry storage area:1 gallon container of barbecue sauce with an expiration date of 04/14/2026.On 05/05/2026 at 9:57AM, V4 and V5 state all opened and prepared food items stored in the walk-in coolers should be labeled with the food item, have an open date, use by date, or expiration date labeled on the food items. V5 states the bowl of beef steaks is personal lunch for the staff to consume. V5 states the beef steak should not be stored in the resident's walk-in cooler. V4 and V5 state all expired food items should not be stored in the dry storage area which is available and intended for resident use. V4 states expired food items should be discarded immediately. V4 states if residents consume expired food items, the residents could acquire a food borne illness and become sick due to bacteria. On 05/05/2026 at 10:21AM, V6 (Lead Cook) return demonstrates the process of handwashing in the kitchen. V6 observed washing his hands for approximately 18 seconds and then touches the motion sensor paper towel dispenser twice with his hands after performing handwashing. Facility census dated 05/05/2026 documents that a total of 53 residents reside in the facility.Facility document dated 05/05/2026 titled Diet Type Report documents that one resident does not receive food from the kitchen and is enteral feed only.Facility policy dated 09/01/2023 titled Hand Hygiene documents in part, Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.According to the CDC/Centers for Disease Control and Prevention at https://www.cdc.gov/clean-hands/about/index.html, titled Clean Hands dated 02/16/2024 Scrub your hands for at least 20 seconds. Need a timer? Hum the Happy Birthday song from beginning to end twice.Facility policy dated 2020, titled, Labeling and Dating Foods documents in part, Once opened, all ready to eat, potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date. Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines or by the manufacturer's expiration date. Prepared food or opened food items should be discarded when the food item does not have a specific manufacturer expiration date and has been refrigerated for 7 days, the food item is older than the expiration date.Facility policy dated 10/25/2022 titled Food Storage documents in part, All products should be dated upon receipt. If a product is removed from its original packaging, it should be tightly completely wrapped, placed into a sealable plastic bag or container with tight-fitting lid then labeled and dated.Facility policy dated 07/11/2024 titled Food Storage documents in part, Any expired or outdated food products should be discarded.

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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 observations, interviews and record reviews, facility failed to follow their policy to ensure medications are immediately removed from the locked medication storage area and disposed of for medications that are unlabeled and without secure closure. This failure has the potential to affect all the residents on the 2nd floor.Findings include:On [DATE] at 12:37 PM, surveyor reviewed the medication cart on the 2nd floor. There was only one medication cart. Surveyor opened the top drawer on the medication cart and saw a pill cup with no name, room number or closure, with unknown and unidentified medications in the pill cup.On [DATE] at 12:38 PM, V8 (Registered Nurse) stated that she thinks these are blood pressure pills but not fully sure. V8 stated that medications are to be discarded and not stored in the medication card without proper closure and labeling.On [DATE] at 11:40 AM, V2 (Director of Nursing) stated) that medications stored in the medication cart are already pre-packaged. The medication should be in the correct packet and placed in the correct bins according to the residents, in the medication cart. Pharmacy delivers the medications and nurses appropriately stock it in the medications cart. V2 stated that medications should not be stored in pill cups in the drawers because the medications are unidentified and can be confused with another resident, it is not covered which is an infection control issue. V2 stated that medication should be disposed immediately if opened and unused.Facility's Medication Storage policy ([DATE]) documents in part: Medication that are discontinued, expired, contaminated, deteriorated, or unlabeled and those that are in containers that are cracked, soiled, or without secure closures are immediately removed from the locked medication storage area and disposed of in accordance with policies and procedures. Medications are stored in the packaging, containers or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to utilize appropriate PPE (Personal Protective Equipment) in a contact precaution room which affected two residents (R2, R30) reviewed for infection control in a total sample of 15 residents reviewed. The Facility also failed to follow their policy to ensure proper hand washing prior to medication administration for three (R13, R5, R19) out of five residents reviewed for medication administration in a total sample of 15 residents. Findings include: On 05/05/2026 at 11:16 AM, surveyor observed there was a contact isolation signage on the R2's door. Surveyor observed the door open, there was a family member inside the room with no gown, gloves. There was a staff member inside the room, with no gown or gloves. On 05/05/2026 at 11:30 AM, surveyors observed there was a family member in V30's room, not wearing proper PPE in a contact isolation room. On 05/05/2026 at 11:43 AM, V7 (Certified Nurse's Aide) stated she was not sure what the contact isolation signage at the door was for. V7 stated all that she was told was to wear personal protective equipment when in close contact with R2. Surveyor asked V7 if she should be wearing a gown and gloves before entering or exiting R2's room. V7 stated if she is feeding, providing activity of daily living task, or changing the linen she must wear a gown and gloves. Surveyor asked to clarify why she was not wearing proper PPE for a contact isolation room. V7 stated she was not wearing the gown and gloves because she was only dropping off the oxygen tank. On 05/06/2026 at 11:29 AM, V3 (Infection Disease Nurse) stated if a resident is on contact precautions, the staff should be wearing gowns and gloves before entering or exiting the resident's room. V3 stated it is important to follow the guidelines to protect the staff and residents from spreading pathogens. V3 stated the nurse on duty will put a sign by the doorway, a fully stocked bin outside of the room, put the order in the computer, make a progress note and communicate with staff. V3 stated families get educated about the precautions and what they should do to keep themselves and the residents safe. V3 stated staff can only encourage and educate the family member to put on a gown and gown but cannot force them. On 05/07/2026 at 2:15 PM, V2 (Director of Nursing) stated that a resident is on contact precaution, gloves, gown, and a mask shield is required. V2 stated staff must follow appropriate PPE once it is made aware that the resident is on contact precautions. V2 stated it is important to follow PPE to prevent the spread of microorganism. V2 stated family is encouraged to wear the proper PPE, however some family members are compliant while others are not. Policy titled Isolation Precautions with review date of 09/01/2023 documents in part, It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. Contact precautions are measures that are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms which are spread by direct contact with the resident or of the resident's environment. On 05/05/2026 at 9:30 AM, surveyor observed V9 (Registered Nurse) pulling medications for R13. Without washing her hands, surveyor observed V9 put on gloves and dispense medications for R13. Wearing the same gloves, V9 threw away the medication pill packets with hands touching the inside of the trash bag. Surveyor then observed V9 administer the medication to R13 with the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/05/2026 at 11:15 AM, surveyor observed V10 (Registered Nurse) dispense medications for R5. Without washing his hands, V10 dispensed R5's Gabapentin and Lisinopril. V10 then took the medications in the pill cup with the blood pressure machine, entered R5's room and checked R5's blood pressure using the blood pressure machine. V10 administered the medications and exited the room without using the hand sanitizer machine. V10 goes back to the nurse's station and does not wash his hands. V10 also does not wipe down the blood pressure machine after using it for R5. Surveyor then observed V10 dispensing R19's medications which were Senna Kot and amlodipine. Surveyor then observed V10 approach R19 in the dining room without washing his hands and wiping down the blood pressure machine and he takes R19's blood pressure. V10 then administers the medication to R19 without washing his hands or wearing gloves. On 05/06/2026 at 11:40 AM, V2 (Director of Nursing) stated that hand hygiene is important during medication administration to prevent infection and ensure infection control. V2 stated that nurses are expected to wash hands or use the alcohol hand sanitizer. V2 stated that blood pressure machine should be disinfected after use on a resident. Sanitizing equipment after every use prevents the spread of infection. Facility's Medication Administration policy (06/01/2023) documents in part: Hands are washed before putting on examination gloves and upon removal for administration of topical, ophthalmic, injectable, enteral, rectal and vaginal medications.

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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, interviews, and review of records, the facility failed to correctly assess resident limitation and failed to follow their policy on using safety equipment for fall prevention of 1 out of 1 resident (R13) reviewed for accidents and hazards for a total of 15 residents in the sample. These failures have the potential to affect safety of 1 resident (R13) with history of falls.Findings include:R13 is a resident in facility initially admitted on [DATE]. Per clinical record, R13 had a fall in the facility on 04/03/2026. R13 went to hospital diagnosed with left femur/upper leg fracture due to mechanical fall. R13 readmitted in facility on 04/08/2026.On 05/05/2026 at 01:22 PM, R13 was seen inside her room lying on the bed. R13 was alert, verbally responsive and able to express thoughts within topic during conversation. R13 stated that she was waiting to go to therapy. V20 (Certified Nursing Assistant) went inside the room and spoke to R13 about scheduled therapy. V20 went out of the room for a few minutes and came back informing R13 that she would be transferred from the bed to her wheelchair. V20 positioned R13 on the edge of the bed and placed both of her arms under R13's arm. V20 lifted R13 with legs dangling, unstable when standing and unable to bear weight, V20 transferred R13 from the bed to the wheelchair. R13 was seen unable to position her leg and feet to bear weight. V20 had a gait belt wrapped on her waist that she did not use in transferring R13. In the hallway, V20 stated that she was not very familiar with R13 but knows that R13 need assistance during transfer. V20 stated, If residents are heavy, I will ask for help. V20 stated that it is safer to use gait belts, but she can lift R13 and R13 can pivot, she (V20) did not use gait belt. V20 stated that she gets her instruction from the nurse. V9 (Registered Nurse) at the medication cart in the hallway stated that since R13 fell she has been having problems physically and psychologically with transfers. V9 stated that R13 can have one (1) person assist but will call for two (2)-persons to assist R13. V9 stated using a gait belt with R13 will be safer because of her unsteady gait while standing.On 05/06/2026 at 11:28 AM, V2 (Director of Nursing) stated that R13 needs one (1) to two (2)-persons assist. Residents that are non-weight bearing need two (2)-persons or Hoyer (mechanical lift). V2 stated R13's present status is to stand and pivot by using gait belt. V2 said Using gait belt is for safety reason for both residents and staff to prevent injury.Per MDS (Minimum Data Set) of R13 on Functional Abilities dated 04/15/2026 (post fall): R13 was assessed as having functional limitation due to impairment on both of upper extremities. R13 requires bed to chair transfer total dependency, R13 cannot do any activity during transfers.On 05/08/2026 at 01:00 PM, V2 clarified that the assessment should have been bilateral lower extremities instead of bilateral upper extremities.Fall Prevention and Management Policy dated 05/23/2024 notes that fall prevention is achieved through managing risk factors and implementing appropriate interventions to reduce the risk of falls. Gait Belt Usage procedure dated 03/01/2026 outlining the use of gait belt for residents during transfers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to change oxygen tubing and reservoir for one resident (R23) reviewed for oxygen therapy in a total sample of 15 residents.Findings include: On 05/05/2026 at 12:41PM, R23 observed lying down in bed receiving oxygen therapy via nasal cannula with oxygen tubing connected via oxygen concentrator. Surveyor observed that R23's nasal cannula oxygen tubing was labeled with two dates 04/27/26 and 05/03/26. Surveyor also observed that R23's humidifier was connected to the oxygen concentrator and labeled with a date of 04/27/26.On 05/05/2026 at 1:10PM, V8 (Registered Nurse/RN) now located inside of R23's room and observes that R23's nasal cannula tubing was labeled with two dates of 04/27/26 and 05/03/26. V8 also observes that R23's oxygen humidifier is dated 04/27/26. V8 states she is not sure why R23's oxygen tubing is labeled with two dates. V8 states she did not label the oxygen tubing or humidifier. V8 states she is not sure who labeled the tubing since there are no initials labeled. V8 states resident's oxygen tubing and humidifier should be changed every week on Sundays and as needed. V8 states if resident's humidifiers and oxygen tubing is not changed as ordered, then bacteria could build up in the humidifiers and tubing and cause the resident to have an infection.R23's Facesheet documents that R23 has a diagnosis of chronic obstructive pulmonary disease/COPD.Record review of R23's POS/physician order sheet documents in part, Oxygen tubing to be changed weekly, on Sundays to include date and initials, every night shift every Sunday.Facility policy dated 12/01/2023 titled Oxygen, Nebulizer Equipment documents in part, Change the reservoir every forty-eight (48) hours.Change the oxygen cannula and tubing every seven (7) days, or as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record reviews failed to follow their policy to ensure controlled medications are documented for 1 (R34) out of the 4 residents reviewed for narcotics reconciliation in a sample of 15.Findings include:On 05/05/2026 at 12:40 PM, surveyor observed R34's Modafinil bingo card (medication card). R34's Modafinil bingo card shows a count of 13.R34's Modafinil Controlled Drugs Receipt/Record/Disposition Form documents in part: Count is 14.On 05/05/2026 at 12:40 PM, V8 (Registered Nurse) stated that she is supposed to document in the Controlled Drug Receipt/Record Form when the controlled medication is administered. V8 stated that she administered the medication but forgot to document right away.On 05/06/2026 at 11:40 AM, V2 (Director of Nursing) verified that R34's bingo card did not match R34's Modafinil Controlled Drugs Receipt/Record/Disposition Form. V2 stated that it is important to document administered controlled medications to reconcile and maintain the accuracy of the documentation. You have to document in order to track the time, date given, and signature of the nurse to maintain accuracy of the documentation. If it is not documented at the time of administration, you run the risk of double administering the controlled medication.Facility's Controlled Substance policy (2001) documents in part: The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Scheduled II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). If the count is correct, an individual resident-controlled substance record is made for each resident who will be receiving a controlled substance. This record contains: the name of the resident, quantity received, number on hand, date and time received, time of administration, method of administration, signature of nurse administering medication. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up. The system of reconciling the receipt, dispensing and disposition of controlled substance includes the following: Records of personnel access and usage, medication administration records, declining inventory records.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to offer an influenza vaccine to a newly admitted resident. This failure affects one resident (R40) in a total sample of 15 residents reviewed.Findings include:On 05/06/2026 at 11:44 AM, surveyor is with V3 (Infection Control Nurse), reviewing immunization records. This surveyor noted R40 was admitted on [DATE], reviewed immunizations records for R40, there is no evidence of R40 receiving an influenza vaccine. There is no record of R40 being offered or declining the Influenza vaccination. V3 stated since R40 was admitted during the peak of the end of the season, R40 did not need the influenza vaccine.On 05/06/2026 at 2:15 PM, V2 (Director of Nursing/ DON) stated if a resident was admitted on [DATE], the resident should had been offered an influenza vaccination. V2 stated the nurse will educate the resident on the vaccine being offered, and hand a consent form before administering the vaccine. V2 stated the flu season is considered from October through March. V2 stated the facility will host 2 clinics in the year, in which residents are being offered either the influenza or Covid-19 vaccines. V2 stated the last clinic that was offered was on April 16, 2026. V2 stated if the resident declines a vaccine offered to them, the staff will educate, provide a handout and encourage to get vaccinated. V2 stated if after education is provided, and the resident is still refusing then we document, and ask the resident to sign a refusal form.Immunization record with review date 04/16/2026 documents R40 has only received the COVID-19 vaccine, and the pneumococcal vaccines were both administered on 04/16/2026. There is no record of the influenza vaccine.Policy titled Immunization program, with review date of 09/01/2023 documents in part, the time frame for immunizations against influenza is generally considered to be from October 1st of each year through March 31st of the following year. Resident, responsible parties, or associates are required to either consent to receive or decline to receive the vaccine in writing on the appropriate form.

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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 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on review of records and interviews, the facility failed to provide required MDS (Minimum Data Set) discharge assessment for 1 out of 1 resident (R55) reviewed for resident assessments. These failures are not according to CMS instruction and affected 1 resident (R55) in determination of proper tracking of resident placement, monitoring and records.Findings include:On 05/06/2026 at 2:15 PM, an inquiry about R55 present location was made to V1 (Administrator/Executive Director). V1 after checking records, stated that R55 currently resides on assisted living but was in the skilled nursing facility in December. V1 stated that R55 was discharged on 12/27/2025, but MDS staff did not do discharge assessment.Per census list, R55 was admitted in the facility on 12/12/2025 and was discharged on 12/27/2025.Per CMS's RAI Version 3.0 Manual dated 10/2025:Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information. Entry is a term used for both admission and a reentry and requires completion of an Entry tracking record. Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.