STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERCARE OF COLLINSVILLE	614 NORTH SUMMIT , COLLINSVILLE, Illinois, 62234

(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 Annual Licensure and Recertification Survey.	S0000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)1)2) 300.1630a)1)2)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 personal care needs of the resident.	S9999		

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: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

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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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. These Requirements were not met as evidenced by: 1A. Based on interview and record review the facility failed to provide pain medication according to physician's order and effectively treat pain for 1 of 4 residents reviewed for pain management is a sample of 67. This failure resulted in R2 experiencing days of increased excruciating pain and feeling like no one cares.	S9999		

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S9999	Continued from page 2 Findings include: 1 R2's Electronic Health Record, not dated, documents admission date of 3/24/2025 and lists the following diagnosis: Peripheral Vascular Disease, Occlusion and Stenosis of bilateral Carotid arteries, Anxiety, Polyneuropathy, Dorsalgia, Weakness, Disease of the Spinal Cord, Chronic Pain, Spinal Stenosis, Cervical region, and Spondylolysis Lumbar Region. R2's Care Plan, dated 9/23/2025, documents that R1 has Acute Pain / Chronic Pain. It also documents interventions: Apply hot or cold packs for comfort. Determine Resident's satisfactory pain level. Establish a pain management treatment plan. Evaluate for non-verbal indicators of pain. Evaluate pain. Monitor for factors / activities that precipitate or aggravate pain. Utilize adaptive equipment as needed. R2's Minimum Data Set, dated 9/25/2025, documents that R2 is cognitively intact. It also documents that R2 frequently experiences pain, and the pain interferes with day-to-day activities. R2's Administration Note, dated 11/27/2025 at 7:21 PM, documents that Orders-Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain oos (Out of stock). R2's Administration Note, dated 11/28/2025 at 8:33 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain Medication unavailable. R2's Administration Note, dated 11/28/2025 at 11:30 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain Medication unavailable. R2's Health Status Note, dated 12/11/2025 at 1:55 PM, documents that Note Text: V32, Physician, in for rounds this day. rec'd order to increase his Norco from 5 mg to 7.5 mg. sent order to pharmacy for fill, requested pharmacy to send proper script to md office for fill out. will have previous order continue until new script is filled and delivered. R2's Administration Note, dated 12/13/2025 at 12:15 PM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days	S9999		

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S9999	Continued from page 3 pain drug unavailable, MD notified of new script needed pharm aware. R2's Administration Note, dated 12/13/2025 8:18 PM Orders - Administration Note, Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain This medication is unavailable at this time. Medication requires a new Rx per pharmacy. This nurse called on call provider and left a voice message informing the MD that medication requires a new Rx. Pending a reply. R2's Administration Note, dated 12/13/2025 8:24 PM, documents that Orders - Note Text: Tizanidine HCl Oral Tablet 2 MG Give 1 tablet by mouth in the evening for Pain Medication is currently unavailable at this time. Medication is not present in Pyxis to administer. Medication is on order at this time Pending delivery from pharmacy. R2's Administration Note, dated 12/14/2025 02:10 AM, documents that Orders - Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain Still waiting for response in regards to pharmacy receiving new script for new dosage. R2's Administration Note, dated 12/14/2025 11:41 Orders - Administration Note, Note Text: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG Give 1 tablet by mouth four times a day for pain for 3 Days pain drug unavailable, talk to pharmacist states some will be delivered tonight. On 12/16/25 at 8:21 AM, V15, LPN, was observed giving R2 his morning medications when R2 told V15 that they changed his pain medication and now he seems to be in pain again. V15 stated she was off for five days and when she looked in R2's orders, she stated "Yes, they did reduce his pain medicine. Why would they do that when he is still in pain. I will have to call and check on that." On 12/16/2025 at 11:20 AM R2 stated that he has severe pain. R2 stated that when he receives his pain medication the pain is manageable. R2 stated that the pain never goes away. R2 stated that they have been running out of his medication. R2 stated that just last week he had to sit in pain for days because they didn't have his medication. R2 stated that the pain is unbearable. R2 stated that he has migraines that feel like someone is tearing open his skull from the inside. R2 stated that the amount of pressure is unbearable. R2	S9999		

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S9999	Continued from page 4 stated that he injured his back years ago and the pain is overwhelming. R2 stated that when he is in that much pain he doesn't want to be bothered, easily irritated, and agitated with everyone even the people he likes. R2 stated that once the medication comes in it takes a long time to get the pain under control. R2 stated that he received an increase in his pain medication last week and have not received it yet. "How am I supposed to live in that much pain." R2 stated that he has not had or been offered any ice packs. R2 stated that the nurses don't even ask him if he is in any pain. "They don't ask. They don't care." On 12/22/2025 at 12:39 PM When asked why R2 hadn't received his Norco 7.5mg pain medication as prescribed on 12/11/2025. V2, Director of Nursing, stated that R2's Norco 7.5mg tablet was not available and R2 hadn't received his Norco 7.5mg because the pharmacy hadn't received a script. V2 then verified that R2 had not received his medication as prescribed. When asked why R2 had not received his Norco 5mg as prescribed on 11/27/2025, 11/28/2025, 11/29/2025, 12/13/2025 and 12/14/2025 V2 stated that there is no excuse for that because the nurses have access to the medication in the Nexus medication machine that's located in the medication room. V2 stated that the Norco is available in the medication machine. V2 stated that when a new or reorder for a narcotic is given the pharmacy is notified and a script is sent. V2 stated that the nurse is to follow up and verify the script was received by the pharmacy and the medication is then sent out. If the medication is not delivered the nurse is to follow up with the pharmacy. V2 stated that this process takes 24 to 48 hours. V2 stated that if a resident missed his dose of pain medication he would be in pain. On 12/23/2025 at 8:48 AM V33, Pharmacist stated that they received an order for R2's Norco 7.5mg. V33 stated that they had not received a script for this medication and was unable to send this medication out. V33 stated that they have requested the script from the provider by fax, phone and email without success. V33 stated that they have also contacted the facility and sent appropriate forms in attempt to get script. V33 stated that at this time R2's Norco has not been filled. V33 stated that they did receive a refill request on 12/14/2025 for Norco 5mg and due to having a script this medication was sent out. V33 stated from 12/11/2025 to 12/14/2025 the nexus system had not been accessed for R2. V33 stated that because of the class of medication the medication requires a code that is given by the pharmacy. The facility's Pain Management policy, dated 6/1/25,	S9999		

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S9999	Continued from page 5 documents that Purpose: To ensure accurate assessment and management of the resident's pain. Policy Facility Staff is responsible for helping the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain. Procedure: II. Pain Management: A. The Licensed Nurse will administer pain medication as ordered, and document medication administered on the Medication Administration Record (MAR). 1B. Based on interview, observation, and record review, the facility failed to administer medications according to the professional standards, including having a Licensed Nurse administer the medications, and ensuring the residents are taking their medications, for 2 of 4 residents (R2, R6) reviewed for medication errors in the sample of 67. The findings include: 1. R6's Admission Record, dated 12/17/25, documents R6 was originally admitted to the facility on 8/14/18 with diagnosis of Malnutrition, Catatonic Schizophrenia, Anxiety Disorder, Hypertension (HTN), Dyskinesia, Falls, Type 2 Diabetes Mellitus (DM), Major Depressive Disorder, and Pneumonitis. R6's Care Plan, dated 3/3/25, documents R6 has Impaired Coping, has a Self-Care Deficit, Risk for Decreased Cardiac Output, Risk for Impaired Communication, Decreased Cardiac Output, Arrhythmia, Hypertension, Disturbed Sensory Perception: Audible/Visual, Malnutrition. It continues 12/1/25: R6 has a behavior problem related to catatonic schizophrenia, anxiety and depression. examples walking fast for hours without sitting down, attempts at grabbing items not belonging to him and walking up onto others quickly. Interventions: Administer medications as ordered. R6 has Diabetes Mellitus. R6 is on anticoagulant therapy related to atrial fibrillation. Interventions: Administer Anticoagulant medications as ordered by physician. R6 is on diuretic therapy. Interventions: Administer Diuretic medications as ordered by physician. R6 is on pain medication therapy. Interventions: Administer Analgesic medications as ordered by physician. R6 uses antidepressant medication related to Depression Diagnosis. Intervention: Administer Antidepressant medications as ordered by physician. R6 uses anti-anxiety medications. Intervention: Administer Anti-Anxiety medications as ordered by physician. R6 uses psychotropic medications. Intervention: Administer Psychotropic medications as	S9999		

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S9999	Continued from page 6 ordered by physician. R6 has fluctuations in mood related to Catatonic Schizophrenia. Interventions: Administer medications as ordered. R6's Minimum Data Set (MDS), dated 11/16/25, documents R6 has a severe cognitive impairment and is dependent on staff for all Activities of Daily Living (ADLs). R6's Physician Order (PO), dated 12/16/25, documents "May crush medication." R6's PO, dated 11/10/25, documents "Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (milligram) Give 2 capsule by mouth one time a day for Anticonvulsants." R6's PO, dated 10/1/25, documents "Austedo Oral Tablet (Deutetrabenazine) Give 6 MG by mouth every 12 hours for Psychosis." R6's PO, dated 9/30/25, documents "Haloperidol Tab 5 MG Give 1 tablet by mouth two times a day for Schizophrenia." R6's PO, dated 2/10/25, documents "Carvedilol Oral Tablet 3.125 MG Give 1 tablet by mouth two times a day for HTN Take with meals." R6's PO, dated 8/29/25, documents "Furosemide Oral Tablet 20 MG Give 1 tablet by mouth two times a day for diuretic." R6's PO, dated 4/17/25, documents "Hyoscyamine Sulfate Oral Tablet Disintegrating 0.125 MG Give 1 tablet by mouth every 4 hours as needed for secretions." R6's PO, dated 3/18/25, documents "Xanax Oral Tablet 0.25 MG Give 1 tablet by mouth four times a day." On 12/16/25 at 8:00 AM, V15, Licensed Practical Nurse (LPN), was observed administering medications to R6. V15 obtained all R6's medications from the medication cart. V15 crushed up all medications except for the Depakote capsules which were opened and put in with all the other crushed meds. V15 mixed the crushed medications with a spoonful of oatmeal. After mixing the medications in the oatmeal, V15 put the spoonful of oatmeal mixed with medications in the bowl of oatmeal and delivered it to R6's room where V16, Certified Nursing Assistant (CNA) was sitting assisting R6 with breakfast. V15 placed the bowl of oatmeal with the spoon of medications onto R6's breakfast tray and left the room. V16 attempted multiple times to feed R6 his oatmeal, not knowing that there were medications in the	S9999		

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S9999	Continued from page 7 bowl, and each time R6 refused to eat the oatmeal. On 12/16/25 at 8:50 AM, V16, CNA, stated "(R6) did not eat any of his oatmeal this morning. Someone came in and took his breakfast tray out of the room." R6 did not get any of his morning medications. R6's Incident Note, dated 12/16/25 at 9:21 AM, and documented on 12/17/25 at 8:22 AM by V2, Director of Nursing (DON), documents "During medication administration it was identified that prescribed oral medications were crushed and mixed into oatmeal for consumption. Resident did not consume the medication mixed with the food as resident refused breakfast this AM. Nurse Practitioner (NP), DON notified, left message for Power of Attorney (POA) to notify. No return call back will continue to attempt." R6's Health Status Note, dated 12/16/25 at 1:44 PM, documents "Resident continues on hospice services with care focused on comfort and safety. Resident remains on 1:1 supervision with 15-minute safety checks in place. During this shift, resident was noted to exhibit wandering behaviors, requiring continued close monitoring. Resident refused breakfast despite staff encouragement, verbally stating “no.” Later in the shift, resident accepted and consumed pudding cups and consumed approximately 50% of lunch. At the time of this note, resident is sitting in the small dining/TV room with staff in close proximity. No acute distress noted. On 12/17/25 at 8:45 AM, R6 seen in bed with V16, CNA, at bedside. R6 appears clean and dry and without odors. When asked if she ever gives a resident their medications, V16 stated "No, I'm not licensed to give medications to a resident and would not do so." On 12/16/25 at 2:25 PM, V4, Assistant Director of Nursing (ADON), was advised of R6 not receiving his morning medications from V15, LPN. V4 stated "Well, that would contribute to some of his behaviors lately." On 12/16/25 at 3:40 PM, V28, Nurse Practitioner (NP), stated "I was not aware of (R6) not getting any of his medications today, only that he was having behaviors this morning and that was probably because he didn't sleep last night. I did stop (R6's) Eliquis, but I did not stop his Plavix or Aspirin. The Depakote DR Sprinkles I believe is approved to sprinkle over food and such, so it is ok for them to open the capsules. I'm not sure what to say about the CNA, but I would not expect the CNA to be given him his medications. (R6)	S9999		

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S9999	Continued from page 8 has all his medications ordered and he should be getting them as ordered. If (R6) has missed multiple doses, that could contribute to behaviors." 2. R2's Admission Record, dated 12/17/25, documents R2 was admitted on 3/24/25 with diagnosis of Peripheral Vascular Disease (PVD), Stenosis of carotid arteries, HTN, Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Polyneuropathy, Dorsalgia, Disease of spinal cord, Alcohol abuse, Depression, Generalized Anxiety Disorder, Major Depressive Disorder, Spondylolysis, and Spinal stenosis. R2's Care Plan, dated 9/23/25, documents R2 is at risk for Harm: Self Directed or Other-Directed, 11/13/25: R2 is/has potential to be verbally aggressive, 9/12/25: R2 has a behavior problem, resident has been verbally aggressive, Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. R2's MDS, dated 9/25/25, documents R2 is cognitively intact and requires supervision/touching assistance for ADLs and transfers. R2's PO, dated 3/24/25, documents "Calcium Carbonate Oral Tablet Chewable, Give 2 tablet by mouth in the morning." On 12/16/25 at 8:21 AM, V15, LPN, gave R24 his medications in one medicine cup with his Calcium Carbonate tablets in another cup. V15 left the Calcium Carbonate sitting on his bedside table and stated, "He will take that when he wants to." and left the room. On 12/23/25 at 8:20 AM, V23, LPN, stated "When passing meds, I make sure the resident takes them before I leave the room and would never leave them for a CNA to give them to the resident." On 12/23/25 at 8:25 AM, V17, LPN, stated "I stand by the resident to make sure they take the medication and don't choke on them. I would not leave them with a CNA for them to give to the resident." On 12/23/25 at 8:35 AM, V15, LPN, stated "I always watch the resident take their meds and would never leave the meds with a CNA for them to give to the resident." On 12/23/25 at 9:20 AM, V2, Director of Nursing (DON), stated "I would expect the nurses to stand by the resident and ensure the resident takes all their medications. They should never leave the medications	S9999		

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S9999	Continued from page 9 with a CNA or at the resident's bedside." The Facility's "Medication Administration" Policy, dated 6/1/25, documents in part "Medications will be administered by a Licensed Nurse per the order of Attending Physician or licensed independent practitioner or as consistent with state law. III. Medications must be given to the resident by the Licensed Nurse to prepare the medication, to as consistent with state law. V. Medications may be administered one hour before or after the scheduled medication administration time. VIII. Medications will not be left at bedside. IX. If the attending physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order. Procedure: VIII. Compare the licensed practitioner's prescription/order with MAR (Medication Administration Record) (first check). XV. Administer the medication to the resident. XVI. The licensed nurse will remain with the resident until the medicine is actually swallowed." (B) 2 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable	S9999		

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S9999	Continued from page 10 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. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure R8's batteries in alarm working, as identified as an intervention for falls for R8, for 1 of 5 residents (R8) reviewed for accidents in the sample of 67. This failure resulted in R8 falling and fracturing humerus. Prior to the survey date of 12/15/2025, the facility had taken the following action to correct the noncompliance: 1 On December 2, 2025, the facility Vice President of Clinical Services reviewed the Fall evaluation and Prevention policy. 2. On December 2, 2025, the Regional Nurse Consultant in-serviced the Facility Administrator, DON, ADON, MDS Coordinator were in-serviced on Fall Prevention Policy. 3. On December 2, 2025, the Administrator/DON/ Designee Initiated In-service with front-line staff on Fall Prevention Policy and where to verify Care Plan Interventions. In-servicing ongoing. 4. On December 3, 2025, the DON/ADON/ CNA staffing coordinator initiated In-serviced Nursing staff on how to find care plan/fall interventions in EHR. Staff will not work next shift until Fall Prevention In-service is completed. In-servicing on going. 5. On December 2, 2025, the RNC/RDO completed an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000309	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

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S9999	Continued from page 11 initial audit of all falls from 4/8/25 to present to ensure current interventions are initiated and effective. Care plans will reflect interventions that are effective and/or within the last 90 days. Audits are ongoing. 6. On December 2, 2025, the RNC/RDO/DON/ADON completed an initial audit of fall risk assessments to ensure that appropriate prevention interventions are in place & care plans are reflecting those interventions. Audits are ongoing. 7. On December 2, 2025, the RDO implemented quality assurance tool. An audit will be completed 5x/week x 4 weeks during clinical meeting to ensure that any fall, has a root cause analysis, progressive intervention, and care plan is updated by the DON/ADON and on-going audit. 8. On December 2, 2025, the Interdisciplinary Team initiated a root cause analysis for Fall Prevention and interventions being placed on care plan and physically in place will be reviewed weekly during Facility Risk Meeting x 4 weeks. Findings include:1. The facility long-term care facility serious injury incident and communicable disease report dated 7/9/2025 at 10:05AM documents nurse observed resident sitting on buttocks in front to the bathroom floor door with her walker flipped over in front of her. Report documents resident was assessed and complained of pain to her right arm, in house x-ray was obtained per dr order x-ray results on 7/9/2025 revealed acute humeral fracture documents investigation initiated per protocol, follow up will be sent. The facility long term care facility serious injury incident and communicable disease report dated 7/11/2025 documents Nurse Practitioner gave order to send resident to the Emergency Room for further evaluation. During Emergency Room evaluation R8 was diagnosed with Urinary Tract Infection (UTI) and Bradycardia. The report documents resident was interviewed prior to leaving for the ER. she stated she was on her way to the bathroom, could not recall why she was on the floor. The report documents in conclusion the Quality Assurance (QA) committee met and determined that the fall and fracture was a result of her R8's altered mental status. Intervention when R8 returned was to include educating her to ask for assistance to and from the bathroom and resuming Occupational Therapy (OT) and Physical Therapy (PT) for strengthening and safety awareness. R8's x-ray of Right humerus 2 plus views dated 7/8/2025 at 16:00pm documents acute humeral fracture. R8's facility	S9999		

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S9999	Continued from page 12 unwitnessed fall report dated 7/8/2025 at 10:05 documents nurse observed resident sitting on buttocks in front of the bathroom door with walker in front of her tipped over, resident is alert and orientated, resident has hematoma to right wrist, resident bed alarm was plugged up but not sounding appropriately. nurse assessed resident with ROM to right arm and resident wasn't able to do ROM to R arm. Resident was assisted from floor to bed with a mechanical lift with assist of two. Report documents R8 stated that she was going to the bathroom, came out of bathroom and loss balance and stated that her arm was twisted and behind her. Report documents hematoma to back of Right hand. Report documents mental status oriented to person, place and time. The report documents predisposing environmental factor; fall alarm. The fall report documents predisposing physiological factor as gait imbalance. The report documents no statements found. R8's progress notes dated 7/9/2025 at 11:33AM documents incident note. Interdisciplinary Team (IDT) met to review resident's unwitnessed fall. Care plan reviewed and updated. Resident is at risk for fall related to uses a walker, weakness, paranoid schizophrenia, diabetes, depression, cardiac arrythmia, bipolar disorder, cardiac medications, antihypertensives, and psychotropic medication use. Current fall interventions include staff assisted resident in organizing her room and ensured the floor was free from clutter, informed to utilize call light for assistance for help for both her and roommate, removed ill-fitting shoes and replaced with non-slip socks, and resident to sit in shower chair for every shower. root cause for fall, alarm was not sounding. Intervention: staff to ensure that fall alarm has working batteries. R8's hospital H and P documents R8 was admitted to the hospital on 7/9/2025 with bradycardia, right humeral fracture with non-op management, pain control and to continue immobilizer.R8's Minimum Data Set (MDS) dated 10/16/2025 documents R8 is cognitively intact with a BIMS of 15. R8's MDS documents R8 requires partial to moderate assistance for personal hygiene, lower body dressing and sit to standing. On12/18/2025 at 1:24PM V19 Certified Nursing Assistant (CNA)stated she is not aware of any interventions in place for falls for R8.On 12/18/2025 at 2:31PM V2, Director of Nursing (DON) stated fall interventions should be in place for residents. V2 stated if a resident has an alarm in place staff should check to make sure batteries are working. On 12/19/2025 per telephone interview at 12:12PM V32, physician stated R8's fall resulting in a fractured humerus could have been prevented if R8's alarm had	S9999		

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S9999	Continued from page 13 been sounding. V32 stated staff need to check batteries to ensure they are working. The facility Fall evaluation and prevention policy dated, reviewed 6/1/25 documents the purpose is to ensure 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. The policy documents the goal is to prevent falls if possible and avoid any injury related to falls. The policy will evaluate residents for their fall risk and develop interventions for prevention. The policy documents the goal is to prevent fall if possible and avoid injury related to falls. The policy documents risk factor associated with aa fall are intrinsic risk factors for falls 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, confusion, incontinence, Parkinson's disease, vision and hearing impairments, depression, seizure disorder, previous falls, certain medication classes such as: antipsychotics, sedatives and hypnotic, tricyclic antidepressants. The policy document the Interdisciplinary team (IDT) will review the plan of care and update the interventions as appropriate. The policy documents education of staff related to fall prevention documents providing a safe environment for residents, cause and risk factor for falls as well as the interventions to manage risk, safe transferring techniques, use of assistive devices, exercise programs to improve balance, gait and strength. (B)	S9999		