STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 neglected to notify the physician and seek medical treatment after a significant decline in condition for one of three residents (R1) reviewed for neglect in the sample of nine. These failures resulted in R1 significantly declining in condition for two weeks before the facility sought medical treatment and sent R1 to the hospital on 5/10/25 for evaluation where R1 was admitted to the ICU (Intensive Care Unit) and remains in the hospital currently for treatment of Medical Neglect, Severe Dehydration, Acute Encephalopathy, Hypernatremia, Bladder Obstruction, Lactic Acidosis, Complicated Urinary Tract Infection, Sepsis, Metabolic Acidosis, Contractures to the Lower Extremities, and Bacterial Pneumonia. These failures resulted in an Immediate Jeopardy. The immediate jeopardy started on 4/29/25 when R1 started declining and the physician wasn't notified and treatment wasn't obtained, resulting in R1 going two weeks without medical treatment and R1 being admitted to the to the ICU and remains in the hospital currently for treatment of Medical Neglect, Severe Dehydration, Acute Encephalopathy, Hypernatremia, Bladder Obstruction, Lactic Acidosis, Complicated Urinary Tract Infection, Sepsis, Metabolic Acidosis, Contractures to the Lower Extremities, and Bacterial Pneumonia.' V1/Administrator and V2/Director of Nursing were notified of the Immediate Jeopardy on 6/3/25 at 3:08 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice was corrected, on 5/13/25, prior to the start of the survey and was therefore Past Noncompliance. Findings include: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Acute Change of Condition Policy, dated 1/23/23, documents Purpose: To provide facility guidance when a change of condition occurs with a resident. Policy: This facility shall identify and treat residents with acute change of conditions. Policy Interpretation and Implementation: 2. Direct care staff, including nursing assistants, will be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the Nurse. 6. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician, for example, the history of present illness and previous and recent test results for comparison. a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident/patient's current symptoms and status, history, current medications and SBAR (Situation, Background, Assessment, and Recommendation) in Point Click Care). 7. The nursing staff will contact the physician based on the urgency of the situation. For emergencies they will call or page the physician and request a prompt response. 8. The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. a. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. 9. The nurse and physician will discuss and evaluate the situation. a. the physician should request information to clarify the situation. 10. The staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, medication regimen, and diagnostic test results. 13. The physician and staff will identify relevant resident/patient wishes, including advance directives and POLST (Physician Orders for Life-Sustaining Treatment) orders related to life-sustaining treatments. 14. If it is decided, after sufficient review, that care or observation cannot reasonable be provided in the facility, the physician will authorize transfer to an acute hospital, Emergency Room, or another appropriate setting. The facility's Abuse Policy, dated 1/9/24, documents Purpose: To provide guidance and Procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse Policy: The 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. The facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Definitions: Neglect means the failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, or mental anguish. Neglect means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, person care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident including deprivation of goods and services. On 5/28/25 at 12:21 PM V4/Director of Rehab stated, (R1) was able to straighten both legs out and he was able to bend both legs by the time he finished physical therapy (2/14/25). (R1) was a little resistant, but with dementia techniques we were able to get him to participate. (R1) was 25% (percent) weight bearing due to his right hip fracture at that time. He could stand up straight but did not know his limitations with weight bearing limitations. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/29/25 at 9:22 AM V10/SSD stated, I had tried to contact (V8/R1's Family Member) a week or so prior to the call on 5/8/25 and 5/9/25 regarding (R1's) major decline. I was trying to reach out to (V8) regarding hospice. I left (V8) a message asking if he could call me back. When I finally spoke to (V8) and let him know that (R1) has been getting worse, has lost weight, not eating, and possibly (R1) needing a gastrostomy tube, (V8) would not give me an answer on Hospice and kept telling me he would have to speak to (V16/R1's Family Member). I did let (V8) know how bad (R1) was and told him he didn't have much time to decide about hospice. I did not call (V14/R1's Physician) regarding (R1's) condition and I am not aware if nursing notified (V14) of (R1's) condition. The nursing staff just tell me what to call the families over and they wanted me to consult with (V8) regarding (R1's) decline in condition. On 5/29/25 at 9:44AM V11/CNA (Certified Nursing Assistant) stated around two weeks prior to R1 being sent out to the hospital R1 started not being as active as he normally was. V11 stated, Usually I could talk to (R1) and (R1) would talk back. (R1) started sleeping all the time and wasn't eating as much. I did notice (R1's) urine was darker than usual with a little less output. I believe I reported (R1's) urine color and output to (V12/Licensed Practical Nurse). (R1's) pain was also getting worse prior to being sent out to the hospital. (R1) just started moaning in pain all the time. (R1's) lower legs were bent at the knees and (R1) was unable to straighten them out. (R1) use to be able to straighten his legs. On 5/29/25 at 9:55AM V12/LPN stated, At least a week (maybe two weeks) before (R1) went to hospital (R1) was having a decline in his condition. (R1) stopped eating and wouldn't let us get him out of bed. I don't remember anyone reporting (R1's) urine color or output to me, I don't typically monitor that the CNA's usually do. I was at least (R1's) nurse two to three times a week. I reported to (V10/SSD) about (R1's) decline in condition. I did not notify the doctor however and should have. I did not document on (R1's) decline because I was communicating with (V10) regarding hospice, I should have documented. If we notice a change in condition, we should notify the physician immediately. On 5/29/25 at 10:15 AM V13/LPN stated I went to (V10/SSD) regarding a hospice consult around a week or so prior to (R1) being sent to the local hospital. I noticed (R1) was not eating and was having failure to thrive. I did not notify (V7/Dietitian or V14/R1's Physician) of my concerns with (R1) not eating and should have. Typically, we would fill out an SBAR (Situation, Background, Assessment, and Recommendation) and would send it to the doctor. I just assumed (V14) had already seen (R1) recently. On 5/28/25 at 1:54 PM V6/Hospital Registered Nurse stated I was the admitting nurse when (R1) got admitted to the ICU (Intensive Care Unit) on 5/10/25. (R1) could not straighten his legs, they were incredibly contracted. (R1's) legs were both completely bent at the knees where (R1) could not straighten either leg out. I doubt (R1) will ever be able to walk again. (R1's) mouth and teeth were caked with black sludge that took me ten minutes and 12 different swabs to even try to get it out of his mouth. (R1) had a lack of oral care like no one ever cleaned his mouth. (R1) had a horrible smell, (R1's) private area was excoriated and had an (indwelling urinary catheter) and a lack of it being cleaned. (R1's) groin was very red everywhere. The head of (R1's) penis, from the catheter rubbing and not cared for was actually split. (R1) was in severe pain and all he could do was cry out. It was one of the worst things I have seen, I felt completely horrible for (R1). (R1) had to have been completely neglected for a while. I was able to give him a bath here and treat him without (R1) refusing any care. (R1) remains in the hospital at this time and is still being treated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/29/25 at 11:27 AM V14/R1's Physician stated that the last time he had visited R1 was on 4/8/25. V14 verified he was not made aware of R1 repetitive refusals of eating and drinking his med pass, refusing weekly weights, R1's significant weight loss, or R1's decline. V14 stated, It's not right if the (local hospital) had emptied two liters of urine from (R1's) bladder when (R1) arrived at the hospital. I am not sure what orders the facility had to change the urinary catheter, but if the facility staff would have notified me, I would have referred (R1) to a Urologist to assist in caring for (R1's) urinary catheter. Not changing (R1's) urinary catheter since January 2025 could have contributed to (R1's) infection and being hospitalized . I was not made aware of (R1's) declining condition. I last saw (R1) on 4/8/25 and I do not have any record of the facility notifying me of (R1's) change in condition. I would have sent (R1) right to the hospital and not messed with doing anything in house if the facility would have notified me of his condition. On 5/29/25 at 2:54 PM V7/Dietitian verified the lack of R1 eating and drinking would have led to hypernatremia. On 5/31/25 at 11:36 AM V8/R1's Family Member stated, I would call and speak to (R1) a couple of times a week from the time of (R1's) admission until he was admitted to the hospital. (R1) wasn't all the way cognitively there, but he could hold a conversation. I would call the facility and speak with the nurses, and they would always tell me (R1) was doing good, and that some Nurse Practitioner would see (R1) every Tuesday and monitor his labs, vital signs, and condition. A few days after (R1) being sent to the hospital I received a call from (V10/SSD) suggesting that (R1) receive hospice care due to (R1) not eating, having a significant weight loss, and (R1's) decline. (V10) stated (R1) started to really decline around a few weeks prior to this where he was becoming super weak. I told (V10) I wanted to speak with (V16/R1's Family Member) before making any decisions because (R1) always wanted to be a full code. I was waiting for a call back from (V16) when I then received a call from (V2/Director of Nursing/DON). (V2) told that we really need to get (R1) on hospice. I asked (V2) if (R1) was going to die and (V2) stated Oh no, no, no (R1) is just declining food at this point. I told (V2) I wanted (R1) sent out to the hospital to be evaluated and (V2) told me if they would send (R1) out to the hospital, the hospital would just send him right back because there is nothing the hospital can do. The next day I received a call from (V15/Registered Nurse/RN) that (R1) was lethargic and barely moving so (V15) sent (R1) to the local hospital. (V15) told me she could not take it anymore with (R1's) condition and that her conscious got the best of her, so (V15) decided she needed to send (R1) to the emergency room. The hospital then reached out to me and told me what (R1's) condition was and told me that my dad was severely dehydrated, malnourished, and was neglected. (R1) was in critical condition and they didn't know if he was going to make it. (R1) remains in the hospital as of today still being treated for his medical conditions. On 6/2/25 at 9:59 AM V18/Hospital Physician stated, I was the admitting physician that admitted (R1) to the hospital on 5/10/25. I did (R1's) assessment. (R1) had an indwelling catheter. (R1's) urine looked very, very dirty and had a lot of sediment in the urine. (R1) appeared very dry looking, he was dehydrated, and his oral cavity had tons of sludge like material with crusting in his mouth. (R1) came in with Acute Kidney Injury and his creatine lab was five times over his baseline number of one, implying that (R1) was very dehydrated and had been dehydrated for a while. His creatine lab was 4.94 which indicates someone has been dehydrated for at least more than two days. (R1) appeared very malnourished. (R1) did not get like that in just one day. I felt (R1) should have been hospitalized well before he was sent to us. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/2/25 at 11:51 AM V2/Director of Nursing verified R1's Electronic Health Record does not include documentation of V14 (R1's Physician) or V7 (Dietician) being notified of R1's 13.9 % weight loss within six months as of 5-7-25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, R1's decreased consumption of med pass between 5/1/25 through 5/9/25, or R1's nutritional care plan not being revised until 5-8-25. V2 stated, I know I spoke to (V8) on 5/9/25 to go over (R1's) decline again and possibly needing hospice services. (V10/SSD) had called (V8) regarding (R1) possibly needing a gastrostomy tube. (V8) had questions regarding that. (V8) did ask if (R1) needed to be sent out to the hospital and I did tell (V8) that if we did send him out, the hospital probably would not do anything and send him right back. I have no documentation of a physician being notified of (R1's) significant decline in condition from 4/29/25 through 5/10/25. (V14/R1's Physician) should have been notified right away when (R1) started not eating/drinking and started having his significant decline. R1's admission Record, dated 5/28/25, documents R1 is a [AGE] year-old male admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Type Two Diabetes Mellitus, Unspecified severe Protein-Calorie Malnutrition, Depression, Poly Osteoarthritis, Chronic Kidney Disease, Obstructive and Reflux Uropathy, Celiac Disease, and Hypertension. R1's Order Summary Report, dated 5/28/25, documents R1 is a full code, has an indwelling urinary catheter, and an order for weekly weights. R1's MDS (Minimum Data Set) Assessment, dated 1/17/25, documents R1 had no behaviors. R1's MDS Assessment, dated 4/18/25, documents R1 had other behavioral symptoms not directed towards others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds). R1's MDS Assessments, dated 1/17/25 and 4/18/25, did not document R1 had rejected cares, had a weight loss, or had any upper or lower impairments. R1's MDS Assessment, dated 5/10/25, documents R1 rejected cares and had a weight loss of five % (percent) or more in the last month or loss of ten % or more in the last six months. R1's Progress Note, dated 3/29/25 and signed by V7/Dietitian documents R1's oral intake is typically 75 to 100% of meals per chart. R1's Nutritional Assessment, dated 4/21/25 and signed by V7/Dietitian documents R1 had no decrease in food intake. R1's Nutritional Risk Assessment, dated 4/29/25 and signed by V7/Dietitian documents R1 had a decrease in oral food intake and eats zero to 75% of meals. R1's Percentage of Meal, dated 4/29/25 through 5/9/25 does not document consistent meal percentages consumed. This forms documents in eleven days R1 consumed 26 to 50% of a meal four times and in eleven days consumed zero to 25% of a meal 15 times. This same form documents in eleven days R1 refused or did not receive a meal three times. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Medication Administration Record (MAR) does not document R1's Physician ordered weekly weights were completed from 3/1/25 through 5/10/25. R1's Contracture Risk Assessments, dated 1/1/25 and 4/14/25, document R1 does not have any contractures. These same assessments document R1 was at moderate to severe risk for contractures related to (R1's) diagnoses. R1's Physical Therapy Evaluation and Plan of Treatment, dated 12/23/25 and signed by V17/Physical Therapist, documents Initial Assessment/Current Level of Function and Underlying Impairments: Musculoskeletal System Assessment- Contracture: Functional Limitations Present due to Contracture= No. R1's Physical Therapy Evaluation and Plan of Treatment, dated 1/14/25 and signed by V17/Physical Therapist, documents Initial Assessment/Current Level of Function and Underlying Impairments: Musculoskeletal System Assessment- Contracture: Functional Limitations Present due to Contracture= No. R1's emergency room Summary, dated 5/10/25, documents Musculoskeletal: Comments: Chronically contracture (to the) lower extremities. R1's Behavior Log, dated March 2025, documents R1 refused care twice out of 31 days. R1's Behavior Log, dated April 2025, documents R1 refused care zero times out of 30 days. R1's Behavior Log, dated 5/1/25 through 5/10/25, documents R1 refused care one time out of ten days. R1's Electronic Health Record does not include documentation of V14 (R1's Physician) or V7 (Dietitian) being notified of R1's 13.9 % weight loss within six months as of 5/7/25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, and R1's decreased consumption of med pass between 5/1/25 through 5/9/25. R1's Electronic Health Record dated 4/28/25 through 5/10/25 (date of hospitalization) does not include documentation of the facility contacting V14 (R1's Physician) or seeking medical treatment for two weeks once R1 started to have a decrease in appetite, decrease in fluid consumption, increase in weakness, increase in behaviors, and rejecting cares. R1's Electronic Medical Record from admission [DATE]) through R1's discharge to the hospital (5/10/25) does not include evidence of the facility monitoring R1's fluid intake. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's care plan, dated 5/20/25, documents (R1) is at high risk for urinary tract infection due to catheter use, related to indwelling catheter secondary to diagnosis of Obstructive Uropathy. Goal: (R1) will not experience any decline in mental status related UTI (Urinary Tract Infection) through review date. Interventions: Change catheter and drainage bag per medical doctor orders, empty catheter drainage collection bag every shift, ensure catheter tubing and drainage bag are properly positioned to prevent urinary backflow or contamination, observe for and notify doctor for fever, abdominal tenderness, flank pain, altered mental status, malodor (odor), hematuria (blood in urine) or abnormal urine clarity/consistency, provide catheter irrigation as ordered. This same care plan documents Date Initiated 12/23/2024: (R1) has potential for altered nutrition and hydration related to diagnoses of Type Two Diabetes Mellitus, Dementia, and Cancer. (R1) also limits himself on foods he eats. Gluten free, no red meat or pork. Goal: (R1) will have no signs or symptoms of altered nutrition/hydration through review date. Interventions dated 12/23/24: Monitor weights as ordered and notify Physician of significant Weight Change. R1's Care Plan does not include any revisions or nutritional interventions to address R1's seven pound weight loss within one week on 4/23/25, R1's 13.9 % weight loss within six months as of 5-7-25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, or R1's decreased consumption of med pass between 5/1/25 through 5/9/25, until 5-8-25 (two days before R1 was admitted to the hospital). On 5-8-25 R1's Nutritional Care Plan documents, 5-8-25 Encourage (R1) to eat all meals in the dining room and chart any refusals. Notify physician of any further increase in oral intake for appropriate intervention. Provide supplements as ordered-refer to MAR. Staff to provide supervision with cueing during mealtimes. R1's Electronic Medical Record, including R1's Progress Notes, Care Plan, and Treatment Administration Records from admission [DATE]) through R1's discharge to the hospital (5/10/25) does not include documentation of R1's urinary catheter being changed. R1's Treatment Administration Record (TAR), dated 4/1/25-4/30/25, does not document R1's urinary output on 4/20, 4/21, 4/24, 4/25, 4/30/25 dayshift amounts and on 4/18, 4/19, 4/23, 4/25 and 4/27/25 evening shift amounts, for a total of ten undocumented urine output recordings in the month of April. R1's TAR, dated 5/1/25-5/31/25, documents a total day shift urine output for R1 on 5/9/25 of 100 milliliters (ml) and a total evening shift urine output of 600 ml (for a total of 700 ml). This TAR does not document R1's urinary output on 5/3/25 dayshift or 5/7/25 evening shift. R1's Progress Note, dated 5/8/25 and signed by V10/SSD, documents (V10) left a message for (V8/R1's family Member) regarding the decline in (R1) and hospice services and new POLST (Physician Orders for Life-Sustaining Treatment). (V10) will follow up. R1's Progress Note, dated 5/9/25 and signed by V10/SSD documents (V10) contacted (V8/R1's Family Member) regarding the decline in (R1). (V10) talked about (R1's) significant weight loss, refusing to eat, and wounds. (V10) explained hospice care or gastrostomy for nutrition. (V8) stated he wanted to talk with (V16/R1's Family Member) first before deciding what to do. (V8) stated that the earliest he would be able to come from out of town would be around 6/1/25. (V10) told (V8) that he needs to make a decision before then. (V8) is going to call back once he speaks with (V16). (V10) will follow up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Progress Note, dated 5/10/25 and signed by V15/RN (Registered Nurse), documents (R1) lethargic with involuntary jerking, very slow to respond, increased weakness and fatigue noted, slow to responds and slurred speech, hypotension noted, Blood Pressure 66 systolic/44 diastolic. Emergency Contact (V16/R1's Family Member) notified and request (R1) be evaluated at Emergency Room. 911 called and Emergency Medical Transport arrived, paramedics placed on IV (Intravenous Fluids) at facility and administered EKG (Electrocardiogram). (R1) in route to (local hospital) at this time. R1's Local Hospital emergency room Note, dated 5/10/25, documents Chief Complaint: Dysuria- Per SNF (skilled nursing facility). (R1) has had a UTI (Urinary Tract Infection) for several days. Had antibiotic and has been completed. (R1) presents with purulent (thick, milky white, yellow, green, or brown discharge) drainage in (R1's) indwelling urinary catheter bag. (R1) alert to self per baseline. HPI (History of Present Illness): (R1) is a [AGE] year-old male presenting to the emergency department for sepsis. (R1) presents to the emergency department by ambulance from nursing home. (R1) has a history of dementia and is alert to self only at baseline. (R1) has a chronic indwelling urinary catheter. Staff reports that (R1) has been treated for UTI for the past several weeks. (R1) has been appearing to have lower abdominal pain. (R1's) catheter isn't having significant urine output but has been noted to have purulent appearing content in urinary catheter bag. (R1) has had blood around his urethra. Review of systems by age: Genitourinary: Positive for dysuria (painful urination). Constitutional: Appearance: (R1) is ill-appearing. Genitourinary: Hypospadias (urethra opening on the posterior of the penile shaft) with blood around urethra. Purulent drainage noted in indwelling bag without significant blood clots or gross blood. Medical Decision Making: (R1) presents to emergency department for concern of Sepsis/Urinary Infection. Nursing home staff reports that (R1) appeared to have lower abdominal discomfort as well as purulent drainage from his chronic indwelling catheter. (R1) had blood around the urethra and had hypospadias noted. Nursing staff replaced (R1's) urinary catheter and had immediate return of two liters (2,000 milliliters) of purulent appearing urine. (R1) has acute renal failure with creatinine greater than four as well as metabolic acidosis with lactic acidosis. (R1's) urinalysis appears significantly concerning for infection. Urine culture was sent. CT (computed tomography) scan showed right-sided hydroureteronephrosis (ureters and kidneys are dilated due to a blockage or obstruction in the urinary tract) without obstructing stone. This same summary notes also documents Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Sepsis, Renal failure, and Cardiac failure. Clinical Impression: 1. Acute Renal Failure, Bladder Obstruction, Complicated UTI, Lactic Acidosis, Metabolic Acidosis, and Bacterial Pneumonia. R1's Hospital Progress Note, dated 5/10/25 and signed by V6/Hospital Registered Nurse documents (R1)'s mouth was caked with crusty sludge like material. It took over ten swabs to perform oral care. Was able to move the sludge from his mouth. (R1) was also noted to have a very crusty indwelling catheter at the penis. (R1) is very thin and dehydrated. Nose is crusty with dried mucous. (R1) has a very unwashed smell about him. This same note documents R1 is contracted and difficult to straighten legs. (continued on next page)

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	145691	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Hospital Progress Note, dated 5/11/25 and signed by V18/Hospital Physician, documents Physical Exam: General- 78-years-old male poorly built, poorly nourished. Assessment and Plan: Acute Cystitis: (R1's) Urinalysis showed 3+ (three plus) blood, positive leukocyte esterase. Urine looked dirty in foley bag with sediment and cloudy urine. On Intravenous antibiotics currently. Acute Kidney Injury, Dehydration, and Chronic Kidney Disease Stage 2: (R1's) baseline creatine is around 1. Current creatinine is around 3.83 which improved from 4.9 with Intravenous fluids. (R1) severely dehydrated on arrival. (R1's) foley catheter was exchanged upon arrival. Concern with Osteomyelitis Pressure Wound on Right Thigh: Ordered x-ray right femur but (R1) has contracture and is not able to extend the right lower extremity due to ongoing pain. Medical Neglect: (R1) arrived at the hospital showing signs of neglect including severe dehydration with poor oral care, and poor foley catheter care. R1's Hospital History and Physical, dated 5/10/25 and signed by V18/Hospital Physician, documents Physical Exam: General- [AGE] year-old male poorly built, poorly nourished, appears to be in moderate distress. Lungs- rhonchi noted on the right lung. Assessment/Plan: Acute Metabolic Encephalopathy: (R1) is alert, not oriented to time, place or person. Not able to follow commands. Ordered computed tomography of brain as well. Encephalopathy is multifactorial likely from infection, dehydration, hypernatremia. Severe malnutrition: Concern for Refeeding Syndrome: (R1) appeared malnourished. BMI (Body Mass Index) is 18. 4. Will consult dietitian once (R1) mentation improves. (R1) is at high risk for refeeding syndrome. Will monitor and replete electrolytes closely. The Immediate Jeopardy that began on 4/29/25 was removed and the deficient practice corrected on 5/13/25 when the facility took the following actions to remove the Immediacy and correct the noncompliance. 1. R1 still remains in the hospital and will not be returning to the facility (as per family.) 2. On 5/13/25 resident chart reviews were conducted for the following areas: Change in condition, Significant Weight Change, Resident Exhibiting Signs/Symptoms of Dehydration, Hydration Status, and Foley Catheter Status by the clinical team and consulting team. 3. On 5/12/25 V30/Chief Executive Officer in-serviced the facility's interdisciplinary team on the Change in Condition Policy, Assessments/Identification/Hydration Policy, Signs of Symptoms of Dehydration, Foley Catheter Policy, Facility Weight and Nutrition Policy, and Physician and Interested Party Notification. 4. On 5/13/25 V2/Director of Nursing in-serviced all licensed nursing staff on the Change in Condition Policy, Assessments/Identification/Hydration Policy, Signs of Symptoms of Dehydration, Foley Catheter Policy, Facility Weight and Nutrition Policy, and Physician and Interested Party Notification. 5. On 5/13/25 V2/Director of Nursing in-serviced all CNA's on Foley Catheter Policy and Hydration Policy. 6. On 5/14/25, 5/18/25, 5/27/25, and 6/3/25 V2/Director of Nursing audited three residents on each date for any changes in condition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	7. On 5/14/25, 5/18/25, 5/27/25, and 6/3/25 V2/Director of Nursing audited three residents on each date to ensure they are receiving catheter care, physician orders to change catheters are in place, care plans are updated, and catheter output is documented. 8. On 5/15/25, 5/22/25, 5/29/25, and 6/5/25 the V1/Administrator held a quality assurance meeting where the results from the quality assurance audits were reviewed, and additional interventions were implemented. Completion Date: 5/13/25.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on Interview and Record review the facility failed to report an allegation of Injury of Unknown Origin to the facility's Abuse Coordinator and the State Agency for one of three residents (R4) reviewed for Injury of Unknown Origin in the sample of nine. Findings include: R4's Nursing progress note, dated 5/16/25 at 2:40 PM and signed by V13 (Licensed Practical Nurse), documents (R4) continues increased confusion, lethargy (weakness) and not at baseline with ADLS (Activities of Daily Living) order received to send to Emergency Department for evaluation and treatment. Family aware and (Emergency services) called. R4's Nursing progress note, dated 5/16/2025 at 8:40 PM and signed by V22 (Licensed Practical Nurse), documents Nurse (V22) received call from (V20, R4's family member). (V20) told nurse that (R4) would not be coming to the facility tonight due to transfer to a (tertiary) hospital. (R4) was given a CT (Computed Tomography) of the head scan which showed internal bleeding. (V20) asked if his (R4) had a fall within the last 24 hours, because the hospital informed (V20) the internal bleeding could be from a possible unwitnessed fall. (V22) informed (V20) that no falls were documented or reported within the last 24 hours. (V20) informed (V22) that he will be keeping in touch if anything else comes up. R4's electronic medical record, dated May 2025, documents the last recorded fall for R4 occurred on 5/13/25 without R4 striking his head or suffering any injury. On 5/31/25 at 8:59 AM, V2 (Director of Nursing) stated We (the facility) do not have any injuries of unknown origin, or bruises of unknown origin in past six months. On 6/3/25 at 2:53 PM, V22 (Licensed Practical Nurse) stated I was the nurse working the evening after (R4) was transferred to the hospital. I took a call from the resident's family (V20) and wrote a nursing note regarding it. I notified the DON (Director of Nursing, V2) of this information because (R4) was sent out prior to my shift and then family called to let me know the emergency room had identified a new head bleed injury that happened in the last 24 hours. I was not able to find any falls or incidents so I felt like the DON should be aware of this information. On 6/3/25 at 2:40 PM, V2 (Director of Nursing) confirmed it was reported to her that R4's family member (V20) called and updated the facility on R4's transfer to a tertiary hospital for a fresh brain bleed that was believed to have occurred in the prior 24 hours. V2 stated We did not do a written investigation or report to (the state agency). We didn't know how he got the injury, and we didn't have any documented falls in the prior 24 hours. On 6/3/25 at 3:34 PM, V1 (Administrator) confirmed she is the facility's Abuse Coordinator. V1 stated I do know that (R4) transferred out and that he had a brain bleed. I was not informed of the injury being reported after he left, to have happened in the prior 24 hours. Reading the nursing note, I do see how it should have been identified and investigated because we don't know what happened and there aren't any recent incidents to show what the bleed was caused from. I did not report the incident (to the state agency) or document an investigation to solve an injury of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Accidents and Incidents policy, dated 9/7/23, documents Purpose: To provide staff with guidelines for investigating, reporting, and recording accidents and incidents. Policy: All accidents/incidents involving a resident shall require an incident report. Accidents and incidents, including injuries of an unknown origin, must be reported to the department supervisor, and an incident report should be completed on the shift that the accident or incident occurred. The facility's Abuse policy, dated 1/9/24, documents To provide guidance and procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). This policy also documents The facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include (the state agency), ombudsman, local police department, power of attorney, and medical doctor in a timely manner. The facility will timely report all allegations of abuse initial/final to (the state agency) according to the state and federal guidelines. This same policy documents Injuries of unknown source is defined as such when all of the following criteria is met: the source of the injury was not observed by any person and the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (the location of the injury is not generally vulnerable to trauma) or the number of injuries noted at a particular point of time or the incident of injuries over time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on Interview and Record Review, the facility failed to investigate an injury of unknown origin for one of three residents (R4) reviewed for Injuries of Unknown Origin in the sample of 9. Findings include: R4's Nursing progress note, dated 5/16/25 at 2:40 PM and signed by V13 (Licensed Practical Nurse), documents R4 was transferred to the local Emergency Department for evaluation and treatment. R4's Nursing progress note, dated 5/16/2025 at 8:40 PM and signed by V22 (Licensed Practical Nurse), documents Nurse (V22) received call from (V20, R4's family member). (V20) told nurse that (R4) would not be coming to the facility tonight due to transfer to a (tertiary) hospital. (R4) was given a CT (Computed Tomography) of the head scan which showed internal bleeding. (V20) asked if his (R4) had a fall within the last 24 hours, because the hospital informed (V20) the internal bleeding could be from a possible unwitnessed fall. (V22) informed (V20) that no falls were documented or reported within the last 24 hours. R4's electronic medical record, dated May 2025, documents the last recorded fall for R4 occurred on 5/13/25 without R4 striking his head or suffering any injury. On 5/31/25 at 8:59 AM, V2 (Director of Nursing) stated We (the facility) do not have any injuries of unknown origin, or bruises of unknown origin in past six months. V2 confirmed there are no abuse investigations to review related to injuries of unknown origin. On 6/3/25 at 2:53 PM, V22 (Licensed Practical Nurse) stated I was the nurse working the evening after (R4) was transferred to the hospital. I took a call from the resident's family (V20) and wrote a nursing note regarding it. I notified the DON (Director of Nursing, V2) of this information because (R4) was sent out prior to my shift and then family called to let me know the emergency room had identified a new head bleed injury that happened in the last 24 hours. I was not able to find any falls or incidents so I felt like the DON (V2) should be aware of this information. V22 confirmed he did not complete an incident report or have any other communications (related to R4's injury) with V2 or R4's family after the phone call on 5/16/25. On 6/3/25 at 2:40 PM, V2 (Director of Nursing) stated We did not do a written investigation or report to (the state agency). We didn't know how (R4) got the injury and we didn't have any documented falls (for R4) in the prior 24 hours. On 6/3/25 at 3:34 PM, V1 (Administrator) confirmed she is the facility's Abuse Coordinator. V1 stated I do know that (R4) transferred out and that he had a brain bleed. I was not informed of the injury being reported after he left, to have happened in the prior 24 hours. Reading the nursing note, I do see how it should have been identified and investigated because we don't know what happened and there aren't any recent incidents to show what the bleed was caused from. I did not report the incident (to the state agency) or document an investigation to solve an injury of unknown origin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Accidents and Incidents policy, dated 9/7/23, documents Purpose: To provide staff with guidelines for investigating, reporting, and recording accidents and incidents. Policy: All accidents/incidents involving a resident shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions. Accidents and incidents, including injuries of an unknown origin, must be reported to the department supervisor, and an incident report should be completed on the shift that the accident or incident occurred. The Interdisciplinary Team (IDT) will conduct a thorough investigation of the accident/incident. Findings of the investigation, including root cause of the accident/incident and appropriate interventions will be in the incident report and implemented. The facility's Abuse policy, dated 1/9/24, documents To provide guidance and procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This policy also documents The facility immediately and thoroughly investigates all allegations of abuse to include but not limited to interviews of residents and staff, visitors, and vendors. This same policy documents Injuries of unknown source is defined as such when all of the following criteria is met: the source of the injury was not observed by any person and the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (the location of the injury is not generally vulnerable to trauma) or the number of injuries noted at a particular point of time or the incident of injuries over time.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record review, the facility failed to ensure a resident was provided nursing assessments, vital signs, and timely provider notifications to ensure medical intervention was received with an acute change of condition for one of four residents (R4) reviewed for change of condition in the sample of nine. Findings include: R4's care plan, dated 4/14/25, documents R4 has diagnoses including but not limited to Atrial Fibrillation, Hypertension, Type II Diabetes Mellitus, Parkinson's Disease, Congestive Heart Failure, Cardiac Pacemaker, and Neurocognitive Disorder with Lewy Bodies. This care plan documents (R4) is at risk for potential falls with injury related to a history of falls prior to admission, weakness, diagnosis of Lewy Body Dementia with confusion, poor balance, gait instability, diagnosis of Diabetes, and daily use of Psychotropic medication. This same care plan documents R4 requires physical assistance of one staff member for transferring and ambulating, and setup help only/ cuing is required with eating. On 6/2/25 at 12:15 PM, V19 (R4's Family Member) stated (R4) was sent out to the hospital on 5/16/25. I was there visiting him just the day before (Thursday 5/15) and he wasn't having confusion. I got a call on 5/16 at 10:47 AM and the nurse (V13, Licensed Practical Nurse) said that (R4) was confused and she thought maybe he had a UTI (Urinary Tract Infection). (V13) said the doctor (V29, R4's Physician) was on his way and would see (R4) today. At 1:10 PM I called back to see what they found out and (V13) said (V29) was on vacation and they (nursing staff) didn't realize it. (V13) said they may send him out for a urinalysis to the hospital. At 2:33 PM, (V13) called me back and said (R4) was going to the hospital. I asked what the (prompt care doctors office) said and (V13) said they didn't get a response back, but that (R4) could not feed himself. I agreed he needed to go out to the hospital because that is a huge change. (R4) would need to be seen right away. (V20, R4's Family) was able to get to the hospital to be with him. (R4) got to the hospital according to the chart records around 3:30 PM. The emergency room told (V20) that (R4) had a fresh brain bleed from hitting his head hard. We (family) had no knowledge of a fall. If (R4) was unable to feed himself that is a big change, not subtle, because he's always been fine with his own meals. On 6/2/25 at 1:58 PM, R9 stated (R4) ate at my table for meals a lot. On the day he went to the hospital (R4) couldn't pick up his fork. He was confused and wasn't making any sense. I think maybe (R4) wasn't at my table for breakfast, but I know at lunch (R4) had a lot of confusion and could not eat on his own which was a big change for him. He had dementia but this was way more, (R4) just was not making any sense. R4's Nursing progress note, dated 5/16/25 at 11:20 AM and signed by V13 (Licensed Practical Nurse), documents Change in condition, increased confusion, increased lethargy, SBAR (Situation, Background, Assessment, Recommendation) sent to (prompt care physician's office), (V19, R4's Family) notified. R4's Nursing progress note, dated 5/16/25 at 2:40 PM and signed by V13, documents (R4) continues increased confusion, lethargy (weakness) and not at baseline with ADLS (Activities of Daily Living), order received to send to Emergency Department for evaluation and treatment. Family aware and (Emergency services) called. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R4's electronic medical record, dated May 2025, does not document a nursing assessment was provided to R4 on 5/16/25 and documents the last neurological assessment for R4 was completed on 5/15/25 at 3:32 AM. This record also documents the last set of vital signs including blood pressure, pulse and oxygen saturation was completed for R4 on 5/15/25 at 3:29 AM. On 6/3/25 at 11:35 AM, V13 (Licensed Practical Nurse) confirmed that R4 was her assigned resident on 5/16/25 when he went to the hospital. V13 stated On 5/16 my shift started at 6:00 AM but I don't think I was R4's nurse right away. V13 stated she first assumed care of R4 at around 11:00 AM and noticed he wasn't acting right. V13 stated I noticed he had a change from his baseline, and he wasn't acting normal. I called the family (V19) and I tried to contact the provider (V29) via fax. R4 was lethargic, not acting normal and was mumbling his words, which was all new behavior. I never got a response back from (V29) and at 2:40 PM (over three and a half hours from the first recognized change in R4's cognition), I sent (R4) to the Emergency Room. I believe when I first saw (R4) he was in his room and then he was taken to lunch and wasn't able to eat or do anything. That would have been around noon. I would assume I took vital signs and if I did, they would be in the computer. (R4's) increased confusion was not normal for him, nor was the mumbled speech. (R4) had a change in condition, was off and needed evaluated which is why I ultimately sent him to the hospital. From the first recognition of his change around 11:00 AM until EMS (Emergency Medical Services) was called (2:40 PM) his condition remained about the same, no better and no worse. V13 confirmed her method of reaching out to providers was all by fax and she did not call the provider (V29) or an on-call provider when no response was received from the fax. R4's local emergency room record, dated 5/16/25, documents R4 admitted to the local emergency room at 3:17 PM with symptoms of left side facial drooping, blurred vision, altered mental status and slurred speech. This record documents R4 was transferred to a higher level of care hospital (tertiary) for a neurosurgical evaluation and admission. R4's Tertiary hospital Discharge summary, dated [DATE], documents R4 was admitted to the tertiary hospital's Intensive Care Unit on 5/16/25 and started on medication (Nicardipine, calcium channel blocker) to keep (R4's) systolic blood pressure below 140 (millimeters of mercury). On 6/3/24 at 3:20 PM, V2 (Director of Nursing) confirmed R4's medical record does not document vital signs, nursing assessments, neurological checks, or a successful provider notification with response, throughout the morning and afternoon of 5/16/25 when R4 was exhibiting a change in baseline and new onset of significant deficits. V2 stated she would expect nurses to complete these nursing assessments when a resident is showing significant changes like R4 was on 5/16/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Acute Change of Condition policy, dated 1/23/23, documents Purpose: To provide facility guidance when a change of condition occurs with a resident. Policy: The facility shall identify and treat residents with acute change of conditions. This policy also documents Direct care staff, including nursing assistants, will be trained in recognizing subtle but significant changes in the resident and how to communicate these changes to the nurse. Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician, for example, the history of present illness and previous and recent test results for comparison. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the residents/patient's current symptoms and status, history, current medications, etc. (etcetera). The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response. The attending physician (or practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record review, the facility failed to ensure a resident with diagnoses of Chronic Kidney Disease and Obstructive and Reflux Uropathy (urine flow obstruction) was monitored for urinary catheter obstruction, failed to document physician ordered urinary output, and provide indwelling urinary catheter changes every 30 days or as needed for one of three residents (R1) reviewed for urinary tract infections in a sample of nine. This failure resulted in R1 experiencing a significant change in condition and being sent to the local emergency room with a subsequent admission to the hospital's critical care unit for diagnoses including Acute Renal Failure, Bladder Obstruction, Complicated urinary Tract Infection, Lactic Acidosis and Metabolic Acidosis. This past noncompliance occurred from 4/29/25 through 5/13/25. Findings include: The facility's Catheter Insertion/Maintenance Policy, dated 5/7/25, documents Purpose: To provide staff with guidelines for the proper insertion of an indwelling urinary catheter. Policy: An indwelling urinary catheter is to be inserted only by order of the physician. Replacement of (indwelling urinary) catheters will be done every thirty days or as needed when clogged/dislodged/accidental removal or ordered by the physician. The indwelling urinary bag shall be changed every week. Indwelling urinary catheters may be flushed as needed for maintenance/to clear clogs or slow drainage. The facility's Indwelling Catheter Care Policy, dated 10/7/22, documents Purpose: To provide guidance to facility staff on the care of residents with an indwelling foley catheter within the facility to prevent catheter-associated urinary tract infections. Policy: The facility shall maintain and care for foley catheters per the facility, following physician orders and adhering to facility infection control and best nursing practice standards. Policy Interpretation and Implementation: c. Empty the collection bag and perform indwelling catheter care at least every shift. R1's MDS (Minimum Data Set), dated 4/18/25 documents R1 has an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's current Care Plan, dated 5/20/25, documents R1 has diagnoses including Chronic Kidney Disease, Obstructive and Reflux Uropathy and Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms. This same care plan documents R1 has Impaired urinary elimination related to obstruction of urethra related to BPH. Interventions: (Indwelling urinary) catheter as ordered, notify doctor of any complaints of problems with voiding. This same care plan documents R1 is High risk for urinary tract infection due to catheter use, related to indwelling catheter secondary to diagnosis of Obstructive Uropathy. Goal: (R1) will not experience any decline in mental status related UTI (urinary tract infection) through review date. Interventions: Change catheter and drainage bag per medical doctor orders, empty catheter drainage collection bag every shift, ensure catheter tubing and drainage bag are properly positioned to prevent urinary backflow or contamination, observe for, and notify doctor for fever, abdominal tenderness, flank pain, altered mental status, malodor (odor), hematuria (blood in urine) or abnormal urine clarity/consistency, provide catheter irrigation as ordered. This care plan also contains a plan of care, dated 4/29/25, that (R1) has a urinary tract infection as evidence by burning at catheter site and abnormal urinalysis. Interventions: Monitor intake and output, monitor/document/report to medical doctor as needed for signs and symptoms of urinary tract infection: frequency, urgency, malaise (feeling unwell), foul smelling urine, dysuria, fever, nausea, and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes, obtain and monitor laboratory/diagnostic work as ordered. Report results to medical doctor and follow up as indicated. R1's Physician Order Sheet, dated 5/1/25, documents R1 has physician orders of (Indwelling urinary) catheter output every shift, start date 4/15/25. This same order sheet documents the following physician orders with a start date of 2/6/25, (Indwelling urinary) catheter 16 French balloon to gravity drainage for Obstructive Uropathy. (Indwelling urinary) catheter may irrigate with 100cc (cubic centimeters) normal saline as needed if tube clogging. May re-insert (indwelling urinary) catheter as needed for malfunction or dislodgement as needed. R1's Treatment Administration Record (TAR), dated 5/1-5/31/25, documents a treatment order dated 5/7/25 to (Indwelling urinary): 16 French 10 ml (milliliter) balloon to gravity drainage for obstructive uropathy, every night shift every 30 days. This TAR does not document that R1's (indwelling urinary) catheter was changed in May 2025. This same administration record documents (Indwelling urinary) catheter output every shift. This TAR documents a total day shift urine output for R1 on 5/9/25 of 100 milliliters (ml) and a total evening shift urine output of 600 ml (for a total of 700 ml). This TAR does not document R1's urinary output on 5/3/25 dayshift or 5/7/25 evening shift. R1's TAR, dated 4/1-4/30/25, documents (Indwelling urinary) catheter output every shift. This TAR does not document R1's urinary output on 4/20, 4/21, 4/24, 4/25, and 4/30/25 dayshift amounts. This same TAR does not document R1's urinary output on 4/18, 4/19, 4/23, 4/25 and 4/27/25 evening shift amounts, for a total of ten undocumented urine output recordings in the month of April. This same TAR does not document R1's (indwelling urinary) catheter was changed for the month of April 2025. R1's Nursing progress notes, dated 1/1/25-5/10/25, do not document R1's (indwelling urinary) catheter has ever been changed. R1's Nursing Progress notes, dated 4/1/2025 at 11:29 PM, document (R1) is having increased confusion, agitation, and burning at (indwelling urinary) catheter site, urine is concentrated and amber in color. Fluids encouraged, resident is afebrile, urine collected for testing. Urinalysis (UA) and Culture and Sensitivity ordered. Urine placed in refrigerator and will go out with lab in AM. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Nursing Progress notes, dated 4/6/2025 at 4:07 PM, document (R1's) (indwelling urinary) catheter is patent and draining cloudy yellow urine. UA results are pending. R1's Provider visit summary, dated 4/8/25 and signed by V14 (R1's Physician), documents Diagnosis and all orders for this visit: Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present. Assessment and Plan: Patient (R1) with recurrent urinary tract infection with UA results demonstrating enterococcus faecalis (bacteria) growth greater than 100,000 colonies per high powered field. I (V14) do not recall this, nor do staff. Do not recall seeing this, nor being treated. R1's Nursing Progress Notes, dated 5/5/25-5/10/25, does not document the consistency/color of R1's urine or the patency of R1's (indwelling urinary) catheter. R1's Nursing Progress notes, dated 5/10/25 at 3:45 AM documents (R1) lethargic with involuntary jerking, very slow to respond, increased weakness and fatigue noted, slow to respond and slurred speech, hypotension (low blood pressure) noted, BP (blood pressure) 66/44. Emergency contact (V16, R1's family) notified and (V16) requested resident be evaluated at ER (Emergency Room) 911 (emergency) called and Emergency Medical Transport's arrived, paramedics placed (Intravenous peripheral line) at facility and administered EKG (electrocardiogram), (R1) in route to (local hospital) at this time. R1's Local Hospital emergency room Note, dated 5/10/25, documents Chief Complaint: Dysuria (painful urination)- Per SNF (skilled nursing facility). (R1) has had a UTI (urinary tract infection) for several days. Had antibiotic and has been completed. (R1) presents with purulent (thick, milky white, yellow, green, or brown discharge) drainage in (R1's) indwelling urinary catheter bag. (R1) alert to self per baseline. HPI (History of Present Illness): (R1) is a [AGE] year-old male presenting to the emergency department for sepsis. (R1) presents to the emergency department by ambulance from (facility). (R1) has a history of dementia and is alert to self only at baseline. (R1) has a chronic (indwelling urinary) catheter. Staff reports that (R1) has been treated for UTI for the past several weeks. (R1) has been appearing to have lower abdominal pain. (R1's) catheter isn't having significant urine output but has been noted to have purulent appearing content in urinary catheter bag. (R1) has had blood around his urethra. Review of systems by age: Genitourinary: Positive for dysuria (painful urination). Constitutional: Appearance: (R1) is ill-appearing. Genitourinary: Hypospadias (urethra opening on the posterior of the penile shaft) with blood around urethra. Purulent drainage noted in indwelling bag without significant blood clots or gross blood. Medical Decision Making: (R1) presents to emergency department for concern of sepsis/urinary infection. (Facility) staff reports that (R1) appeared to have lower abdominal discomfort as well as purulent drainage from his chronic (indwelling) catheter. (R1) had blood around the urethra and had hypospadias noted. Nursing staff replaced (R1's) urinary catheter and had immediate return of two liters (2,000 milliliters) of purulent appearing urine. (R1) has acute renal failure with creatinine greater than four as well as metabolic acidosis with lactic acidosis. (R1's) urinalysis appears significantly concerning for infection. Urine culture was sent. CT (computed tomography) scan showed right-sided hydroureteronephrosis (ureters and kidneys are dilated due to a blockage or obstruction in the urinary tract) without obstructing stone. This same summary notes also documents Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Sepsis, Renal failure, and Cardiac failure. Clinical Impression: 1. Acute renal failure, Bladder Obstruction, Complicated UTI, Lactic Acidosis, Metabolic Acidosis, and Bacterial Pneumonia. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Hospital Progress Note, dated 5/10/25 and signed by V6 (Hospital Registered Nurse), documents (R1) was also noted to have a very crusty (indwelling urinary) tube at the penis. (R1) is very thin and dehydrated. R1's Hospital Progress Note, dated 5/11/25 and signed by V18 (Hospital Physician), documents Physical Exam: General- 78-years-old male poorly built, poorly nourished. Assessment and Plan: Acute Cystitis: (R1's) Urinalysis showed 3+ blood, positive leukocyte esterase. Urine looked dirty in foley bag with sediment and cloudy urine. On Intravenous antibiotics currently. Acute Kidney Injury, Dehydration, and Chronic Kidney Disease Stage 2: (R1's) baseline creatine is around 1. Current creatinine is around 3.83 which improved from 4.9 with Intravenous fluids. (R1) severely dehydrated on arrive. (R1's) (indwelling urinary) catheter was exchanged upon arrive. Medical Neglect: (R1) arrived at the hospital showing signs of neglect including severe dehydration with poor oral care, and poor (indwelling urinary) catheter care. On 5/28/25 at 1:54 PM V6 (Hospital Registered Nurse) stated I was the admitting nurse when (R1) got admitted to the ICU (Intensive Care Unit). (R1's) private area was excoriated and had a (indwelling urinary) catheter and a lack of it being cleaned. (R1's) groin was very red everywhere. The head of (R1's) penis, from the catheter rubbing and not cared for was actually split. On 5/28/25 at 3:10 PM V2/DON (Director of Nursing) stated that they notified R1's physician via fax on 4/6/25. V2 stated that they never received a response from the physician regarding R1's urinalysis results. V2 confirmed they did not try to get ahold of R1's physician again on 4/6 or 4/7/25 and R1's physician did not provide orders until 4/8/25 for an antibiotic to start on 4/9/25 (three days after facility received urinalysis results). On 5/29/25 at 9:44AM V11/CNA (Certified Nursing Assistant) stated that around two weeks prior to R1 being sent out to the hospital R1 started not being as active as he normally was. V11 stated, Usually I could talk to (R1) and (R1) would talk back. (R1) started sleeping all the time and wasn't eating as much. I did notice (R1's) urine was darker than usual with a little less output. I believe I reported (R1's) urine color and output to (V12/Licensed Practical Nurse/LPN). I usually go to (V12) for most things. We (CNA's) were responsible for catheter care. I noticed (R1's) tip of penis was getting slimy and then would start to crust over. I am not sure what was causing it. On 5/29/25 at 9:55AM V12/LPN stated, At least a week (maybe two weeks) before (R1) went to hospital (R1) was having a decline in his condition. (R1) stopped eating and wouldn't let us get him out of bed. I don't remember anyone reporting (R1's) urine color or output to me, I don't typically monitor that the CNA's usually do. I was at least (R1's) nurse two to three times a week. I reported to (V10/Social Service Director) about (R1's) decline in condition. I did not notify the doctor however and should have. I did not document on (R1's) decline because I was communicating with (V10) regarding hospice, I should have documented. If we notice a change in condition, we should notify the physician immediately. V12 stated that when the nursing staff receives lab results and they are abnormal, they would expect the physician to respond that day. If they don't the next nurse that would come on shift should follow up and if they cannot get ahold of the physician there is an on-call number to call after hours. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/29/25 at 11:27 AM (V14/R1's Physician) confirmed he did not receive R1's urinalysis results, dated 4/6/25, until he was at the facility on 4/8/25 and stated he would have started R1 on an antibiotic for a UTI prior to 4/8/25 if he would have received R1's urinalysis results. V14 stated, It's not right if the (local hospital) had emptied two liters of urine from (R1's) bladder when (R1) arrived at the hospital. I am not sure what orders the facility had to change the urinary catheter, but if the facility staff would have notified me, I would have referred (R1) to a Urologist to assist in caring for (R1's) urinary catheter. Not changing (R1's) (indwelling urinary) catheter since January 2025 could have contributed to (R1's) infection and being hospitalized . I was not made aware of (R1's) declining condition. I last saw (R1) on 4/8/25 and I do not have any record of the facility notifying me of (R1's) change in condition. I would have sent (R1) right to the hospital and not messed with doing anything in house if the facility would have notified me of his condition. V14 verified the facility should have monitored R1's urine color and output every shift. On 6/2/25 at 9:59 AM V18/Hospital Physician stated, I was the admitting physician that admitted (R1) to the hospital on 5/10/25. I did (R1's) assessment. (R1) had an (urinary indwelling) catheter. (R1's) urine looked very, very, dirty and had a lot of sediment in the urine. On 6/2/25 at 11:51 AM V2/DON verified R1's urinary catheter outputs should have been documented every shift. Prior to this survey date, the facility had taken the following action to correct the noncompliance: 1. R1 still remains in the hospital and will not be returning to the facility (as per family.) 2. On 5/13/25 resident chart reviews were conducted for Residents Exhibiting Signs/Symptoms of Dehydration, Hydration Status, and Foley Catheter Status by the clinical team and consulting team. 3. On 5/12/25 V30/Chief Executive Officer in-serviced the facility's interdisciplinary team on Assessments/Identification/Hydration Policy, Signs of Symptoms of Dehydration, and Foley Catheter Policy. 4. On 5/13/25 V2/Director of Nursing in-serviced all licensed nursing staff on Assessments/Identification/Hydration Policy, Signs of Symptoms of Dehydration, and Foley Catheter Policy. 5. On 5/13/25 V2/Director of Nursing in-serviced all CNA's on Foley Catheter Policy and Hydration Policy. 6. On 5/14/25, 5/18/25, 5/27/25, and 6/3/25 V2/Director of Nursing audited three residents on each date to ensure they are receiving catheter care, physician orders to change catheters are in place, care plans are updated, and catheter output is documented. 8. On 5/15/25, 5/22/25, 5/29/25, and 6/5/25 the V1/Administrator held a quality assurance meeting where the results from the quality assurance audits were reviewed, and additional interventions were implemented.

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 obtain physician ordered weekly weights and notify the Physician and Registered Dietitian of a resident's repetitive nutritional supplement refusals, decreased meal consumption, and significant weight loss for a resident with a diagnosis of Severe Protein-Calorie Malnutrition for one of three residents (R1) reviewed for weight loss in a sample of nine. These failures resulted in R1 experiencing a severe significant weight loss of 13.9 percent in less than six months and requiring admission to a local hospital critical care unit for treatment of the diagnoses of Hypernatremia, Acute Metabolic Encephalopathy, and Severe Malnutrition/concern for refeeding syndrome (Fatal Metabolic Response). This past noncompliance occurred from 4/29/25 through 5/13/25. Findings include: The facility's Weight Assessment and Intervention Policy, dated 11/22/24, documents Policy Statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. 2. Weights will be recorded in (Electronic Computer System) under the resident's Weight/Vitals tab. 7. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight equals (usual weight minus actual weight) / (usual weight) times 100): c. 6 months- 10% (percent) weight loss is significant; greater than 10% is severe. 9. If this is an undesirable weight change, resident will be referred to Dietitian, Doctor and family will be notified. Care Planning: 1. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Physician, nursing staff, the Dietitian, the Consultant Pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address to the extent possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment. The facility's Hydration Policy, dated 5/8/24, documents Policy: This facility will strive to provide adequate hydration and to prevent and treat deyhdration. 1. Policy interpretation and Implementation. b. The Physician will be notified of any nutritional or hydration changes. R1's admission Record documents R1 is a [AGE] year-old male who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Unspecified Severe Protein-Calorie Malnutrition, Dementia, and Type Two Diabetes Mellitus with Diabetic Chronic Kidney Disease. R1's Physician's Order dated 1/16/25 documents, Med Pass (Medication) Pass 2.0 Calorie (nutrition supplement) TID (Three Times Daily). R1's Order Summary Report, printed 5/28/25, documents Order date: 1/30/25. Start date: 2/5/25. Weekly weights one time a day every Wednesday for weekly weights. R1's Progress Note, dated 3/29/25 and signed by V7/Dietitian, documents R1's current weight of 151 pounds. This same progress notes documents R1's oral intake typically is 75 - 100% (percent) of meals per day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's MAR (Medication Administration Record) dated, March 2025, documents R1 has an order for weekly weights one time a day every Wednesday for weekly weights and does not document weekly weights on 3/5, 3/12, 3/19, and 3/26/25. R1's MAR dated, April 2025, documents R1 has an order for weekly weights one time a day every Wednesday for weekly weights and does not document weekly weights on 4/2, 4/9, 4/16, and 4/30/25. This same MAR documents a physician order for Med (Medication) Pass 2.0 Calorie (nutrition supplement) three times a day related to unspecified severe protein-calorie intake administer 90 ml (milliliters). From 4/1 through 4/30/25 this same MAR does not document milliliters consumed of the Med Pass. R1's MAR, dated May 2025, documents R1 has a physician order for Med Pass. This same MAR documents on 5/1, 5/3, and 5/4/25 at 9:00 AM R1 consumed zero milliliters of med pass, on 5/1, 5/4, and 5/9/25 at 2:00 PM R1 consumed zero milliliters of med pass, and on 5/1, 5/2, and 5/3/25 at 8:00 PM R1 consumed zero milliliters of med pass. R1's Nutritional Risk assessment dated [DATE] and signed by V7 (Dietitian) documents R1's weight on 4/18/25 was 150.5 pounds and within one-week R1 lost seven pounds, weighing 143.5 pounds on 04/23/25. This same Nutritional Risk Assessment documents R1's seven-pound weight loss was undesirable and V7 ordered an increase in R1's med pass to 60 ml three times daily, even though R1 has been receiving med pass 60 ml three times daily since 1/16/25. R1's MDS (Minimum Data Set) Assessment, dated 5/10/25, documents R1 had a weight loss of five % or more in the last month or loss of ten % or more in the last six months and was not on a physician-prescribed weight loss regimen. R1's Percentage of Meal, dated 4/29/25 through 5/9/25 does not document consistent meal percentages consumed. This forms documents in eleven days R1 consumed 26 to 50% of a meal four times and in eleven days consumed zero to 25% of a meal 15 times. This same form documents in eleven days R1 refused or did not receive a meal three times. R1's Weights and Vital Summary, dated 5/29/25, documents R1's weights on 12/22/24 was 157lbs (pounds), on 4/18/25 was 150.5lbs and on 5/7/25 was 135.2lbs, reflecting a 13.9% (percent) weight loss in less than six months and a 10.2% weight loss from 4/18/25 to 5/7/25 (less than three weeks). R1's Progress Note, dated 5/8/25 and signed by V3/ADON (Assistant Director of Nursing), documents Weight Warning: (R1) continues to lose weight due to poor appetite. (R1) is on med pass during the day. Remeron may need to be increased due to poor appetite. (R1) refuses to eat even when fed. Message sent to (family members) about a possible hospice evaluation. R1's Electronic Health Record does not include documentation of V14 (R1's Physician) or V7 (Dietitian) being notified of R1's 13.9 % weight loss within six months as of 5-7-25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, and R1's decreased consumption of med pass between 5/1/25 through 5/9/25. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's Care Plan dated 5/20/25, documents Date Initiated 12/23/2024: (R1) has potential for altered nutrition and hydration related to diagnoses of Type Two Diabetes Mellitus, Dementia, and Cancer. (R1) also limits himself on foods he eats. Gluten free, no red meat or pork. Goal: (R1) will have no signs or symptoms of altered nutrition/hydration through review date. Interventions dated 12/23/24: Monitor weights as ordered and notify Physician of significant Weight Change. R1's Care Plan does not include any revisions or nutritional interventions to address R1's seven pound weight loss within one week on 4/23/25, R1's 13.9 % weight loss within six months as of 5-7-25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, or R1's decreased consumption of med pass between 5/1/25 through 5/9/25, until 5-8-25 (two days before (R1) was admitted to the hospital). On 5-8-25 R1's Nutritional Care Plan documents, 5-8-25 Encourage (R1) to eat all meals in the dining room and chart any refusals. Notify physician of any further increase in oral intake for appropriate intervention. Provide supplements as ordered-refer to MAR. Staff to provide supervision with cueing during mealtimes. R1's Progress Note, dated 5/9/25 and signed by V10/SSD (Social Service Director/SSD), documents (V10) contacted (V8/R1's Family Member) regarding the decline in (R1). (V10) talked about (R1's) significant weight loss, refusing to eat, and wounds. (V10) explained hospice care or gastrostomy for nutrition. (V8) stated he wanted to talk with (V16/R1's Family Member) first before deciding what to do. (V8) stated that the earliest he would be able to come from out of town would be around 6/1/25. (V10) told (V8) that he needs to make a decision before then. (V8) is going to call back once he speaks with (V16). (V10) will follow up. R1's Progress Note, dated 5/10/25 and signed by V15/RN (Registered Nurse), documents (R1) lethargic with involuntary jerking, very slow to respond, increased weakness and fatigue noted, slow to responds and slurred speech, hypotension noted, Blood Pressure 66 systolic/44 diastolic. Emergency Contact (V16/R1's Family Member) notified and request (R1) be evaluated at Emergency Room. 911 called and Emergency Medical Transport arrived, paramedics placed on IV (Intravenous Fluids) at facility and administered EKG (Electrocardiogram). (R1) in route to (local hospital) at this time. R1's Hospital History and Physical, dated 5/10/25 and signed by V18/Hospital Physician, documents Physical Exam: General- [AGE] year-old male poorly built, poorly nourished, appears to be in moderate distress. Assessment/Plan: Dehydration: (R1's) baseline creatinine is around 1. Current creatinine is around 3.3, which improved from 4.9 with intravenous fluids. (R1) is severely dehydrated on arrival. Hypernatremia: Likely from poor oral intake. Switch intravenous fluids to D5W (dextrose and water) after reviewing labs. Acute Metabolic Encephalopathy: (R1) is alert, not oriented to time, place or person. Not able to follow commands. Ordered computed tomography brain as well. Encephalopathy is multifactorial likely from infection, dehydration, hypernatremia. Severe malnutrition: Concern for Refeeding Syndrome: (R1) appeared malnourished. BMI (Body Mass Index) is 18.4. Will consult dietitian once (R1) mentation improves. (R1) is at high risk for refeeding syndrome. Will monitor and replete electrolytes closely. On 5/28/25 at 1:54 PM V6 (Hospital Registered Nurse) stated that she was the admitting nurse when R1 got admitted to the ICU (Intensive Care Unit) on 5/10/25 and R1 appeared severely malnourished, thin, and dehydrated. V6 stated, (R1) had to of not been eating or drinking anything or very little for days. It was one of the worst things I have seen, I felt completely horrible for (R1). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Healthcare of Pekin	2501 Allentown Road Pekin, IL 61554

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/29/25 at 9:44 AM V11/CNA (Certified Nursing Assistant) stated around two weeks prior to R1 being sent out to the hospital R1 started not being as active as he normally was. V11 stated, Usually I could talk to (R1) and (R1) would talk back. (R1) started sleeping all the time and wasn't eating as much. On 5/29/25 at 9:55AM V12/LPN (Licensed Practical Nurse) stated, At least a week (maybe two weeks) before (R1) went to hospital (R1) was having a decline in his condition. (R1) stopped eating and wouldn't let us get him out of bed. I was at least (R1's) nurse two to three times a week. On 5/29/25 at 10:15 AM V13/LPN stated I went to (V10/Social Service Director) regarding a hospice consult around a week or so prior to (R1) being sent to the local hospital. I noticed (R1) was not eating and was having failure to thrive. I did not notify (V7/Dietitian) or (V14/R1's Physician) of my concerns with (R1) not eating and should have. Typically, we would fill out an SBAR (Situation, Background, Assessment, and Recommendation) and would send it to the doctor. I just assumed (V14) had already seen (R1) recently. On 5/29/25 at 3:43 PM V15/LPN stated I know (R1) hadn't been eating or drinking very well for a while. (R1) would just lay there. On 4/26/25 I received an order from (V14/R1's Physician) to start (R1) on Mirtazapine, but I did not notify (V14/R1's Physician) of R1 refusing any meals or drinks and/or losing weight after that. I know the week prior to (R1) being sent to the hospital (R1) was not wanting to eat or drink anything when I was there. On 5/29/25 at 11:27 AM V14/R1's Physician stated the last time he had visited R1 was on 4/8/25. V14 verified he was not made aware of R1 repetitive refusals of eating and drinking his med pass, refusing weekly weights, R1's significant weight loss, or R1's decline. V14 stated, I was not aware of R1's condition after 4/8/25. I last saw (R1) on 4/8/25 and I do not have any record the facility notified me of any major changes in (R1's) condition. On 5/29/25 at 2:54 PM V7/Dietitian verified the lack of R1 eating and drinking would have led to hypernatremia. The last time I reviewed (R1) was on 4/29/25. I was not aware of the significant weight loss that triggered on 5/7/25. I was aware that (R1's) oral intake had decreased when I reviewed him on 4/29/25. I was not aware that (R1) had not been drinking his Med Pass 2.0 or I wouldn't have suggested to increase his Med Pass from 60 ml (milliliters) to 90 ml. If (R1) was having a significant decline with eating and drinking that is a pattern, then they should be letting me know right away as well as documenting it every shift so I can review it. On 6/2/25 at 9:59 AM V18/Hospital Physician stated, I was the admitting physician that admitted (R1) to the hospital on 5/10/25. I did (R1's) assessment. (R1) appeared very malnourished and thin. (R1) did not get like that in just one day. I felt (R1) should have been hospitalized well before he was sent to us. On 6/2/25 at 11:51 AM V2/Director of Nursing verified R1's Electronic Health Record does not include documentation of V14 (R1's Physician) or V7 (Dietitian) being notified of R1's 13.9 % weight loss within six months as of 5-7-25, R1's decrease in meal consumption and refusal of meals between 4/29/25 through 5/9/25, and R1's decreased consumption of med pass between 5/1/25 through 5/9/25, or R1's nutritional care plan not being revised until 5-8-25. V2 also stated, If (R1) was refusing weights or his meals/drinks the physician should have been notified at that time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prior to the survey date, the facility had taken the following action to correct the noncompliance: 1. R1 still remains in the hospital and will not be returning to the facility (as per family.) 2. On 5/13/25 resident chart reviews were conducted for the following areas: Significant Weight Change, Resident Exhibiting Signs/Symptoms of Dehydration, and Hydration Status. 3. On 5/12/25 V30/Chief Executive Officer in-serviced the facility's interdisciplinary team on the Assessment/Identification/Hydration Policy, Signs of Symptoms of Dehydration, Facility Weight and Nutrition Policy, and Physician and Interested Party Notification. 4. On 5/13/25 V2/Director of Nursing in-serviced all licensed nursing staff on the Assessments/Identification/Hydration Policy, Signs of Symptoms of Dehydration, Facility Weight and Nutrition Policy, and Physician and Interested Party Notification. 5. On 5/13/25 V2/Director of Nursing in-serviced all CNA's on Facility Weight and Nutrition Policy. 6. On 5/14/25, 5/18/25, 5/27/25, and 6/3/25 V2/Director of Nursing audited three residents on each date to ensure weekly weights are being done for a resident with physician ordered weekly weights, significant weight losses are being identified, physician and dietician notification is being done regarding the significant weight loss and any nutritional refusals. 7. On 5/15/25, 5/22/25, 5/29/25, and 6/5/25 the V1/Administrator held a quality assurance meeting where the results from the quality assurance audits were reviewed, and additional interventions were implemented.