STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET , HILLSBORO, Illinois, 62049

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S0000	Initial Comments Facility Reported Incident of October 14, 2025 2646881 Complaint Investigation 25410584 / 2654602	S0000		12/03/2025
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.3210 t) 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 personal care needs of the resident.	S9999		12/03/2025

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

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent abuse from occurring and failed to document progressive interventions for 3 of 3 residents (R3, R7, R9) reviewed for abuse in the sample of 10. These failures resulted in R3 having R4's hands around her neck aggressively, R7 being hit in head by R4 and also being pushed down in chest by R4 while in bed, and R9 being slapped by R4. Using a reasonable person concept, R3, R7, and R9 would experience discomfort/pain and feelings of being scared, unsafe, shame, and humiliation. Findings include: R4's face sheet documents an admission date of 1/6/2025. Diagnoses include Vascular Dementia, Peripheral Vascular Disease, Chronic Atrial Fibrillation, and Cerebral Infarction. R4's Minimum Data Set (MDS), dated 8/20/2025, documents R4 is severely cognitively impaired. R4 is independent with walking. R4's care plan, updated 8/6/2025, documents R4 has the potential to be aggressive related to dementia diagnosis. Interventions include approach/speak in a calm manner, divert attention, remove from situation ant take to alternative location as needed. Intervene as necessary to protect the rights and safety of others. Medication review will be done when appropriate, by psych Nurse Practitioner, NP. Transfer to inpatient psychiatric facility. R4 lives on a closely supervised unit. R4 on 1:1 observation. R4 will be redirected by offering activities or snack when agitation is noted. R4's care plan does not document abuse. R4's care plan does not include documentation of	S9999		

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S9999	Continued from page 2 progressive interventions for incidents that occurred on 10/7/2025, 10/18/2025, 10/21/2025. 1.R3's face sheet documents admission date of 7/16/2024. Diagnosis include Alzheimer's Disease, Cerebrovascular Disease, Cerebrovascular Infarction, Heart Failure, Aphasia. R3's MDS, dated 10/13/2025, documents R3 is severely cognitively impaired. R3's MDS dated 10/15/2025 documents R3 requires moderate assist with walking. R3's care plan, updated 10/23/2025, documents R3 has been identified as being a vulnerable person related to her diagnosis of dementia. Interventions include frequent rounding by staff is provided to maintain safety and ensure resident needs are met. R3 resides on a closely supervised unit. Facility initial report, dated 10/14/2025, documents on 10/7/2025, it was reported R4 put her hands on R3's neck. The residents were immediately separated by staff and were placed on 1:1 monitoring. All parties were notified. An investigation initiated. Head to toe assessment completed with no injury to either resident. Neither resident can make a statement as to what happened. Staff were interviewed. Following the investigation into the incident, the staff responded appropriately to the incident. Staff placed R4 on 1:1 observation and sent to local hospital. On 10/30/2025 at 10:00AM, V19, CNA/Certified Nursing Assistant, stated, "I was working on 10/7/2025 when R4 had an altercation with R3. I was walking with R4 back to her room for bed. When R4 and I walked into the room R4 looked at her roommate (R3), who was lying in bed, and said, 'Is that my grandmother?' I said, 'No that is not your grandmother'. R4 suddenly walked over to R3's bed, put her hands around R3's neck and began choking her. I immediately leaned across R3's body while at the same time taking R4's hands off R3's neck. When I got R4's hands released I took R4 out to the nurse working the hall and R4 was sent out to the hospital. I know R4 was on 1:1 observation for a while. I don't know for how long. No one was injured." 2.R7's face sheet documents an admission date of 7/21/2025. Diagnoses include Dementia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Atrial Fibrillation. R7's MDS, dated 10/16/2025, documents R7 is severely cognitively impaired.	S9999		

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S9999	Continued from page 3 R7's care plan indicates R7 has been identified as a vulnerable person. Interventions include R7 lives on a closely supervised unit. Facility's initial report, dated 10/18/2025, documents on 10/18/2025 at 5:45PM, R4 smacked R7 on the top of the head. Residents immediately separated. R4 was placed on a 1:1 observation for monitoring until R4 was sent to local hospital. Licensed nursing staff conducted a head-to-toe assessment with no injury noted. Investigation initiated. Neither resident able to make a statement regarding incident. On 10/30/2025 at 11:00AM, V21, Licensed Practical Nurse/LPN, stated, "The incident on 10/18/2025 was between (R4) and (R7). We were in the dining room and (R4) had gotten up to leave. As (R4) was exiting the dining room she looked at (R7), who was sitting in her wheelchair. (R4) walked over and tap, tap, tapped (R7) on the head. (R7) turned around and grabbed (R4's) hands. They had their hands locked. I ran over and unlocked their hands and separated them. I called (V1, Administrator) and had (R4) sent out to the hospital. She came back a couple hours later and was put on 1:1 observation. When I work back there, I try to keep the medication cart in the center of the hallway so I can keep an eye on both ends of the hallway." Facility's initial investigation, dated 10/21/2025, documents on 10/21/2025 at approximately 1:30AM, it was reported to the administrator that R4 acted in an inappropriate manner to R7. R4 and R7 were immediately separated. R4 placed on 1:1 for monitoring until R4 sent to local hospital. R4 returned to facility and continued 1:1 monitoring until R4 transferred to psychiatric facility. On 10/30/2025 at 10:00AM, V19, CNA, stated, "I was working on 10/21/2025 when (R4) had an altercation with (R7). I heard screaming in one of the rooms and ran into the room. (R4) had her hands on (R7's) chest pressing down on her chest. I immediately ran over to (R7) and laid my body over (R7) while removing (R4's) hands from (R7). I led (R4) out of the room and told the nurse what happened. (R7) said, 'I'm scared, I 'm scared.' I told her she was safe, and I would stand outside her door. I think (R4) was sent out and then was put on 1:1 observation again." 3.R9's face sheet documents an admission date of 6/27/2025. Diagnoses include Chronic Obstructive Pulmonary Disease, Dementia, Type 2 Diabetes, and Epilepsy.	S9999		

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S9999	Continued from page 4 R9's MDS, dated 10/1/2025, documents R9 is severely cognitively impaired. R9's Care plan, dated 8/5/2025, documents R9 has been identified as being a vulnerable person related to the dementia diagnosis. Interventions include frequent rounding by staff is provided to maintain safety and ensure resident needs are met. Report any changes in resident condition/behaviors to physician following incident. R9 resides on a closely supervised unit. Trauma assessment completed. Facility's initial investigation, dated 10/28/2025, documents on 10/28/2025 at approximately 4:30AM, it was reported to the administrator R4 acted in an inappropriate manner to R9. R4 and R9 were immediately separated. Head to toe assessments completed with no injury noted. Investigation initiated. Notifications being made. Final report to follow. On 10/30/2025 at 1:00PM, V23, CNA, stated, "On 10/28/2028, it was toward the end of shift, and we were doing our last round. R4 had been asleep all night and I heard screaming. I ran down the hall and found R4 in R9's room. R9 said "She slapped me." Her roommate said "Yes she (R4) slapped her (R9). We kept the residents separated and (R4) was put on a 1:1 supervision." On 10/29/2025 at 3:30PM, R4 lying in bed with eyes closed and audibly snoring. V10, CNA, sitting in room with R4. V10 stated, "I've been here since 6:00AM and (R4) has been asleep all day." On 10/30/2025 at 8:00AM, R4 lying in bed with eyes open. R4 stated, "I have to get up and finish this." V16, CNA, stated, "I am here until 6:00PM. (R4) has been awake and ate her breakfast." On 10/30/2025 at 1:45PM, V1, Administrator, stated, "I don't know what to do with (R4). Until we get her Power of Attorney (POA) situation straightened out we are at a standstill. Her husband is her POA, and he is divorcing her. He even blocked our calls. We are trying to get (R4's) POA changed to her daughter. The only answer until we can find (R4) new placement is to be on continuous one on one observations. I would expect progressive interventions to be updated and in the care plan. I expect the interventions to keep (R4) and the other residents safe." On 10/31/2025 at 11:15AM, V17, Nurse Practitioner, NP, stated, "When I see (R4), she is usually pleasant or sleeping. I think some of her behaviors happen at night. I know (R4) has had a couple of urinary tract	S9999		

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S9999	Continued from page 5 infections she was treated for. I think one on one observations help but I am not sure what the facility's policy is on when those are implemented and how staffing would be managed." Facility's abuse policy, with a revision date of 3/2025, states, "This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property. The residents must not be subjected to abuse by anyone. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement." (B) 2 of 2 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)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.	S9999		

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S9999	Continued from page 6 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. 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: 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. 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to transfer 1 (R5) of 3 residents properly and failed to update a resident's care plan (R10) with progressive interventions to prevent future falls for 2 residents reviewed for accidents and falls in the sample of 3. These failures resulted in R5	S9999		

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S9999	Continued from page 7 having swelling and bruising to left ankle/lower leg and being diagnosed with an acute on chronic distal tibial fracture. Findings include: 1. R5's Care Plan documents at risk for falls r/t (related to deconditioning. Goals: the resident will be free from falls and injury through the review date. Intervention included utilize 2 assist for transfers dated 9/28/2025. R5's Quarterly Minimum Data Set (MDS), dated 9/30/2025, documents R5 is alert. R5's Physician's Order Sheet (POS), dated 10/1/2025, documents resident requires assist of 2 for all transfers due to knee giving out without notice. R5's Health Status Note, dated 10/21/2025 at 8:13 AM, documents, "Sending patient out to local ER (Emergency Room) after staff attempted to get resident up this morning and her Lt (left) ankle became twisted and caught up during transfer. lateral Lt ankle has an area of localized bruising and swelling along with a noted discoloration going up her leg above the ankle. she has a history of multiple fractures and hardware to her Lt ankle. needing stat imaging and evaluation." R5's Health Status Note, dated 10/21/2025 at 10:50 AM, documents, "PT (Physical Therapy) staff informed RN (Registered Nurse) that patients left anterior lower extremity was swollen and bruised. NP (Nurse Practitioner) was in house and was notified to take a look, patient had a silver dollar sized bruise on the anterior shin/ankle, with redness and edema spreading around the bruise. Patient stated that she has broken that same leg/foot 3x and there is some hardware in there from past surgeries. Patient said when they were transferring/pivoting her feet gave out. NP assessed patient quickly and RN was given the order to sent patient to the ER for imaging evaluation. Patient was sent to the ER at approx 8:45am via EMS (Emergency Medical Services). R5's Health Status Note, dated 10/21/2025 at 10:54 AM, documents, "the resident is experiencing a change in condition. See SBAR assessment for further information and family/physician The change in condition the resident is currently experiencing is Bruise and edema on left anterior ankle. NP gave orders to send patient to the ER." R5's Health Status Note, dated 10/21/2025 at 11:39 AM,	S9999		

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S9999	Continued from page 8 documents, "This RN spoke with (RN) at the ED at (local) area hospital regarding patient. A 2 view Xray of tib/fib (tibia/fibula) came back with findings of Medial tibial plateau fracture is present. There is intramedullary rod in the distal fib and tib, and indeterminate obliquely oriented fracture involving the distal tibial shaft. Patient is coming back splinted and 4mg of morphine was given at 8:45am from EMS. Patient has an appointment with Dr. Ott 8:45am. Administrator, ADON, Transport all made aware." R5's SBAR Communication Form and Progress Note, dated 10/21/2025, documents, "situation: bruise and edema on left anterior ankle which started on 10/21/2025, symptoms worse when moving it and nothing makes it better. Other relevant information: patient was transferring/pivoting and legs gave out. Functional Status Changes: weakness. Nursing Note: NP gave orders to send patient to the ER (Emergency room.)" R5's Emergency Medical Services (EMS) Run Sheet, dated 10/21/2025, documents they were called to the facility due to R5 fell and had an injury to her ankle. Left leg pain, swelling and tenderness documented and EMS staff administered 4 milligrams (mg) Morphine intravenous for pain. R5's ED (Emergency Department) Paperwork, dated 10/21/2025, documents, "chief complaint: fall. History of Present Illness Narrative: patient presents after sustaining an injury yesterday in which her leg became caught in a wheelchair, resulting in pain and a fall. She reports pain localized to the distal third of the right (should be left) leg with associated swelling and bruising. X Ray imaging reveals an indeterminate fracture involving distal tibial shaft, raising concern for an acute fracture following the recent trauma. ED course: this patient sustained a traumatic injury resulting in pain, swelling and bruising localized to the distal third of the right (should be left) leg. This injury requires evaluation by orthopedics and may involve multiple management options depending on the final diagnosis and recommendations. The presence of swelling and bruising, along with the need for a specialist consultation, increases the complexity of the problem addressed beyond a simple, uncomplicated injury." R5's Health Status Note, dated 10/22/2025 at 7:38 AM, documents, "Resident was sent to hospital to be eval. Resident has an appointment with ortho (orthopedics). Resident is a (mechanical lift) for all transfers at this time."	S9999		

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S9999	Continued from page 9 On 10/29/2025 at 10:45 AM, V7, CNA (Certified Nurse Aide), and V8, CNA, entered R5's room to transfer her from recliner to bed. V7 and V8 used a mechanical lift to transfer R5 at that time. On 10/29/2025 at 11:50 AM, R5 sat in her recliner in her room. R5 was alert and stated when she injured her left foot, it was a freak accident because 1 staff member, V11 who is a CNA, transferred her from bed to wheelchair and her left foot got stuck behind the wheelchair wheel and started hurting immediately. R5 stated she doesn't want to get anyone in trouble, but V11 told her (R5) she knows she's supposed to be a 2 person transfer, but they were short staffed that morning and she had to get her up. R5 recalled she fell in the middle of the transfer back onto her bed and that was when her left foot got stuck in the wheelchair wheel. R5 stated V11 then got her to her wheelchair and left her in her room. R5 stated it wasn't until therapy staff (name unknown) came to get her for therapy that staff assessed her left ankle and stated it was bruised and swollen and she was transferred to the hospital shortly after. R5 stated she had a few fractures in her left leg in the past, and she hoped she didn't fracture it again. R5 stated she has to wear a boot for a while to keep her left foot/ankle from moving. R5 stated she wished V11 would have tried to find additional staff to transfer her because she isn't stable enough to be transferred by 1 staff, and that's why she fell and hurt her ankle. R5 had a boot on her left foot from her toes to her knee. On 10/29/2025 at 11:20 AM, V7, CNA, stated she wasn't working 10/21/2025, but she is usually assigned to 200 hall on day shift and she knows the residents well. V7 stated R5 was a 2 person assist with transfers until she recently had an incident and now, she is now a mechanical lift. V7 stated she always transferred R5 with a 2 person assist with a gait belt because she has Parkinson's is unstable at times, that's why she is a 2 person assist with transfers. V7 stated staff including CNAs find how residents transfer by reading the resident's care plan which they have access to. V7 stated she never transferred V5 without 2 staff and a gait belt, and she wouldn't ever do that because R5 is too unstable to transfer and she definitely doesn't want any residents, including R5, to be injured. On 10/29/2025 at 1:28 PM, V18, RN, stated she worked day shift on 10/21/2025 and was assigned to R5. V18 stated she is an agency nurse and recalled a therapy staff (name unknown) reported to her sometime that morning that R5's left ankle/lower leg was swollen, red, and bruised and she wanted a nurse to assess the	S9999		

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S9999	Continued from page 10 area prior to R5 receiving therapy. V18 stated she went to R5's room and observed V17, NP, was in the room and assessed R5's left ankle/lower leg was bruised, red, and swollen, and she heard R5 tell V17 that she was transferred with 1 staff and it was supposed to be 2 and her left foot got caught in her wheelchair wheel and she knew it was hurt. V18 stated R5 cried when V17 let her know she was transferring her to the emergency room for x rays because she was recently at the hospital for unrelated medical issue. On 10/29/2025 at 2:05 PM, V21, Licensed Practical Nurse/LPN stated she worked day shift on 10/21/2025 but wasn't assigned to R5. V21 stated no staff reported to her that any resident including R5 fell that morning or that staff couldn't find R5's nurse to report that R5 fell. V21 stated she didn't know where to locate how residents transfer other than the nurse report sheet. On 10/30/2025 at 11:05 AM, V21, LPN, stated she spoke to V1, Administrator, and she told her the resident's transfer status is documented on the resident's care plan and Kardex. V21 stated she started working at the facility in June 2025 and didn't know the transfer status was documented there until V1 told her that today. On 10/30/2025 at 9:51 AM, V11, CNA, stated she worked 10/21/2025 day shift and was assigned to R5. V11 stated she got to the facility at 6:00 AM that day. V11 stated around 6:30 AM, she answered R5's call light and she wanted to get up for breakfast. V11 stated she assisted R5 to sit up on the side of the bed and put her wheelchair in front of her, as that is how she always transfers from bed to recliner, and she assisted R5 to stand by herself. She instructed R5 to pivot towards her recliner but when R5 went to pivot, she got shaky and her left foot got stuck in the wheelchair wheel, and R5 fell forward onto her stomach onto the bed. V11 stated she panicked and immediately turned R5's call light on, but 5 minutes went by and no staff responded, so she called the facility and spoke to V6, Business Office Manager, and told her she needs assistance from staff in R5's room, and V6 told her she'd sent staff to the room. V11 stated V4, Wound Nurse, entered R5's room approximately 10 minutes later and she assisted her to get R5 up and transferred R5 to her recliner. V11 stated she asked R5 many times if she was OK, and R5 stated she was OK. V11 left R5's room at approximately 6:50 AM and she was up in her recliner and was OK. V11 stated she looked for R5's nurse to report the resident fell and she couldn't find her nurse anywhere at the facility, and so she started getting other residents up and started passing breakfast trays. It was around 8:00	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET , HILLSBORO, Illinois, 62049

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S9999	Continued from page 11 AM when she noticed V18, RN, V17, NP, and an unknown therapy staff were in R5's room. After they left R5's room, she entered her room and asked what was going on, and R5 told her that they think her left ankle is broken and she has to go the emergency room. V11 stated V2, DON (Director of Nurses), and V3, ADON (Assistant Director of Nurses), spoke to her the same day at 11:00 AM. She was told she was suspended pending the investigation of R5's improper transfer and she was in-serviced at the facility on 10/29/2025 and she comes back to work 11/1/2025. V11's Employee Personnel File documents an employee corrective action form, dated 10/29/2025, documents "date of offense 10/21/2025 employee failure to follow departmental policies and procedures. Proper transfer procedures were not followed according to resident Kardex and/or plan of care." On 10/30/2025 a 12:07 PM, V3, ADON, stated she was working when R5 had a change in condition and was transferred to the emergency room. V3 stated she recalled the incident and was alerted by V17, NP, to go assess R5's left ankle/lower leg, and when she did she noted R5's left lower leg was swollen and bruised and she asked R5 how this occurred. R5 told her foot got caught in her wheelchair wheel during a transfer and she fell back onto the bed. V3 stated when a resident falls, she expects the CNA to notify the resident's nurse immediately, and if they can't find the resident's nurse to notify any nurse of a fall, and a nurse should assess the resident immediately for injury and pain and then should document the assessment and notify the resident's provider about what occurred. V3 stated when a resident initially falls, she expects staff to document a change in condition form (SBAR) which should document an immediate intervention which can include resident transferred to emergency room. After the resident is readmitted to the facility, the interdisciplinary (IDT) team will put a permanent intervention in place to prevent future falls on the resident's care plan. V3 would expect the permanent intervention to be documented on the resident's care plan within 24 hours of being readmitted to the facility. R5's permanent intervention was to have her be a mechanical lift, and V3 stated R5's care plan has been updated. V3 stated staff were verbally in-serviced on 10/21/2025, she ran around and verbally educated all staff working that they were to ensure residents were transferred properly to prevent injuries because R5 was improperly transferred and she sustained a left ankle/left leg bruising and swelling. V3 stated she put the in-service paperwork at the employee clock in for staff to read and some staff signed they were	S9999		

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S9999	Continued from page 12 in-serviced prior to working, but not all staff were in-serviced prior to working. R5's Care Plan as of 10/31/2025 documents at risk for falls and intervention: utilize 2 assist for transfers dated 9/28/2025. No update to R5's care plan to show she is now to be transferred by (mechanical lift) as of 10/21/2025. On 10/31/2025 at 2:47 PM, V28, Care Plan Nurse, and V5, Regional Nurse Consultant, stated R5's care plan documents R5 is a mechanical lift under the ADL (Activities of Daily Living) category and is a 2 person assist under the fall category, V5 stated R5's transfer status should be the same in both places so it doesn't confuse staff. V28 stated she wasn't aware R5's fall care plan documented 2 person assist and she will update it immediately to reflect that R5 is now a mechanical lift. On 10/29/2025 at 11:50 AM, V17, Nurse Practitioner, stated she was at the facility on the morning of 10/21/2025, and therapy staff (unknown name) reported to her R5 had new bruising, redness, and swelling to her left ankle/lower leg. V17 stated she went and assessed R5 immediately and R5 told her she was transferred with 1 staff and her foot got caught in the wheelchair wheel and she fell forward onto the bed. V17 stated no nursing staff reported this injury to her, therapy was the first to report this injury to her. V17 stated R5 was crying at that time and stated she didn't want to go back to the hospital because she was recently there for pneumonia and she didn't want to go back. V17 stated she spoke to R5 and let her know due to the extent of the injury she needed to be assessed at the local emergency room for imaging to see the extent of the injury to ensure she received proper care and treatment. V17 stated she's not sure if the fracture is new or not because R5 was assessed by a foot and ankle specialist, and he documented the fractures on the x rays were past chronic fractures, not acute, but V17 did confirm that R5's left foot/leg was bruised, red and swollen upon assessment after she was transferred by 1 staff on the morning of 10/21/2025. V17 expects staff to follow the resident's care plan because that recommendation is the safest mode of transfer for the resident per therapy. If staff questioned how a resident is transferred, they can check the resident's care plan, and she expected the care plan to be up to date at all times, so staff know what the therapy recommendation is and residents are transferred properly to ensure no injuries are sustained during transfers.	S9999		

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S9999	Continued from page 13 2. R10's Undated Face Sheet, documents initial admission date 12/9/2021, with diagnoses including history of falls, neurocognitive disorder with Lewy bodies, unsteady on feet and lack of coordination. R10's Quarterly MDS, dated 7/1/2025, documents cognitively impaired and no falls since admission/entry or reentry. R10's Fall Risk Data Collection Form, dated 7/1/2025, documents he is a low risk for falls. R10's SBAR note, dated 9/26/2025 at 4:45 AM, documents, "The resident is experiencing a change in condition. See SBAR (change in condition) assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is unwitnessed fall. This nurse walked into resident's room & found resident lying on his back next to his bed. This nurse call for CNA assistance. Resident was safely transferred to his w/c. Resident noted to have a drop in BP (blood pressure) when changing positions from lying to sitting, all other VS (vital signs) WNL (within normal limits). Neuros WNL. Resident c/o (complains of) pain to his rt (right) big toe. Resident noted to have new generalized redness to back. Resident was frequently monitored. Resident noted to be attempting to self-transfer again after the fall. This nurse attempted to notify (name), resident's POA. voicemail left to call the facility back. DON & provider notified of the fall. VS/Neuros initiated & N.O. (new order) for orthostatic BP x 3 days." R10's SBAR progress note, dated 9/26/2025 at 11:20 PM, documents "The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is Unwitnessed Fall CNA found resident next to his bed on the ground on his back. Resident was safely transferred to his bed with the assistance of 2 staff members. No injuries noted. Denies pain. VS/ROM/Neuros WNL. VS/Neuros initiated. Resident noted to continue attempt to self-transfer at times. Resident's bed move to station 2 & mattress was placed next to bed. ADON notified of fall & provider notified. Will attempt to call POA in AM." R10's Care Plan addressed his risk for falls, but no progressive interventions added to care plan after the two falls on 9/26/2025 to prevent future falls until	S9999		

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S9999	Continued from page 14 10/3/2025 staff documented two new interventions to prevent falls: scoop mattress and low bed. On 10/31/2025 at 11:50 AM, V28, Care Plan Nurse, stated she doesn't understand why R10's care plan when printed documents the scoop mattress and low bed fall interventions were initiated on 9/26/2025, but in R10's Electronic Medical Record (EMR) documents those same fall interventions were created on 10/3/2025. V28 stated she's never seen this issue with the dates not matching before and wasn't sure what the issue is. V28 stated she didn't know what date the fall interventions were implemented on, either 9/26/2025 or 10/3/2025. On 10/31/2025 at 12:00 PM, V1, Administrator, observed R10's care plan fall interventions dates didn't match and stated she will ask V5, Regional Nurse Consultant, why the fall intervention dates of created and initiated don't match. V1 stated she's never seen this documentation issue before. On 10/31/2025 at 12:11 PM, V5, Regional Nurse Consultant, stated she called the facility's corporate office and she stated no one including her understand or has ever observed this documentation issue in a resident's EMR care plan. V5 stated the created date and the initiated date always match, and she doesn't know what's going on with the computer system and didn't know when R10's fall interventions of the scoop mattress or the low bed was implemented. On 10/31/2025 8:55 AM, R10 was observed sitting up in wheelchair in hallway. V26, CNA, propelled R10 to his room. V27,CNA, applied a gait belt around R10's waist and V26 and V27 assisted R10 to stand and pivoted him to sit on the side of his bed. V26 held R10's top half and V27 picked up R10's feet and assisted him to lay in bed. R10 didn't respond to surveyor's questions regarding the fall. R10 had a scoop mattress and he had a low bed. On 10/31/2025 at 2:00 PM, V5, Regional Nurse Consultant, stated the facility's physician's order policy only covers staff needing to administer medications per physician's orders and doesn't include following physician's order for transfer status and V5 stated the facility doesn't have a proper transfer status policy. (B)	S9999		