STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008239	A. BUILDING: _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE	2120 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Health Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 1. 300.610a) 300.1210b) 300.1210d)5 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on interview, observation and record review, the facility failed to implement intervention to prevent, timely identify, and monitor pressure ulcers for 2 of 5 residents (R3, R113) reviewed for pressure ulcers in the sample of 31. This failure resulted in R113 developing an unstageable pressure ulcer to her right buttocks five days after admission. Findings include: 1. R113's Order Summary Report, dated 4/18/23, documents that R113 was admitted on 4/13/23 with diagnoses of a fracture of left femur, Type 2 Diabetes Mellitus and Peripheral Vascular Disease.	S9999		

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R113's Nurse (N) Advance (Adv) -Clinical Admission Form, dated 4/13/23, documents, R113 arrived at the facility via transport another facility. The Form documented R113 used a wheelchair. It continues, " Resident is alert & (and) oriented x (times) 3. Oriented to place. Oriented to time. Oriented to person." The Form documented that R113 had a pressure ulcer/injury to R113's left buttock measuring 3.2 centimeters (cm) length by 2.8 cm width.

R113's N Adv - Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 4/13/23, documents, "Braden Evaluation: Sensory Perception: No impairment. Moisture: Occasionally moist. Activity: Chairfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: Adequate. Friction and shear: Potential problem. N Adv - BRADEN Score: 17.0."

R113's Health status Note, dated 4/17/23, documents, "Resident seen today in facility by (V18 Nurse Practitioner) with New orders for: Facility wound doctor to evaluate and treat for left buttocks wound - (pressure relieving) cushion on wheelchair and bed -Patient requesting bariatric bed."

On 4/17/23 at 10:05 AM, R113 was lying in bed with a knee immobilizer on. R113 was on a regular mattress and has no side rails for turning and repositioning. R113 stated that she was recently admitted because she broke her femur above her below the knee amputation, she is a diabetic and goes to renal dialysis 3 times a week. R113's stated that she believes she has a wound on her buttocks. R113 stated, "I think I got it here. I have been asking for a better mattress

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and side rails, but I haven't gotten either yet. I really want the side rails so I can turn and reposition myself. It is hard to move with this knee immobilizer on."

On 4/18/23 at 8:10 AM, R113 was lying in bed. R113 has the same mattress as 4/17/23 and no side rails on her bed. R113 stated, "The nurse last night found a new area on my buttocks. She called the doctor, and he wants me to have a CT (Computerized Tomography) scan."

On 04/18/23 at 12:56 PM, V11, Licensed Practical Nurse (LPN), Wound Nurse, stated, "She (R113) developed an in-house pressure ulcer to her right buttock., The night nurse called (V16, Physician), and he said send her to ER (Emergency Room) and get a CT. I think he was half asleep because it was in the middle of the night the wound is 2 (centimeters) x (by) 2. (R113) did not want to do that. This morning I called him, and he wants an Xray to rule out osteomyelitis. I contacted our wound doctor, (V17 Wound Doctor), and got orders for a sheet of thera honey and cover with a dry dressing bid (twice a day). I looked into her history because she has been here before and last time, she had a pressure ulcer in the same spot."

R113's Health Status Note, dated 4/18/23 at 06:34 AM, documents, "Resident has open area to right buttocks, 3cm x 3cm, heavy dark serosanguinous drainage with foul odor noted, resident c/o (complaint of) pain 7 out of 10, notified PCP (Primary Care Provider), rcvd (received) an order to send resident to ER for CT scan and rcvd a referral order to see Wound MD for eval (evaluation) and tx (treatment), resident made aware of n.o. (new order)"

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S9999	Continued From page 4 R113's Health Status Note, dated 4/18/23 at 09:05 AM, documents, "Wound MD gave order to cleanse right upper buttock with wound wash and pat dry and then apply thera honey sheet to right upper buttock and cover with dry dressing twice daily." R113's Health Status Note, dated 4/18/23 at 2:05 PM, documents, "Received call from (V18) who states no need for CT or x-ray since wound isn't open and just continue with her orders for pressure relief equipment, resident currently has air loss mattress on bed with bariatric bed and side rails." R113's Ulcer / Wound documentation, dated 4/18/23, documents that R113 has an unstageable pressure ulcer on her right buttock that measures 2 centimeters x 2 centimeters that has moderate serous drainage. On 4/18/23 at 9:00 AM, V11 Wound Nurse, entered R113's room to change R113's right buttock pressure ulcer dressing. R113 was rolled onto her left side. V11 removed the old dressing that was on the right buttock. R113 stated that removing the dressing hurt the pressure ulcer. The dressing had a moderate amount of black, brown drainage on it. The wound was the approximate size of a quarter. The peri wound was red. The wound bed was black. 2. R3's Admission Profile, print date of 4/19/23, documents that R3 was admitted on 6/23/22 and has diagnoses of Metabolic Encephalopathy and Epilepsy. R3's Hospice Admitting Orders, dated 4/4/23, documents admitted to hospice on 4/4/23 with severe protein malnutrition. Activity: bedrest turn	S9999		

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S9999	Continued From page 5 every 2 hours. Skin Care Orders: Clean open areas twice daily." R3's Minimum Data Set, dated 1/10/23, documents that R3 is severely cognitively impaired and requires extensive assistance of 1 staff member for bed mobility. R3's Braden Scale for predicting pressure ulcers, dated 4/4/23, documents that R3 is at high risk of developing a pressure ulcer. R3's Hospice Nursing Initial Comprehensive Admission Assessment, dated 4/4/23, documents that R3 has a coccyx Stage 2 pressure ulcer measuring 1 cm x 1 cm x 0.1 cm with a pink bloody wound bed and a right heel pressure ulcer that is unstageable that measures 2 cm x 3 cm. R3's Ulcer / Wound documentation, dated 4/12/23, documents that R3 has an unstageable pressure ulcer to the sacrum that measures 2 cm x 2 cm. R3 Medical Record fails to document on R3's right heel pressure ulcer on 4/12/23. R3's Ulcer / Wound documentation, dated 4/19/23, documents that R3 has a Stage 2 pressure ulcer to the sacrum that measures 3 cm x 2.5 cm. R3's Ulcer / Wound documentation, dated 4/19/23, documents that R3 has an unstageable Pressure ulcer of the right heel measuring 3.5 cm x 4 cm, the wound bed is Necrotic tissue and that the pressure ulcer was first identified on 4/19/23. R3's Ulcer / Wound documentation, dated 4/19/23, documents that R3 has a deep tissue	S9999		

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S9999	Continued From page 6 injury on the right lateral foot measuring 0.5 cm x 0.5 cm that was first identified on 4/19/23. R3's Physician Orders, print date 4/11/23, documents, "Monitor black area of right heel start date of 4/11/23, Cleanse open area to coccyx with soap and h2o (water) or saline apply optifoam drsg (dressing) change every 5 days and PRN (as needed) when soiled or dislodge start date of 4/4/23, Resident may stay in bed and turn and reposition q (every) 2hrs (hours) start date of 4/4/23. On 4/18/23 at 3:10 PM, V11, Wound Nurse, stated, "(R3) has not had her right heel measured. She got that wound while she was in the hospital, but I cannot find any documentation of that. She came back from the hospital on hospice, and they ordered just to monitor the wound. (R3's) son is a doctor and he does not want any treatment done to her pressure ulcers." On 4/19/23 at 2:10 PM, V11, stated that R3's right heel was never measured because the pressure ulcer was not put onto the 24-hour report, so I didn't know about it. Pressure ulcers should be measured every week at least." On 4/19/23 at 8:25 AM, R3 is lying on her back with the head of the bed elevated 20 degrees. R3 is wearing bilateral heel boots. The right foot is in the middle of the boot not in the heel pocket of the boot. On 4/19/23 from 8:25 AM to 11:20 AM, based on 15 minute or less interval observations R3 was not given the benefit of turning or repositioning to relieve pressure. On 4/19/23 at 11:20 AM, V21, Certified Nurse's	S9999		

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S9999	Continued From page 7 Aide, entered R3's room to provide incontinent care. R3's incontinent brief was removed. R3's buttocks were red with crease marks on it. R3's back was red with crease marks on it also. At that time, R3 was wearing bilateral heel boots. R3's right foot was in the middle of the boot not in the heel pocket. At 11:30 AM, V11 and V12 both LPNs entered the room to change R3's sacrum pressure ulcer dressing and to exam R3's right heel. The sacrum pressure ulcer measured 3 cm x 2.5 cm. The wound bed is covered in 50% slough and the other 50% is red tissue. The pressure ulcer was cleansed with wound cleanser and a border foam dressing was applied. R3's bilateral heel boots were removed. R3's right heel has a dark black necrotic pressure ulcer measuring 3.5 cm x 4 cm. R3's right lateral foot has a pressure ulcer measuring 0.5 cm x 0.5 cm that is black and necrotic. R3's left heel has an area that is dark pink the approximate size of a quarter. R3's heel boots were reapplied. On 4/19/23 at 11:30 AM, V12, LPN, stated, "I have not been here in 4 days the last time I saw her heel it was just red. It was about the same size." V12 further stated that R3's left heel is soft. On 4/19/23 at 11:30 AM, V11, LPN, stated, "I have not seen her heel until now. I am going to call hospice and see about getting her a pressure relief mattress. The interventions (to prevent pressure ulcers) for her are her boots and turning and repositioning." V11 was questioned if he knew about the area on the outside of R3's right foot before it was noticed it by the surveyor, V11 stated that he did not know about it until it was pointed out. On 4/19/23 at 4:10 PM, V2, Director of Nurses and V20, Regional Nurse, both stated that they	S9999		

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expect pressure relieving devices to be put into place for a resident at risk for pressure ulcers and used correctly, turning and repositioning should be done, measuring of the pressure ulcer should be done weekly or if there is a worsening of the pressure ulcer and no one should sustain a pressure ulcer while they are at the facility. V20 further stated that since it was known that R113 had previous pressure ulcers R113 should have had a preventative mattress and side rails to aide in repositioning as soon as possible.

The policy Wound & Ulcer Policy and Procedure, dated 1/10/2018, documents, "Wound & Ulcer Policy and Procedure. It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: All residents will be assessed to determine the degree of risk of developing a pressure ulcer using the Braden Scale - Ulcer risk Assessment. the resident will be assessed upon admission, once a week for four weeks, and monthly thereafter. Protocols may include any or all of the following based upon the needs and condition of the resident. Additional measures may be added at the discretion of the facility. High Risk Protocol: Residents with existing ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment Score. Daily skin checks completed by direct care staff. The "Skin Observation Report" may be used to communicate skin observation or changes to the nurse. Specialty mattress (low air loss, alternating pressure, etc.) with enhanced pressure reducing / relieving properties may be placed on the resident's bed and chair as indicated. Skin contact surfaces may be padded to protect boney prominences. Range of motion may be provided

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S9999	Continued From page 9 if clinically indicated. The resident may be placed on a turn and position schedule if clinically indicated." It continues, "When a resident is found to have a wound our licensed nurse will complete ulcer, either on admission or during their stay, the following: Document assessment of the wound / ulcer in the medical record. Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessed. The classification and treatment of wounds, including ulcers, will follow the wound management program protocols for the wound type / ulcer stage assessed unless otherwise specified by the physician. Document wound / ulcer treatment provisions on the treatment administrations record." It continues, "Assessment of progress toward healing in completed at least weekly and the physician is notified at least monthly of progress toward healing. If there is regression, the physician is notified of the condition change." (B) 2 of 2 Licensure Violations 300.610a) 300.1210b) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.	S9999		

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S9999	Continued From page 10 The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor, provide progressive intervention, implement dietician recommendations, and encourage the resident to eat or offer substation for 1 of 6 residents (R40) reviewed for weight loss. This failure resulted in R40 having a 19% weight loss in 3 months and a 23.8% weight loss in 6 months. Finding includes: R40's Care Plan, dated 09/20/2021, documented, "Eating: supervision with set up/clean up assistance."	S9999		

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R40's Minimum Data Set, dated 01/05/2023, documented that R40 required supervision with 1-person physical assistance for eating.

On 04/17/2023 at 12:31 PM, R40 was in bed with the head of her bed elevated and her meal tray sitting in front of her, with the lid off. On her tray was a piece of ham, not cut up, a baked sweet potato, without any butter nor was it cut up, a biscuit, not buttered or cut up and green beans. R40 had not eaten any food on the tray. R40 had some broken front teeth and 1 tooth totally intact. From 12:30 PM to 1:30 PM R40's room was under continuous observation. No staff member entered nor was any eating encouragement given.

On 04/17/2023 at 01:30 PM, V13, Certified Nurse's Assistant picked up R40s tray and placed it on the hall cart. When asked how much R40 consumed of her meal, V13 stated that she only took a couple of drinks but didn't touch her food. R40's meal tray was covered with a dome and under dome was a piece of ham, not cut up, a baked sweet potato, not cut up, biscuit and green beans.

On 04/19/2023 at 12:05 PM, a staff member served R40 her lunch tray. The staff member cut up R40's meat, pepper steak, buttered her biscuit and made sure all of her lids to her drinks were off. At 12:10 PM, R40 was sitting at the table and had not even took a bite of her food or a drink of any of her fluids. No staff members approached her to give her verbal cues to remind her to eat. Then at 12:15 PM, R40 was still sitting at the dining room table and had not even attempted to feed herself nor did any of the staff members assist or cue her to eat. At 12:20 PM, V13 asked R40 if she wanted to drink her milk and she told

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him she wanted chocolate milk. V13 went and retrieved a carton of milk for her, opened it and poured it in a cup with a handle. He then handed it to her, and she started to drink it. At 12:30 PM, R40 drank most of her chocolate milk but no staff gave her any verbal cues to eat or offer any other substations for her meal.
On 04/19/2023 at 02:00 PM, R40 stated that she did not care for the lunch today when she was asked.

R40's weight log documented weights on 05/12/2022 as 161.7 and on 08/08/2022 at 143.6 pounds as this was a 11.19% weight loss in three months.

R40's weight log documented weights on 10/01/2022 as 158.4 and on 03/31/2023 as 120.7 pounds as this was a 23.8% weight loss in six months.

R40's Dietician's Note, dated 05/23/2022 at 2:11 PM, documented, "Nutrition Note Text: RD monthly weight note: Current weight is 161.7# (5/12/22). Weight is stable over the past month from 162#(4/5/22). She continues to trigger for significant wt. (weight) loss. Weight is down 11.6%(21.3#) over the past 5 months from 183#(12/8/21). BMI (Body Mass Index) is 27.8 (overweight but acceptable per age). Diet is LCS (low concentrated sweets) with thin liquids. She feeds herself. Intake has been variable lately due to AMS/confusion/hallucinations. often poor <25%. increased behaviors noted. Variable intake meal to meal with some refusals. Weight loss likely r/t (related to) confusion and hospitalization. Supplements include 60 ml (milliliters) med (medication) pass TID (three times daily) which were recently increased. Blood glucose levels have ranged 88-184mg(milligrams)/dL(deciliter)

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	IL6008239	A. BUILDING: _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE	2120 WEST WASHINGTON SPRINGFIELD, IL 62702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the past month. Skin: No edema noted. meds reviewed Continue to encourage adequate intake. increase supplements. liberalize diet. Monitor nutritional parameters. RD (registered dietician) f/up (follow-up) PRN (as needed)."

R40's Dietary note, dated 05/31/2022 at 10:27 AM, documented, "Note Text: 5 day completed. (R40) is currently on a LCS (low concentrated sweets) diet with thin liquids and is receiving 60cc (cubic centimeters) med (medication) pass TID (three times daily). She consumes varies amounts of her meals but lately 0-25% with an average fluid intake of 360ml per meal sometimes more. Her current weight is 161.7 pounds with BMI of 27.8. Dietary will continue to provide ordered diet, monitor her weight, monitor her for her changing needs, and refer her to the dietitian PRN (as needed)."

R40's Dietician's Note, dated 08/10/2022 at 1:33 PM, documented, "Nutrition Note Text: RD monthly weight note: Current weight is 143.6#(8/8/22). 146.5#(7/6/22) Weight is down 16.7% over the past month 6 months from 172.4#(2/11/22). wt. hx (weight history): 153.9#(6/9/22); 169.5#(1/20/22). Weight has continued to decline. BMI is 24.6(WNL). Intake is poor and she has been refusing to eat. Diet remains LCS with thin liquids. She feeds herself. Intake has been variable lately due to AMS/confusion/hallucinations. often poor <25%. increased behaviors noted. Variable intake meal to meal with many refusals. Weight loss likely r/t confusion and poor appetite. Supplements include 90ml med pass TID. Blood glucose levels have been acceptable most often this past month.
Rec adding high protein ice cream with meals and liberalize diet to regular.

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S9999	Continued From page 14 Skin: No edema noted. meds reviewed Continue to encourage adequate intake. continued increased supplements. offer between meal snacks. Monitor nutritional parameters. RD f/up PRN." R40's Dietary Note, dated 10/10/2022 at 11:23 AM, documented, "Dietary Note Text: Readmission completed. (R40) is currently on a cardiac diet with thin liquids. She is consuming 51-75% of her meals with an average fluid intake of 241ml-480ml per meal. Her current weight is 158.4 pounds with a BMI of 27.2. Dietary will continue to provide order diet, monitor her weight, monitor her intakes, and refer her to dietitian PRN." R40's Dieticians Note, dated 02/28/2023 at 08:30 AM, documented, "Nutrition Note Text: RD Wt. (weight)/Skin Note: Stage 3 pressure injury to sacrum. Previously healed in August but has reopened per DON. Tx (Treatment) in place. Current Ht-64", Current Wt-122.2#, BMI-21.0 Noted higher wts on 1/3 and 2/1 likely scale errors. Nursing to review wt. and reweigh to confirm loss. CBW is a 12.6% loss x 5 mo. Also noted a 17.9% loss x 2 mo (months) (12/6 wt.=148.8#). Poor PO noted at many meals. Fluid changes w/ CHF (Congestive Heart Failure) and diuretic rx (medication) could also influence wt. BMI is healthy and wt within IBW range. Further wt loss not desirable for resident. Diet Rx: NAS (no added salt)/reg/thin, 60ml med pass TID. Many intakes <25%, but a few meals in 26-75% range. No chew/swallow concerns noted. 2/10 Hgb A1c 5.3. Recent D/C of DM meds and accuchecks per MD. Will cont. to monitor A1c. Recommend 30ml liquid protein AWC d/t stage 3 wound. Due to wt. loss and poor PO, suggest MD consider addition of appetite stimulant.	S9999		

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Diet/supplements adequate to meet/exceed needs and support healing. RD prn."

R40's Progress notes were reviewed and there was not documentation that R40's physician was notified of weight loss, nor was it documented about asking for an appetite stimulant.

R40's Dietician Notes, dated 03/22/2023 at 12:07 PM, documented, "Nutrition Note Text: RD Wt/Skin Note: Stage 3 pressure injury to sacrum. Previously healed in August but has reopened per DON. Tx in place, improving per most recent Wound MD review. Current Ht-64", Current Wt-122.8#, BMI-21.1. Per Wt Exception Summary wt loss of 22.5% from wt on 10-1-22. Wt stable x 1 mos. Poor PO noted at many meals. Fluid changes w/ CHF and diuretic rx could also influence wt. BMI is healthy and wt within IBW range. Further wt loss not desirable for resident. Diet Rx: NAS/reg/thin, 60ml med pass TID. Many intakes <25%, but a few meals in 26-75% range. No chew/swallow concerns noted. Recently began receiving 30mL Liquid PRO daily. Meds reviewed, no nutrition-related med changes since last RD review. No recent labs available to review. Diet and supplements exceed estimated needs and are appropriate to support skin healing. RD will continue to monitor and f/u PRN."

On 04/19/2023 at 02:20 PM, V10, Dietary Manager stated that R40 was placed on Med Pass 3 times a day on 12/22/22 they have been trying to stabilize her weight since then. She also stated that R40's meal intake has been decreased. V10 continued to state that R40 is not one of the residents that the normally watch or assist. V10 continued to state that she reviews weights weekly looking for a 5% to 10% weight gain or weight loss and then sends a report to the

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S9999	Continued From page 16 nurse management team and the dietician. On 04/20/2023 at 10:00 AM, V24, Dietician, stated that nursing should have assisted R40 with her meals and that R40's weight loss has slowed down and has been minimized. On 04/20/2023 at 11:10 AM, V26, Certified Nurse Assistant (CNA) stated that it depends on R40's mood if she wants to eat or not but she likes to drink. V26 continued to state that R40 does require verbal cueing to eat her meals. On 04/20/2023 at 11:15 AM, V27, CNA, stated that R40 requires assistance with eating her meals. On 04/20/2023 at 10:05 AM V2, Director of Nurses stated that the staff should assist R40 if she is not eating or offer substitutes. V2, stated that she did not know that the Dietician recommend that R40 be on an appetite stimulant because she was not here at the facility at that time, but she will look into it. The Facility's policy, "Weight Management Policy and Procedure," dated 2/2016, documented, "Any resident with a significant or insidious weight change will be referred to the dietitian for assessment of condition. The dietitian will implement any necessary clinical interventions or make recommendations regarding diet and supplementation to the physician. The physician will be notified of any significant weight change and be made aware of any recommendations made by the dietitian." (B)	S9999		