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S 000	Initial Comments Complaint Investigation: 2599624/IL197891 - 330.710a) 330.710c) 3) A) B) C) D) E) F) G) H) 330.710d) 1) 2) 330.1145a) 330.1145c) 330.1145d) 330.1145e) 1) 2) 3) 4) 330.1145f) 330.1145g) 330.1145h) 1) 2) 330.1145i) 1) 2) 3) 4) 5) 330.1145j) 330.1145k) 330.1145l) 330.1145m) 330.1145n) 330.1145o)	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.710c) 3) A) B) C) D) E) F) G) H) 330.710d) 1) 2) 330.1145a) 330.1145c) 330.1145d) 330.1145e) 1) 2) 3) 4) 330.1145f) 330.1145g) 330.1145h) 1) 2) 330.1145i) 1) 2) 3) 4) 5) 330.1145j) 330.1145k) 330.1145l) 330.1145m)	S9999		

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S9999	Continued From page 1 330.1145n) 330.1145o) 1 of 2 330.710a) 330.710c) 3) A) B) C) D) E) F) G) H) 330.710d) 1) 2) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs.	S9999		

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B) Education and training of nurses and other direct resident care providers in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling and on safe lifting policies and techniques and current lifting equipment.

C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.

D) Restriction, to the extent feasible with existing equipment and aids, of manual resident handling or movement of all or most of a resident's weight, except for emergency, life-threatening, or otherwise exceptional circumstances.

E) Procedures for a nurse to refuse to perform or be involved in resident handling or movement that the nurse, in good faith, believes will expose a resident or nurse or other health care worker to an unacceptable risk of injury.

F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

G) Consideration of the feasibility of incorporating resident handling equipment or the physical space and construction design needed to incorporate that equipment when developing architectural plans for construction or remodeling of a facility or unit of a facility in which resident handling and movement occurs.

H) Fostering and maintaining resident safety,

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dignity, self-determination, and choice. (Section 3-206.05 of the Act)

d) For the purposes of subsection (c)(3):

1) "Health care worker" means an individual providing direct resident care services who may be required to lift, transfer, reposition, or move a resident. (Section 3-206.05 of the Act)

2) "Nurse" means an advanced practice registered nurse, a registered nurse, or a licensed practical nurse licensed under the Nurse Practice Act. (Section 3-206.05 of the Act)
(Source: Amended at 48 Ill. Reg. 7397, effective May 3, 2024)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to develop and implement service plans and failed to provide adequate supervision for one (R1) of three residents, assessed at risk for fall and with a history of documented falls. As a result, R1 sustained three falls, two of which required R1 to be sent to the hospital. One fall resulted in a laceration requiring sutures, and another required staples to close a separate laceration.

Finding include:

Fall 1: R1's progress note, dated 9/09/25 at 1:29am, documents, in part, "Resident (R1) was found on the floor outside his room, no injuries noted at this time, resident (R1) denies any pain at this time ... Writer will continue to monitor for any change condition."

Fall 2: R1's "State Report Of Patient Incident (IL

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Only)," date of incident 9/09/25 at 4:00am, documents, in part, "Resident just moved into the community approximately 10 hours earlier 9/08/25 6:00pm ... After bed check he (R1) got up, went into another resident's room and fell. 911 was called. Went to ER (emergency room) received 3 to 4 stitches to forehead and returned to community at approximately 10:00am ..."

Fall 3: R1's progress note, dated 9/21/25 at 9:45am, documents, in part, "Resident (R1) observed on the floor in the kitchen area. Resident (R1) was still in his wheelchair. It appeared that the resident fell backwards. Resident (R1) was lifted forward and assessed. Resident (R1) noted with a laceration to the back of his head with moderate bleeding. Pressure was applied to the area until bleeding stopped. 911 was called for hospital transfer ... Fire department arrived, and resident (R1) was transferred to (Hospital) for an evaluation ..." R1's progress note, dated 9/21/25 at 2:35pm, documents, in part, "Resident (R1) returned from hospital in stable condition ... Resident (R1) noted with 2 staples to the back of head ..." R1's "State Report Of Patient Incident (IL Only)," date of incident 9/21/25, documents, in part, "Resident (R1) was sitting in kitchen, at counter ... caregiver turned away for a moment and resident (R1) threw himself back landing on the floor and hitting the back of his head ..."

R1's face sheet documents a "move in date of 9/09/25."

R1's "Admission Physician Orders," dated 9/14/25, documents diagnoses that include but are not limited to falls, dementia, and depression.

On 10/06/25 at 11:03am, R1 was observed in a

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recliner, in the living room, and the recliner was fully extended into a flat/horizontal position, with the backrest reclined and the footrest raised, positioning the R1 in a supine or lying posture.

On 10/06/25 at 11:05am, surveyor attempted to interview R1, however R1 was unable to be interviewed due to altered mental status. R1 exhibited disorientation regarding place and time and was unable to offer reliable responses. Consequently, no significant information could be gathered. R1 was yelling, "Help me get up! I have to go pee! I have to pee!" R1 was observed attempting to rise from the recliner by using both hands for support; however, the attempt was unsuccessful, and the resident was unable to achieve a standing position without assistance. V7 (Caregiver) assisted R1 into R1's wheelchair and R1's wheelchair was observed to have a wheelchair belt.

R1's "MORSE Fall Scale," dated 10/07/25, documents, in part, a score of 95 and high risk for falls.

Upon review of R1's EMR (electronic medical record), there were no service plans in place for R1.

On 10/06/25 at 11:06am, V7 (Caregiver) affirmed that R1's recliner is fully extended into a flat/horizontal position, with the backrest reclined and the footrest raised, to prevent R1 from getting up. V7 said, "I (V7) don't know if we (staff) can do this (recline the recliner in a way to prevent R1 from getting up), but there's really no other way. He's (R1) all over the place, all the time. We (staff) do this this (recline the recliner in a way to prevent R1 from getting up) so he (R1) doesn't fall. The seat belt for his (R1) wheelchair

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helps keep him (R1) from falling out of it (wheelchair). No, R1 cannot unsnap it (wheelchair belt) on his (R1) own. He's fallen a lot, check the back of his (R1) head. Interventions to prevent him (R1) from falling is just constantly watching him (R1)."

On 10/06 at 11:55am, V4 (Resident Services Supervisor/Licensed Practical Nurse/LPN) said, "Oh yeah, I (V4) know him (R1). I (V4) would have to read the progress notes from that day (9/09/25) to see if R1 fell twice. I (V4) know that he (R1) fell once that night, and he (R1) was in between door and hallway and seen him (R1) on floor. The very first night I (V4) had to send him (R1) out for sutures. We (staff) just keep a close eye on him (R1). That's all we (staff) can do."

On 10/06/25 at 12:02pm, V3 (Caregiver) said, "Yesterday (10/05/25), I (V3) was at work. Yesterday, I (V3) worked the (R1's area). R1 is up, down, up, down. I've (V3) witnessed him (R1) with the belt around him (R1) so he (R1) can't get up before. The wheelchair's seat belt prevents him (R1) from getting up. R1 cannot unbuckle the seatbelt ... He (R1) yells all day long saying, "Bring me to the restroom. Bring me to the restroom. Cu*** and Nig****. R1 is at risk of falling. He (R1) is really unsteady, very unsteady. Very shaky. In the kitchen, we (staff) are seated at the desk. We (staff) must watch him (R1) watched closely. R1 is similar to a baby. We (staff) have to keep him (R1) at our hip. He (R1) needs someone to watch him (R1) all day, one on one. We (staff) don't have a sitter. When I (V3) have to do care on another resident, I (V3) have to bring R1 outside the door of the other resident's room cause I (V3) have to keep an eye on him (R1) at all times. The management is aware. You (staff) have to be by his (R1) side, you

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(R1) can't care for other people (residents). He's (R1) up when you turn around. Impulsive."

On 10/06/25 at 12:12pm, while observing R1's EMR (electronic medical record), with V1 (Executive Director), V1 said, "There's no service plans for R1. Of course there should be. Actually, the way it's (service plans) done here, is I'm (V1) supposed to start them but I'm (V1) not clinical."

On 10/06/25 at 12:16pm, V5 (Resident Services Supervisor/Licensed Practical Nurse/LPN) said, "Oh yeah, I'm (V5) familiar with R1. That was his (R1) second fall that day (9/09/25). He (R1) came from skilled and then we (facility) got him (R1). Oh, it does look like R1 fell twice that day (9/09/25). We (staff) are all doing our best with him (R1). He (R1) fell again at 6:30am and was sent out. Came back with sutures. We (staff) do straight monitoring and redirecting for him (R1). He'll (R1) get up on his own and put himself (R1) on the floor. Wanderer. Jesus, he's (R1) a wanderer. The DON (Director of Nursing) usually does the service plans for the residents. I'm (V4) not sure if he (R1) has service plans. Service plans are specific to the resident and help with the care the resident needs. We currently don't have a DON."

R1 lacks a Service Plan with supervision interventions as well as updated interventions after previous falls.

R1 had a history of falls, but there was no documented change in supervision levels or interventions implemented between falls.

Documentation shows lack of supervision: "Resident (R1) was found on the floor outside his room; After bed check he (R1) got up, went into

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another resident's room and fell; Resident (R1) observed on the floor in the kitchen area. Caregiver turned away for a moment and resident (R1) threw himself back landing on the floor and hitting the back of his head."

Facility policy titled, "Planning and Monitoring Services," original date 6/2025, documents, in part, "Purpose: Residents' service needs, and requirements are identified, planned, implemented, monitored, and reassessed on an on-going basis in accordance with the pre-move-in, move-in and resident's stay procedures. Service needs and requirements are coordinated with other entities, such as hospice, on an ongoing and as needed basis. Procedure: 1. Background information is collected on each resident during the pre-move-in phase in order to: Identify and plan for the resident's service needs requirements and preferences; Develop the Resident's Service Plan. 2. Additional information is gathered during move-in to supplement the initial Service Plan. 3. Residents are reassessed within 30 days and annually thereafter unless they experience a significant change for better or worse (change of condition) or per state requirement. Service Plans are modified accordingly. 4. The community team is responsible for ensuring that the service plan/care plan is properly implemented through day to day activity and engagement with the resident. 5. If resident receives hospice, home health, or similar care this should be indicated on the service plan and coordination occurs with changes to the hospice or home health service as needed. 6. Refer to the process flows (pre-move-in, move-in and resident's stay) and other forms that identify and support these processes located on the company Intranet."

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Facility policy titled, "Change of Condition Protocol," original date 5/2025, documents, in part, "Purpose: To provide guidance in the identification of clinical changes that may constitute a change in condition and require intervention and notifications. 1. Reporting of Observations and Evaluations Phase: Resident Caregiver Responsibility: Notify the nurse of a suspected change of condition. Nurse's Responsibility: Identify the resident involved and the issue -ask when the incident/change began and/or when was it identified? Is the resident known to the nurse? Has this occurred before?; Review previous condition and current medication orders; Review the Service Plan; If the nurse notified is the RCC or RSS, he/she determines if the DON/HSD/RSC needs to be notified for consultation. 3. Intervention Phase: Plan the intervention based on the information obtained from above; Perform a complete evaluation and review of the situation including VS/physical assessment, if indicated; Notify the attending physician and obtain instructions or orders as directed; Document all interventions, results, and follow-up needed in the Resident Health Record; Notify the responsible party. 4. Follow-Up Phase: Ensure that change of condition is documented, per procedure, and that Call Logs are completed Perform follow-up tasks as needed per procedure; Check 24-Hour Report, Resident Record as appropriate; determine if documentation and follow up actions are complete."

Facility policy titled, "Planning and Monitoring Services," original date 6/2025, documents, in part, "Purpose: Residents' service needs, and requirements are identified, planned, implemented, monitored, and reassessed on an on-going basis in accordance with the

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pre-move-in, move-in and resident's stay procedures. Service needs and requirements are coordinated with other entities, such as hospice, on an ongoing and as needed basis. Procedure: 1. Background information is collected on each resident during the pre-move-in phase in order to: Identify and plan for the resident's service needs requirements and preferences; Develop the Resident's Service Plan. 2. Additional information is gathered during move-in to supplement the initial Service Plan. 3. Residents are reassessed within 30 days and annually thereafter unless they experience a significant change for better or worse (change of condition) or per state requirement. Service Plans are modified accordingly. 4. The community team is responsible for ensuring that the service plan/care plan is properly implemented through day to day activity and engagement with the resident. 5. If resident receives hospice, home health, or similar care this should be indicated on the service plan and coordination occurs with changes to the hospice or home health service as needed. 6. Refer to the process flows (pre-move-in, move-in and resident's stay) and other forms that identify and support these processes located on the company Intranet."

Facility job description titled, "Resident Services Supervisor (LPN)," revised date 2/08, documents, in part, " ... 1. Following all policies and procedures established in the RSC Manual, Pharmacy Manual, and the Infection Control Manual to maintain a safe environment ... 4. Assisting in managing and monitoring the delivery of all resident services including personal care, ordering, and dispensing medications, monitoring the health care status of the residents to include, taking vital signs, observes for symptoms, ensures adherence to prescribed treatments or

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interventions, observes nutritional status, etc. Ensures that treatments are administered and documented on in accordance with doctor's orders and State/Company policy and guidelines, identifies and communicates changes in condition to responsible parties and Health Care providers ... 6. Assisting the Resident Services Coordinator in ensuring that established standards of resident care are followed and met. Participates in the On-Call program, as established by the supervisor. 7. Assisting in monitoring service delivery and maintaining service documentation: To include review of 24-Hour reports, Individual Service Notes in the RIB, with follow-up to Health Care providers, as applicable. 8. Assist in service plan meetings with the Executive Director and family/responsible parties, as requested by supervisor. 14. Assist in the assessment process for potential move-ins, as requested by supervisor and in accordance with state regulations ..."

Facility job description titled, "Resident Caregiver," revised date 7/18, documents, in part, " ... The Resident Caregiver assists residents in all aspects of their daily life as indicated in the resident service plan, including personal care, food service, housekeeping, laundry, behavior management, socialization, activities, orientation, and information needs. This position requires tact, sensitivity, and professionalism due to the constant interaction with residents and families to guarantee their satisfaction ... 2. Documenting exceptions to Service Plans utilizing 24-Hour Reports and Individual Service Notes. 3. Participating in weekly service planning sessions, as needed. 4. Providing and assisting residents with services delineated in residents' individual Service Plans including personal care (personal hygiene, bathing, toileting, dressing, mobility,

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S9999	Continued From page 12 etc.), activities, meal service, housekeeping, etc. 5. Monitoring and communicating residents' changes in condition and service requirements to Supervisor, as appropriate ... 7. Complies with monitoring and documenting mandatory hourly/courtyard checks, as per facility protocol ..." (B) 2 of 2 330.1145a) 330.1145c) 330.1145d) 330.1145e) 1) 2) 3) 4) 330.1145f) 330.1145g) 330.1145h) 1) 2) 330.1145i) 1) 2) 3) 4) 5) 330.1145j) 330.1145k) 330.1145l) 330.1145m) 330.1145n) 330.1145o) Section 330.1145 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident	S9999		

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from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part.

c) Physical restraints shall only be used in an emergency as specified in Section 330.1150.

d) Neither restraints nor confinements shall be employed for the purpose of punishment or for the convenience of any facility personnel. No restraints or confinements shall be employed except as ordered by a physician who documents the need for such restraints or confinements in the resident's clinical record. (Section 2-106(b) of the Act)

e) Criteria for determining whether physical restraints are needed for a resident shall include, but not be limited to whether:

1) The assessment of the resident's capabilities and an evaluation and trial of less restrictive measures has led to the determination that the use of less restrictive measures would not attain or maintain the resident's highest practicable physical, mental or psychosocial well-being;

2) The assessment of a specific physical condition or medical treatment indicates the condition, or medical treatment requires the use of physical restraints.

3) Consultation with appropriate health

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professionals, such as registered professional nurses, occupational or physical therapists, indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and

4) Demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental, or psychosocial well-being. (Section 2-106(c) of the Act)

f) The use of chemical restraints is prohibited.

g) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. A restraint may be used only for specific periods, if it is the least restrictive means necessary to attain and maintain the resident's highest practicable physical, mental or psychosocial well-being, including brief periods of time to provide necessary life-saving treatment. (Section 2-106(c) of the Act)

h) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.

1) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact

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on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.

2) After 50 percent of the period of physical restraint use authorized by the informed consent has expired, but not less than five days before it has expired, information about the actual effectiveness of the physical restraint in treating the resident's medical symptoms or as a therapeutic intervention and about any actual negative impact on the resident shall be given to the resident, resident's guardian, or other authorized representative before the facility secures an informed consent for an additional period of time. Information about the effectiveness of the physical restraint program and about any negative impact on the resident shall be provided in writing.

i) Whenever a period of use of a restraint is initiated, the resident shall be advised of their right to have a person or organization of their choosing, including the Guardianship and Advocacy Commission, notified of the use of the restraint. A recipient who is under guardianship may request that a person or organization of their choosing be notified of the restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted. (Section 2-106(e) of the Act) If the resident requests that the Guardianship and Advocacy Commission be contacted, the facility

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S9999	Continued From page 16 shall provide the following information, in writing, to the Guardianship and Advocacy Commission: 1) The reason the physical restraint was needed; 2) The type of physical restraint that was used; 3) The interventions utilized or considered prior to physical restraint and the impact of these interventions; 4) The length of time the physical restraint was to be applied; and 5) The name and title of the facility person who should be contacted for further information. j) Whenever a physical restraint is used on a resident whose primary mode of communication is sign language, the resident shall be permitted to have their hands free from restraint for brief periods each hour, except when this freedom may result in physical harm to the resident or others. (Section 2-106(f) of the Act) k) A facility may not issue orders for the use of physical restraints on a standing or as needed basis. l) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well-being.	S9999		

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m) A resident placed in a restraint must be checked at least every 15 minutes by staff trained in the use of restraints and a record of these checks and usage of restraints must be kept. A resident wearing a physical restraint shall have it released for a period of not less than 10 minutes during each two-hour period in which the restraint is employed, or more often if necessary. During these times, residents shall be given the opportunity for motion and exercise or shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate. A record of this activity during a period of restraint shall be kept in the resident's medical record.

n) Restraints shall be designed and used in a way that does not cause physical injury to the resident and that results in the least possible discomfort.

o) In no event may restraint continue for longer than 2 hours unless within that time period a nurse with supervisory responsibilities, advanced practice psychiatric nurse, or a physician confirms, in writing, following a personal examination of the resident, that the restraint does not pose an undue risk to the resident's health in light of the resident's physical or medical condition. The order shall state the events leading up to the need for restraint and the purpose for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for the length of time. No order for restraint shall be valid for more than 16 hours. [405 ILCS 5/2-108(a)].

Source: Amended at 48 Ill. Reg. 7397, effective May 3, 2024)

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S9999	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an environment free of physical restraints for one (R1) of three residents reviewed for restraints. Finding include: R1's face sheet documents a "move in date of 9/09/25." R1's "Admission Physician Orders," dated 9/14/25, documents diagnoses that include but are not limited to falls, dementia, and depression. On 10/06/25 at 11:03am, R1 was observed in a recliner, in the living room, and the recliner was fully extended into a flat/horizontal position, with the backrest reclined and the footrest raised, positioning the R1 in a supine or lying posture. On 10/06/25 at 11:05am, surveyor attempted to interview R1, however R1 was unable to be interviewed due to altered mental status. R1 exhibited disorientation regarding place and time and was unable to offer reliable responses. Consequently, no significant information could be gathered. R1 was yelling, "Help me get up! I have to go pee! I have to pee!" R1 was observed attempting to rise from the recliner by using both hands for support; however, the attempt was unsuccessful, and the resident was unable to achieve a standing position without assistance. V7 (Caregiver) assisted R1 into R1's wheelchair and R1's wheelchair was observed to have a wheelchair belt. On 10/06/25 at 11:06am, V7 (Caregiver) affirmed	S9999		

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that R1's recliner is fully extended into a flat/horizontal position, with the backrest reclined and the footrest raised, to prevent R1 from getting up. V7 said, "I (V7) don't know if we (staff) can do this (recline the recliner in a way to prevent R1 from getting up), but there's really no other way. He's (R1) all over the place, all the time. We (staff) do this this (recline the recliner in a way to prevent R1 from getting up) so he (R1) doesn't fall. The seat belt for his (R1) wheelchair helps keep him (R1) from falling out of it (wheelchair). No, R1 cannot unsnap it (wheelchair belt) on his (R1) own. He's fallen a lot, check the back of his (R1) head. Interventions to prevent him (R1) from falling is just constantly watching him (R1)."

On 10/06/25 at 11:33am, V1 (Executive Director) said, "They (staff) asked me (V1) if they (staff) can recline the recliner flat and I (V1) told them (staff) no." V1 affirmed that reclining the recliner in a way to prevent R1 from getting up is a restraint. V1 also affirmed that if a resident has a wheelchair belt that the resident cannot unlock, it can be considered a restraint.

On 10/06/25 at 12:02pm, V3 (Caregiver) said, "Yesterday (10/05/25), I (V3) was at work. Yesterday, I (V3) worked the (R1's area). R1 is up, down, up, down. I've (V3) witnessed him (R1) with the belt around him (R1) so he (R1) can't get up before. The wheelchair's seat belt prevents him (R1) from getting up. R1 cannot unbuckle the seatbelt. I (V3) don't see the recliner as a restraint, he (R1) usually sits up in the recliner. He (R1) yells all day long saying, "Bring me to the restroom. Bring me to the restroom. Cu*** and Nig****. R1 is at risk of falling. He (R1) is really unsteady, very unsteady. Very shaky. In the kitchen, we (staff) are seated at the desk. We

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(staff) must watch him (R1) watched closely. R1 is similar to a baby. We (staff) have to keep him (R1) at our hip. He (R1) needs someone to watch him (R1) all day, one on one. We (staff) don't have a sitter. When I (V3) have to do care on another resident, I (V3) have to bring R1 outside the door of the other resident's room cause I (V3) have to keep an eye on him (R1) at all times. The management is aware. You (staff) have to be by his (R1) side, you (R1) can't care for other people (residents). He's (R1) up when you turn around. Impulsive."

On 10/06/25 at 12:12pm, while observing R1's EMR (electronic medical record), with V1 (Executive Director), V1 said, "There's no service plans for R1. Of course there should be. Actually, the way it's (service plans) are done here, is I'm (V1) supposed to start them but I'm (V1) not clinical."

On 10/06/25 at 12:16pm, V5 (Resident Services Supervisor/Licensed Practical Nurse/LPN) said, "Oh yeah, I'm (V5) familiar with R1. That was his (R1) second fall that day (9/09/25). He (R1) came from skilled and then we (facility) got him (R1). Oh, it does look like R1 fell twice that day (9/09/25). We (staff) are all doing our best with him (R1). He (R1) fell again at 6:30am and was sent out. Came back with sutures. We (staff) do straight monitoring and redirecting for him (R1). He'll (R1) get up on his own and put himself (R1) on the floor. Wanderer. Jesus, he's (R1) a wanderer. The DON (Director of Nursing) usually does the service plans for the residents. I'm (V4) not sure if he (R1) has service plans. Service plans are specific to the resident and help with the care the resident needs. We currently don't have a DON."

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S9999	Continued From page 21 Facility policy titled, "Resident Safety: Restraints and Devices," original date 5/2025, documents, in part, "Purpose: Devices such as Bed Rails, Assist Rails, Halo Bar, Seat belt, Lap Buddy, Bed Bolster are considered physical restraints ... Such devices are prohibited from use due to the potential negative impact or adverse event ... Procedure: 1. Upon move-in and during the resident's stay, the Executive Director or designee informs the family/responsible party/resident that the above noted devices are prohibited due to the potential negative or adverse event 2. If a device is brought into the community, the responsible party/family/resident will be advised by the Executive Director or designee that it needs to be immediately removed ... 4. Upon move-in and during the resident's stay, the resident will be evaluated according to the move in criteria. This includes "minimum to moderate mobility" and "requires supervision/assistance with Activities of Daily Living". If a resident no longer meets the criteria and a device is required for transfer on a permanent basis the Executive Director will discuss alternate placement options with the family/responsible party. Best Practices: 1. Residents experiencing falls, ambulation and/or transfer issues will be referred for discussion with the physician and family for possible consultation with Physical Therapy, Occupational Therapy, Home Health, or Hospice 2. A negotiated risk acknowledging a discussion of a particular risk(s), i.e. falls will take place with the family/responsible party and a mutual understanding and agreement on the potential factors/risks, possible outcomes, and interventions will be reached 3. Alternate interventions may include: electric bed in lowest position. assistive devices such as canes/ walkers, wheelchairs, diversional programming,	S9999		

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increased observation during peak times of falls."

Facility policy titled, "Resident Protection," original date 5/2025, documents, in part, "POLICY: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms ..."

Facility job description titled, "Resident Services Supervisor (LPN)," revised date 2/08, documents, in part, " ... 1. Following all policies and procedures established in the RSC Manual, Pharmacy Manual, and the Infection Control Manual to maintain a safe environment ... Resident Rights: 1. Knows and respects resident rights. 2. Ensures protected health information is kept confidential. 3. Reports complaints made by residents to supervisor. 4. Reports all allegations of resident abuse, neglect and/or misappropriation of resident property ..."

Facility job description titled, "Resident Caregiver," revised date 7/18, documents, in part, " ... The Resident Caregiver assists residents in all aspects of their daily life as indicated in the resident service plan, including personal care, food service, housekeeping, laundry, behavior management, socialization, activities, orientation, and information needs. This position requires tact, sensitivity, and professionalism due to the constant interaction with residents and families to guarantee their satisfaction ... 8. Ensuring that residents are free from abuse, mistreatment, and neglect, and reporting any such instance, as appropriate ... Resident Rights: 1. Knows and respects resident rights. 2. Ensures protected

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S9999	Continued From page 23 health information is kept confidential. 3. Reports complaints made by residents to supervisor. 4. Reports all allegations of resident abuse, neglect and/or misappropriation of resident property ..." (B)	S9999		