STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF SWANSEA	1405 NORTH SECOND STREET , SWANSEA, Illinois, 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2592568/IL2547798 2590814/IL2547678 Final Observations	S0000		09/19/2025
S9999	Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210c) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and	S9999		09/19/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

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S9999	Continued from page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Requirements were not met as evidenced by:Based on interview and record review, the facility failed to initiate, implement, and add progressive care plan intervention for 2 of 3 residents (R5 and R8) reviewed for falls in a sample of 23. This failure resulted in R5 falling and sustaining a laceration to his head and R8 falling and sustaining a fracture to her left wrist.1. R8's Admission Record, print date of 08/05/25, documented R8 has diagnoses of but not limited to Multiple Sclerosis and other abnormalities of gait and mobility. R8's Minimum Data Set (MDS), 05/27/25, documented R8 is cognitively intact with a brief interview of mental status (BIMS) of 14 out of 15 and she requires substantial/maximum assistance from staff for toileting hygiene and she requires partial/moderate assistance with transfers from bed to chair and toilet transfers. R8's Baseline Care Plan, dated 05/16/25, documented under section Functional Abilities and Goals- Mobility for toilet transfer: The ability to get on and off a toilet or commode not assessed/no information. Under safety risks does resident have a history of falls? There was no documentation noted. R8's Care Plan, admission date of 05/16/25, documented R8 has had an actual fall with injury to left wrist Poor Balance, Poor communication/comprehension,	S9999		

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S9999	Continued from page 2 Unsteady gait (Date initiated 07/03/25). Goal: resident's left wrist will resolve without complication by review date. Interventions include but not limited to Resident will ask for assistance with transfers. R8's Un-witnessed Fall, dated 07/02/25 at 10:50 AM, documented the nurse heard someone yelling for help, sound coming from 200 hall shower room. Resident observed sitting on the floor near toilet in shower room. No emergency light flashing for assistance at time of incident. Resident stated "I fell trying to go to the bathroom. I think I broke my hands and wrists when I fell." A full body assessment was completed and there was bruising noted to the back of bilateral hands. STAT x-ray was ordered. Predisposing Physical Factors were gait imbalance, predisposing situation factors ambulating without assist and during transfer. R8's Progress Notes, dated 7/2/2025 at 11:08 AM, documented Incident Note Nurse heard someone yelling for help, sound coming from 200 hall shower room. Resident observed sitting on the floor near toilet in shower room. No emergency light flashing for assistance at time of incident. Resident stated "I fell trying to go to the bathroom. I think I broke my hands & wrists when I fell". Full body assessment completed. Bruising noted to BILAT (bilateral) wrists. ROM (range of motion) WNL (within normal limits) to BILAT Upper extremities. ROM WNL to BILAT Lower extremities. Resident stated she "did not hit her head". C/O (complained of) pain to wrists/hands BILAT. No other c/o pain noted. Resident assisted to toilet and into w/c (wheelchair) after. Ice applied to BILAT wrists/hands. STAT X-rays orders of BILAT upper extremities. MD (medical doctor), DON (director of nursing), Administrator made aware immediately. POA (Power of Attorney) to be made aware. R8's Progress Notes, dated 7/2/2025 at 11:37 AM, documented Note Text: Biotech Xray Tech here to obtain x-rays of BILAT wrists/hands. Awaiting results. R8's Progress Notes, dated 7/2/2025 at 2:55 PM, documented POA contacted and given update on results (negative/no Fx's (fractures) noted) and assured that if any new orders are received, she would be notified. R8's Progress Notes, dated 7/3/2025 at 10:53 AM, documented Biotech called back with update stating that the Medical Director will be reviewing the reading we received from yesterday's x-ray since there had been a discrepancy in reading with new results stating the L (left) wrist has a transverse fracture of the distal radius.	S9999		

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S9999	Continued from page 3 R8's X-ray report, dated 07/02/25, documented Findings: There is no significant soft tissue swelling appreciated. There is a traverse fracture of the distal radius. Impression: transverse fracture of the distal radius. R8's Progress Notes, dated 7/3/2025 at 12:56 PM, documented Ambulance arrived to transport resident to local hospital related to (r/t) left wrist swelling r/t fall. Bruising and visible swelling to Left wrist. Able to make needs know and voice discomfort upon discharge (d/c). Refused noon medication upon leaving. R8's Physician's Orders, dated 07/07/25, Occupational Therapy (OT) clarification order: OT to treat 3-5x/wk (times/week) x 41 days for ADL retraining, neuro re-ed, therapeutic activities, therapeutic exercise and group therapy as per Plan of Care (POC). R8's Physician's Orders, dated 07/08/25, documented Physical Therapy (PT) clarification order: Skilled PT 3-5x/week for 41 days with treatment to include therapy exercises (ex), therapy activities (act), neuro re-ed, gait training, group and manual therapy for treatment of diagnoses M62.81 and R26.81 per PT initial POC. R8's Illinois Department of Public Health Long- Term Care Facility & IID- Serious Injury Incident and Communicable Disease Report, Incident Date of 07/03/25, documented Final Report R8 had a fall with physical harm or injury. She uses a wheelchair and is a transfer with two assists. R8 is interviewable, can make informed decisions, and is alert and oriented times three. The conclusion: R8 suffered a transverse fracture of the distal radius to the left wrist during a fall where she was transferring without asking for assistance. R8 does have several diagnoses that would make her more susceptible to fractures. Root cause of that fall was due to R8 lack of safety awareness which is shown by not asking for assistance or use of a call light, nor did she turn on the lights while trying to self-transfer. R8 was educated (BIMS 14) and reminded to use call light system if needing assistance. R8 stated understanding. On 08/19/25 at 9:05 AM, R8 had an orange plaster cast on her left hand and wrist. She (R8) said she fell while trying to go to the bathroom. She said she was using the bathroom in the shower room when she fell. She said there was no handrail to help her, and she feels that is part of the reason she fell. On 08/25/25 at 11:06 AM, V10, Regional Maintenance Man	S9999		

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S9999	Continued from page 4 said not all of the bathrooms have handrails in them. He said they would do a safety assessment on the resident first and if they had no issues with them, they would install the handrails. He said as far as he knows there is no regulation about having handrails in the bathrooms. On 8/26/25 at 1:02 PM, Follow up interview with R8. R8 was propelling self-down hall in wheelchair. Stated she goes to the bathroom by herself and went to the bathroom by herself before she broke her wrist. Denies getting any assist from staff for toileting. On 8/26/25 at 1:05 PM, V32, CNA, stated R8 is standby assist for toileting. R8 is pretty independent and likes to do things on her own but she does let us know when she needs to use the bathroom because she likes someone to be there with her. She can do just about everything, but we help her pull her pants up. R8 did not require any assist with toileting prior to breaking her wrist and was independent with toileting. On 08/26/25 at 1:41 PM, V33, Nurse Practitioner (NP) said if someone has a diagnosis of Multiple Sclerosis (MS) they are a higher risk for falls, and she would assume the facility would have something in place for falls. 2. R5's Admission Record, print date of 08/10/25, documented R5 has diagnoses of but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, Alzheimer's disease, muscle weakness, and seizures. R5's MDS, 06/25/25, documented R5 is moderately cognitively impaired with a BIMS of 09 out of 15 and he is dependent on staff or requires substantial/maximal assistance with his activities of daily living (ADLs). He is always incontinent of bowel and bladder. R5's Care Plan, admission date of 01/17/25, documented R5 has had an actual fall related to (r/t) mobility, weakness. 05/08/25 actual fall, 06/15/25 actual fall, 08/09/25, actual fall. Goal: R5 will remain free from falls and injury. Interventions include but not limited to 5/8/25: Keep bed in lowest position (date initiated: 05/15/25). 6/15/25: Do not leave in room up in wheelchair if resident is restless (date initiated: 08/05/25). 8/9/25 Educate resident on allowing staff to assist with getting out of his wheelchair (date initiated 08/20/25). R5's Progress Notes, dated 05/08/2025 at 05:18 AM, documented Incident Note This Nurse was on 100 hall	S9999		

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S9999	Continued from page 5 passing meds (medications) when notified by staff that the resident was on the floor. When this Nurse entered the room, the resident was found lying flat on his back side, head against his nightstand with left leg bent up dressed in his sleepwear. This Nurse did a full head to toe assessment and found a slight lump/bump on the top of his head. No skin tears noted. Resident was unable to give description of the incident. Resident voices pain to back and neck. On the pain scale 0-10 resident stated pain was an 8. Resident is A&Ox2 (alert and oriented times two). V/S (vital signs) WNL (within normal limits). DON (Director of Nursing) notified and made aware. R5's son was contacted, no answer, message left. Local ambulance was contacted; they arrived at 23:02pm (11:02 PM). 2 EMT (emergency medical technicians) transferred resident out to local hospital for further evaluation. Report was called and given to hospital RN (Registered Nurse), ER (emergency room) charge Nurse. R5's Progress Notes, dated 6/15/2025 at 1:42 PM, documented Staff assisted resident back to own room after lunch. Resident was fidgeting in w/c (wheelchair). Resident lowered self out of w/c onto floor softly and laid down on back. Resident alert entire time and did not hit head during change of plain. Full body assessment completed. Resident assisted back into w/c and positioned. No s/s (signs or symptoms) of injury noted. No c/o (complaints of) pain noted. ROM (range of motion) WNL. 5's vital signs were stable. Administrator & Family made aware. R5's Fall Risk Evaluation, dated 06/15/25, documented R5 has had 1-2 falls in the past three months, he is chairbound/incontinent, predisposing diseases: respond based on the following predisposing conditions: hypotension, vertigo, cardiovascular accident (CVA), Parkinson's Disease, loss of limb(s), Seizures, Arthritis, osteoporosis, fractures, and delirium. It documented he had none of the predisposing conditions present. Under Gait/Balance it documented R5 has decreased muscular coordination. Under risk for falls there is no documentation noted. R5's Fall Investigation Worksheet, dated 08/09/25 at 9:50 PM, documented R5 takes antianxiety, antihypertensive, and cardiovascular medications. He was agitated, restless, and combative. It also documented R5 had an unwitnessed fall in his room, and he requires supervision. Contributing clinical factors: Hemiplegia/Hemiparesis and Cognitive impairment. Root cause of fall was he was attempting to get up without assistance. It documented he did not have a call light within reach because he was sitting in front of the	S9999		

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S9999	Continued from page 6 television (TV). Handwritten statement by V25, CNA documented she tried to lay R5 down around 7:40 PM. R5 didn't want to go to bed at that time. Later another CNA went in to try to get him to lie down and he became combative, so she let his CNA (V25) know. V25 then went in at around 8:30 PM to see if she could get him to lie down before it was time for her to leave for the evening. It documented she went to gather her things and her, and another CNA were going to go and put R5 to bed. When they walked into R5's room at 9:46 PM R5 was on the floor face down. R5's Progress Notes, dated 8/10/2025 at 01:28 AM documented Incident Note 2150p (9:50 PM) This nurse was notified by assigned CNA (Certified Nursing Assistant) staff resident was found face down on the floor by door of assigned living area. Resident was laying prone on the floor with face (left face down) looking over right shoulder. Resident was bleeding from left side of head (unknown origin) with large hematoma on left upper forehead. Resident was conscious A/O x3 and able to respond to verbal commands. Resident was not moved from original position. Patient stated that he did not have any pain/discomfort from extremities; however, expressed discomfort when his head was touched. Resident's vitals were assessed with BP (blood pressure) 108/53 / PR (pulse rate) 68 / O2 (oxygen) 95%. Resident informed of transport and agreed to be taken to local hospital via ambulance upon arrival of local Ambulance at 10:10p. DON notified of incident at 10:15p once resident stable and assessed by EMS (emergency medical services) with neck brace applied and soft stretcher used to log roll resident to supine position. Resident further assessed and taken by ambulance. Local PD (police department) responded to call. Note: Resident has verbal challenges that made it difficult to assess situation. R5's Progress Notes, dated 8/10/2025 at 01:34 AM, documented Resident transported to local hospital via ambulance after 911 call made due to fall. Resident refused to be placed in bed with staff reporting multiple attempts to transfer resident to bed with resident being combative. Resident was redirected several times per assigned staff resulting in resident refusing to leave position in chair. Nurse observed resident in prone position with injury to left side of head. All details of incident reported by CNA. DON notified of findings	S9999		

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S9999	Continued from page 7 R5's Progress Notes, dated 8/10/2025 02:38 AM, documented Resident being monitored for injury with report from hospital RN noting that resident is in the ER pending stiches/staples to laceration on left forehead. All scans returned with no fx (fracture) found. Resident is resting well awaiting discharge from ER. DON notified of all findings. R5's Progress Notes, dated 8/10/2025 at 04:29 AM, documented Per local hospital ER Resident has been treated with three steri strips to the wound on left forehead. Resident is waiting for transport by ambulance back to facility. DON updated on progress of resident. R5's Emergency Room Report, dated 08/09/25, documented the reason for his visit was due to a fall and his diagnoses were fall and head contusion. On 08/25/25 at 10:45 AM, V24, Vice President (VP) of Clinical Services said it would depend on the situation. If the resident was restless and up in their chair, she would expect them to bring the resident out to the common area unless it would upset them more. If it would cause them to become more agitated, then they should increase monitoring due to increased behaviors. She said they are wanting to change R3's wheelchair so it is more comfortable and safer for him. On 08/26/25 at 1:41 PM, V33, NP said she would expect the nursing staff to keep a close eye on him (R5) if he was restless and became combative due to not wanting to go to bed. You can't force them to go to bed so she would expect the nursing staff to keep a close eye on him. The facility's fall evaluation and prevention policy, not dated, documented Purpose: "To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. Policy The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls." It further documented "RESIDENTS SHOULD BE EVALUATED FOR THEIR FALL RISK *On admission/re-admission to the home, *Following any change of status that may affect balance, mobility, or safety, *Following a fall, and *Quarterly. RISK FACTORS ASSOCIATED WITH A FALL Intrinsic risk factors for falls	S9999		

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S9999	Continued from page 8 include changes that are part of normal aging as well as certain acute or chronic conditions and medications. The following are examples of common intrinsic risk factors: *Gait and balance disorders, *Muscular weakness (particularly of the lower extremities), *Stroke, *Seizure disorder, and *Previous falls." It also documented "Extrinsic risk factors for falls are part of the resident's environment and are most likely to be seen in areas such as the bedroom, bathroom, dining room, and hallways. The following are typical examples of extrinsic risk factors: *Lack of or loose handrails." It also documented Fall Evaluation and Prevention "Provide an elevated toilet seat and grab bars in the bathroom if indicated. Refer resident to PT or OT." It further documented "Evaluate the environment where the fall occurred, noting any factors that may have contributed to the fall (i.e., wet floor, socks without skid resistant pads, assistive device out of reach). Ask the resident what happened prior to the fall or what may have caused the fall. Root Cause." The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 08/15/25 documents there are 56 residents living in the Facility. (B) 2 of 2 300.610a) 300.1010h) 300.1210c) 300.1210d)3)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies	S9999		

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S9999	Continued from page 9 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met as evidenced by:Based on interview and record review the facility failed to assess and develop behavioral interventions for a resident with diagnoses of schizophrenia and bipolar disorder and notify the physician of resident having active hallucinations for 1 of 1 resident (R3) reviewed for behavioral services in a sample of 23. This failure resulted in R3 being sent out to the emergency room (ER) for evaluation and found to have a fractured nose and two fractured ribs.Findings Include:R3's Admission Record, print date of 08/20/25, documented R3 has diagnoses of but not limited to Schizophrenia and bipolar disorder. R3's Minimum Data Set (MDS), dated 08/18/25, documented R3 is severely cognitively impaired with a Brief	S9999		

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S9999	Continued from page 10 Interview for Mental Status (BIMS) of 04 out of 15, he requires supervision/touching assistance with most of his activities of daily living (ADLs), and he doesn't have any behavioral symptoms. R3's Care Plan, admission date of 08/04/25, documented Behavior Management New Delusional/hallucinations behavior related to his schizophrenia 8/16/25 resident was seeing snakes and bugs and trying to stomp on them. Resident also jumping around off and on furniture, swinging arms around swatting at birds, "diving" onto the floor. Goal: Cause of new onset behaviors will be evaluated/determined and undesirable behavior(s) will be monitored/managed. Interventions include but not limited to ensure the safety of resident and others and evaluate medication schedule and possible pharmacologic causes of hallucinations. The date created for this problem was 08/18/25. R3's Progress Note, dated 8/17/2025 at 01:12 AM, documented Behavior Note: Resident running up and down the hallway screaming rat's, snakes and birds were in his room. resident jumping up and down stomping on the floor saying he is stomping the rats. Resident re-directed back to his room. R3's Progress Notes, dated 8/17/2025 at 02:33 AM, documented Note Text: Resident came out of his room with blood on his face and nose. Resident nose twisted to the right. Local ambulance called to transport resident to local hospital. Call placed to Power of Attorney (POA) with no answer. Message left to call the facility. R3's Physician's Orders, dated 08/06/25, documented R3 has an order for Ziprasidone Mesylate (Geodon) Intramuscular Solution Reconstituted 20 milligrams (MG) (Ziprasidone Mesylate) Inject 0.5 milliliters (ml) intramuscularly as needed (PRN) for extreme agitation. R3's Medication Administration Record (MAR), for the month of August 2025 had documentation he was given his PRN Geodon on 08/11/25 and on 0813/25. There was no documentation he received his any PRN medication on any other days. R3's Progress Notes were reviewed and had no documentation the physician was notified of R3 having active hallucination. R3's Emergency Room History and Physical Report, dated 08/17/25, documented R3 is a 70-year-old male patient with a medical history significant for but not limited to bipolar disorder, schizophrenia, dementia,	S9999		

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S9999	Continued from page 11 hypertension, anemia presents to the ED via EMS from local nursing home with a chief complaint of facial injury. R3's Computed Tomography scan (CT-scan) of Facial Bones, dated 08/17/25, documented R3' findings as a minimally impacted anterior nasal bone fracture. R3's CT-scan of the Cervical Spine, dated 08/17/25, documented R3 had findings of Other osseous structures: Mildly impacted fractures of the right 2nd and 3rd ribs. On 8/21/25 at 1:10 PM, V8, Certified Nursing Assistant (CNA) stated V2, Director of Nursing (DON) asked her about R3, but she wasn't here that day. She said he had been running around, chasing snakes, hallucinating, jumping around, wandering into other resident rooms. V8 doesn't know what happened to R3. He could have run into a wall or something, the way he was acting. He had been like that since he got to the facility but hadn't been there too long. She said maybe this facility was not a good fit for him. On 8/21/25 at 1:13 PM, V25, CNA, stated R3 was always running everywhere. He was a safety risk to himself and may have been better in a lockdown unit. V8, CNA was standing in the area and stated We do have a lot of guys that can get angry and territorial around here. On 8/21/25 at 3:52 PM, V30, CNA stated she did not see it happen, he had gone to his room, came out, stood at nurse's station, and she asked what happened to his nose because it had blood at the bridge of it. R3's nose looked crooked, so the Nurse assessed him and made some calls. One was to the sister, there was no answer, so a message was left. Then they called 911. V30 said she hadn't worked with R3 before. She said he was up and down the halls, around nurse's station, sitting on floor, in hallway, stating he saw bugs or a snake, saw a bird. She said R3 was bad, and he had been acting like that all shift. She saw him go towards a few doors but never actually went in that she saw. V30 said she had never seen him that bad, never seen him act like that. He would walk up and down the halls and around the nurse's station. DON interviewed me about this. On 8/21/25 at 4:00 PM, V29, CNA said R3 was acting different, running around nurse's station, skipping, wasn't saying anything to nobody. When you told him to slow down or to sit down, he would for about two minutes and then he would get back up. He was really fidgety that night. She gave R3 a snack and some water and when he was done, he said he was going to bed. He	S9999		

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S9999	Continued from page 12 would go to his room and then he would come right back out. V29 said around 3:00 AM she went to the bathroom and she heard a bump in his room due to it is right next to the bathroom wall. She said she came out and he was coming out of his room and another CNA asked what was wrong with his nose. The nurse said it was crooked and it had some drops of blood on it. V29 said they just thought he may have hit it on the headboard or maybe he fell and hit his nose. She said they had never seen him act like that before. On 8/22/25 at 8:14 AM, V28, Licensed Practical Nurse (LPN) stated R3's fall and bloody nose were two separate incidents. R3 fell earlier in the night around 7:30 PM. He had been running up the hall toward the 100 hall and ran into her. He fell on his bottom. No injuries. Around 3AM he came out of his room after being in there about 45 min and he had blood on his face. She said she was cleaning him up and noticed his nose was crooked, so she sent him out because she assumed it was broken. V28 called an ambulance and tried to call the family several times with no answer and left a message to call the facility back. R3 told V28 a man picked him up and threw him and when asked who he said he didn't know, it was dark. V28 said she went in his room and bathroom and the only person in there was his roommate who is not steady enough to stand up and do that. She said there were a couple drops of blood on the floor, so she knows whatever happened, happened in his room. She said he was hallucinating all night, beating on the floor to kill snakes and he was seeing birds. She said he always runs but he was different that night and she had never seen him act that way. V28 said R3 doesn't bother anybody, he just walks around and sometimes looks in rooms but doesn't go in and he is easily redirected. V28 said R3 is always confused and doesn't sleep good at all and is usually up all night. He has PRN Geodon, but it only works for about 10 minutes. doesn't work. V28 said she did not contact the Nurse Practitioner (NP) or the Medical Doctor (MD) regarding R3's unusual behaviors. On 08/26/25 at 1:41 PM, V33, Nurse Practitioner said if someone has hallucinations, they are a harm to themselves. She said she would expect the nursing staff to notify her or the physician if the resident was getting worse. She said if the resident had PRN medication that was ordered she would expect it to be given. The facility's Behavior Management Policy, review date of 08/01/25, documented Purpose "To implement the most desirable and effective	S9999		

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S9999	Continued from page 13 interventions to change, modify decrease, or eliminate behaviors that are distressing to the resident, and/or are decreasing or negatively impacting the residents' quality of life. Policy The concept of behavior management is an interdisciplinary process. The key components of this process are: • Identifying residents whose behaviors may pose a risk to self or others; • Developing individual and practical care strategies based on assessed needs; • Implementing the behavior management program; and • Ongoing assessment, monitoring and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs. The goal of any behavior management process is to maintain function and improve quality of life. The goal of the Intradisciplinary Team (IDT) team is to promptly identify behavior management issues and develop an effective management program." It further documented When a resident displays adverse behavioral symptoms (e.g. Crying, yelling, hitting, biting etc.), Licensed nursing staff will assess the behavioral symptoms to determine possible causal factors, contact the attending physician, and implement non-drug interventions to alleviate the behavioral symptoms before initiating any psychotherapeutic agent(s). The facility must provide necessary behavioral health care and services which include: • Ensuring that the necessary care and services are person-centered and reflect that resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety; • Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well- being; • Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident's customary routines, interests,	S9999		

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S9999	Continued from page 14 preferences, etc. and enhance the resident's well-being. • Providing an environment and atmosphere that is conducive to mental and psychosocial well-being; and • Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. Procedure I. Assess Causal Factors a. When a resident exhibits adverse behavioral symptom (e.g., crying, yelling, hitting, biting, etc.) licensed nursing staff will document those behaviors in the medical record, noting the time the behavior(s) occur, antecedent events, possible causal factors and interventions attempted. b. Upon observing the adverse behavioral symptom, staff will do the following as indicted: i. Ensure the safety of the resident as well as all other residents. ii. Document notification of attending physician iii. Document notification of resident's family and/or responsible party about the change in behaviors and the attending physician response. iv. Document the incident. c. The charge nurse will assign a staff member(s) to monitor/shadow the resident as needed. i. Such monitoring is for the protection of the resident as well as all others and is not meant to restrict their movement or mobility." The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 08/15/25 documents there are 56 residents living in the Facility. (B)	S9999		