STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054890	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARA'S REHAB & SENIOR CARE	1450 CASTLE MANOR DRIVE , LINCOLN, Illinois, 62656

(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 Certification.	S0000		01/02/2026
S9999	Final Observations 1 of 2 Statement of Licensure Violatioms: 300.610a) 300.1210b) 300.1210c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. 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. Restorative measures shall include, at a minimum, the following procedures:	S9999		01/02/2026

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. These Requirements were not met evidenced by: Based on observation, interview, and record review the facility failed to implement pressure relieving interventions to prevent a facility acquired pressure ulcer and failed to do proper hand hygiene to prevent infection of a pressure ulcer for one of two residents (R101) reviewed for pressure ulcers in the sample of 38. These failures resulted in R101 developing an infected stage four facility acquired pressure ulcer to the right buttock that required, surgical debridement, hospitalization, and intravenous antibiotics. The (facility) Operations Group Policy and Procedure for Dressing Change- Aseptic Technique dated 4/13/2021 documents “Policy: Dressing changes will be completed using aseptic technique as ordered by the physician/practitioner. Purpose: To prevent resident with impaired resistance from becoming infected. Procedure: Wash hands. Disinfect surface where clean field will be set up. Perform hand hygiene. Assemble materials on clean field. Place waste receptacle within reach of workspace. Explain procedure to resident. Perform hand hygiene. Apply clean gloves (gown and face shield/goggles if needed). Remove old dressing place in waste receptacle. Remove and dispose of contaminated gloves. Perform hand hygiene. Apply clean gloves. Cleanse wound. Pat skin dry with clean gauze pad. Remove and dispose of gloves. Perform hand hygiene. Apply clean gloves. Apply primary dressing and or medication per physician’s orders. Remove gloves and dispose of contaminated waste material. Perform hand hygiene.” The (facility) Operations Group Policy and Procedure for Wound and Ulcer dated 3/28/24 documents “It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: all residents will be assessed to determine the degree of risk of developing a pressure ulcer using the Braden scale-ulcer assessment the resident will be assessed upon admission, once a week for four weeks, quarterly, and any significant change in condition after admission. When an existing or newly developed pressure ulcer is present, a skin assessment skin check will be documented each shift to monitor the individual resident tolerance to the repositioning schedule tissue	S9999		

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S9999	Continued from page 2 tolerance and the facility reevaluate frequency of positioning indication of the breakdown occur. Ulcer Definitions- Pressure Ulcer: A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing factors may be associated with pressure ulcers. Pressure ulcers are classified according to the amount of visible tissue loss using the international NPUAP/EPUAP Pressure Ulcer Classification System. The classification of pressure ulcers is called “staging.” Pressure Injury Stage III- Full Thickness Skin Loss - Full thickness tissue loss involving damage of necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss period undermining or tunneling may or may not be present. Pressure Injury Stage IV- Full Thickness Tissue Loss - Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Exposed bone/tendon is visible or directly palpable. Equipment, Prevention, and Treatment Resources – Equipment: Positioning aids; special mattress and/or chair cushion (low air loss, alternating pressure, etc. (etcetera) with pressure reducing/relieving properties. Prevention: The following prevention measures may be initiated to address pressure, moisture, friction, and/or shearing. The facility may also implement additional measures. Pressure: Pressure reduction surface on bed/chair when indicated. Turn and reposition at least every 2 (two) hours. Avoid positioning on an area of erythema or breakdown whenever possible. Limit time out of bed if needed.” R101's computerized Medical Record documents that R101 is a 75-year-old that admitted to the facility on 7/30/25 with diagnoses which included Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Arthrodesis Status, Paraplegia, Type 2 Diabetes Mellitus with Other Circulatory Complications. R101’s Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 9/28/25 scores R101 at a score of 20, indicating R101 was at a low risk of developing pressure ulcers. This same Braden Scale Evaluation documents R101 has no impairment in sensory perception, even though R101 has a diagnosis of Paraplegia. This Braden Scale also documents R101 mobility is slightly limited, R101 can make changes in position independently, and R101 has no problems with friction or shearing, even though R101’s current Care Plan documents R101 requires assistance of staff for positioning every two hours. This Braden Scale has a	S9999		

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S9999	Continued from page 3 section that includes interventions to prevent skin breakdown. There are no individualized interventions indicated on this assessment to prevent R101 from sustaining skin breakdown. R101's MDS (Minimum Data Set) assessment dated 9/30/25 documents a BIMS (Brief Interview for Mental Status) of 15, indicating (cognition intact). R101 has lower extremity impairment on both sides, uses a walker/wheelchair, is dependent on staff for toileting and lower body dressing, requires substantial assistance for bed mobility/transfers, and has an indwelling urinary catheter. This same MDS documents R101 had no pressure ulcers. R101's MDS assessment dated 10/28/25 documents a BIMS of 15, indicating (cognition intact). R101 uses a wheelchair for mobility, is dependent on staff for toileting, requires substantial assistance for dressing, bed mobility/transfers, has an indwelling urinary catheter and is frequently incontinent of bowel. R101 has one stage three pressure ulcer that was not present upon admission to the facility. R101's current Care Plan documents a diagnosis of Stage Four Pressure Ulcer of Right Buttock. Focus- R101 is at risk for impaired skin related to fragile aged skin, need for assist with mobility and transfers, use of indwelling catheter, incontinence of bowel, current pressure area, use of anticoagulant medication, and recent spinal surgery. Date initiated 6/25/25. Interventions: R101 needs assistance to turn and reposition every two hours per assessed need, and more often as needed or requested. Date initiated 6/25/25. R101 requires a low air loss mattress to the bed and cushion to the chair. Date initiated 6/25/25. On 10/3/25 R101 had a right gluteal fold shearing. On 10/14/25 per Wound Doctor R101 has a Stage Three Pressure Ulcer to his right lower buttocks. Interventions – Monitor and apply treatment to right gluteal fold shearing. Date initiated 10/3/25. 10/14/25 per Wound Doctor R101 has a Stage Three Pressure Ulcer to right lower buttocks. Treatment as ordered per primary care physician until healed. R101 requires evidence-based precaution isolation due to wound and contact isolation for Carbapenem Resistant Acinetobacter Baumannii (a dangerous, multi-drug resistant bacteria causing tough to treat wound infections) in wound. Date initiated 12/4/25. R101's Nursing Note dated 10/3/25 at 8:30 PM, documents that while rolling R101 onto his left side it was noted that R101 has a 0.5cm (centimeter) dark pink shiny shearing area to his right lateral gluteal fold. R101's Wound Clinic Evaluation dated 10/14/25 documents a Stage Three Pressure Wound of the right, lower buttock full thickness. Wound size 1.5cm by 2cm by 0.1cm. This same Wound Clinic Evaluation documents "(R101) changed wheelchair cushion from (pressure relief) to foam	S9999		

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S9999	Continued from page 4 cushion. (R101) sits in wheelchair all day. Developed wound 10 (Ten) days ago. (R101) has gone back to (pressure relief) cushion. Explained need for offloading of wound." Surgical excisional debridement was done to excise 1.20cm of devitalized tissue and necrotic muscle level tissue were removed at a depth of 2.1cm and a healthy tissue was observed." R101's Wound Clinic Evaluation dated 11/18/25 documents a Stage Four Pressure Wound of the right, lower buttock full thickness. Wound size 1.5cm by 2cm by 2cm. Surgical excisional debridement was done to excise 1.20cm of devitalized tissue and necrotic muscle level tissue were removed at a depth of 2.1cm and a healthy tissue was observed. R101's Nursing Note dated 11/23/25 at 1:00 PM, documents that R101 reported at lunch that his right buttock wound area was sore. "(R101) reported to staff at lunch today that his R (right) buttock wound area was sore, that he has low back discomfort, and that when he got up from bed today, he was feeling more weak than usual. Requested to go to bed refusing lunch and shower due to all over body aches and chills." R101 has a temperature of 102.1 degrees (Fahrenheit/F) and Tylenol was given. R101's dressing to right gluteal fold was removed due to being soiled and wound bed had thick yellowish drainage with a foul odor. Call placed to doctor. R101's Nursing Note dated 11/23/25 at 2:00 PM, documents that R101's vitals were blood pressure 108/54, pulse 98, respirations 20, temperature 102.2 degrees, oxygen level 94 percent at room air. R101 reports he continues to feel weak and sleepy and continues to have chills and all over body aches. R101 denies shortness of breath or difficulty breathing but respirations are increased and more shallow than usual. "Spoke with on call nurse regarding possible wound infection and protocol." The doctor was paged. R101's Nursing Note dated 11/23/25 at 3:11 PM, documents an order to send R101 to the Emergency Room for evaluation and treatment due to a change in R101's condition. R101's Hospital Report dated 11/23/25 at 3:49 PM, documents admitting diagnosis of "Fever, Wound Infection." R101's Physician Clinical Report dated 11/23/25 at 5:49 PM, documents "This is a 75-year-old with a past medical history of paraplegia after a fall off a ladder. (R101) presents to the ER (Emergency Room) today for fever and feeling generally unwell. (R101) does have a known wound on his right posterior upper leg and reports that it has had a foul smell coming from it. (R101) states that his symptoms of feeling generally unwell started a few days ago and then today he spiked a fever of 101. (R101) denies chest pain shortness of breath, cough, congestion, headache, neck pain, back pain, abdominal pain, nausea, vomiting, diarrhea, or urinary symptoms." Physical Exam- R101 is alert in no acute distress. Rectal:	S9999		

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S9999	Continued from page 5 “There is a tunneling quarter-size wound just below (R101’s) right buttock. There is a piece of packing in it that has purulent drainage, there is surrounding redness, (R101) currently has stooled himself. Impression: “There is a partial visualization of pronounced inflammation within the posterior aspect of the right upper thigh. There is fluid and gas density in this region secondary to infection which is adjacent to the ischial tuberosity. There could be underlying ischial decubitus ulcer. Correlation physical exam recommended.” Course of Care: “On examination R101 does have a tunneling wound with surrounding redness and purulent drainage. Concerned for Cellulitis, Soft Tissue infection, and Osteomyelitis. Results reviewed from CT (Computed Tonometry) showed tunneling wound with concern for decubitus ulcer of the right ischial tuberosity. Labs collected 11/23/25 at 4:13 PM documents Enterobacter Cloacae Complex. R101’s Hospital Progress Note dated 11/26/25, Radiology Results of MRI (Magnetic Resonance Imaging) of R101’s Pelvis show “Soft tissue tract involving the inferior right gluteal region extending to the posterior right thigh soft tissues and to the level of the ischial tuberosity. There is fluid signal along this tract without distinct drainable Abscess. 2. Only increased STIR (Short Inversion Time Inversion Recovery) signal within the right issue tuberosity which may indicate osteitis versus early osteomyelitis. No bone destruction was noted. R101’s Infectious Disease Progress Note dated 12/1/25 documents that R101 is a paraplegia from a fall complicated by a decubitus ulcer and fecal and urine incontinence. R101 is currently on an intravenous vancomycin and zosyn (both medications are used to treat serious bacterial infections). Care Timeline – Admitted 11/23/25 with debridement of Right Ischial Pressure Sore and Wound Vac (Vacuum) placement. On 12/16/25 at 11:20 AM, R101 was lying in bed on his left side holding on to the side rail with his left hand. R101 was receiving an intravenous antibiotic in his right arm. There was no low air loss mattress on R101’s bed. R101 stated that he is getting the antibiotic for an infected pressure wound that was acquired at the facility. R101 also stated that he cannot reposition himself and needs assistance from the staff. R101 stated “There are times I have to advocate for myself and remind staff to turn and reposition me.” On 12/16/25 at 11:25 AM: V9/Infection Preventionist performed wound care on R101’s Pressure Ulcer to R101’s Right Ischial Wound. When the old dressing was removed the wound was a Stage IV Pressure Wound, with serosanguineous drainage, and a malodorous smell. V9 stated “(R101) did not have the pressure wound on admission to the facility. (R101) was sent to hospital due to infection of the wound and was diagnosed with	S9999		

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S9999	Continued from page 6 Carbapenem-Resistant Acinetobacter Baumannii (CRAB) of the wound and returned to the facility with a Wound VAC and intravenous antibiotic for the wound." V9 cleaned R101's bedside table with a disinfectant wipe prior to putting the barrier down. V9 stated the drying time is three to five minutes but V9 would need to confirm the time. V9 fanned the bedside table with her hands and blew on table with her mouth. V9 did not do any hand hygiene after taking off R101's old dressing dated 12/15/25 and before changing her gloves. V9 did not do hand hygiene after cleansing R101's wound and applying R101's skin protectant. There was no hand hygiene or glove change performed after V9 put her gloved hand in the trash bin with the soiled dressing and then put a new dressing on R101. When V9 had completed R101's dressing change V9 was asked when hand hygiene should be done. V9 stated "Hand hygiene should be performed before and after each glove change and gloves should be changed between tasks." On 12/18/25 at 2:40 PM V8/Wound Nurse stated, "(R101's) pressure ulcer to the right buttock was caused by pressure, was facility acquired, and was caused from (R101) sitting up in the wheelchair all day. (R101) would sit up in the wheelchair from around 7:00 AM until 9:00 PM, except for when staff would change (R101) after lunchtime. (R101's) medical record does not include education given to (R101) or staff to change (R101's) position at least every two hours to prevent pressure ulcers prior to (R101's) development of the pressure ulcer to the right buttock." V8 verified R101's Care Plan documents R101 should have a low-air loss mattress for pressure relief and R101 does not have a low-air loss mattress. V8 also verified R101's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 9/28/25 was inaccurately coded and R101 should have been evaluated as a high-risk of developing pressure ulcers. V8 verified this same Braden Scale does not include pressure relieving interventions to prevent R101 from developing pressure ulcers. On 12/18/25 at 10:20 AM V19/Wound Physician stated, "Had the Braden Score been accurately completed and pressure relieving interventions been implemented according to that Braden Score prior to the pressure ulcer development, that could have helped to prevent (R101) from developing the (right buttock) pressure ulcer." V19 confirmed R101's right buttock wound was acquired in house due to pressure. (A) 2 of 2 300.610a)	S9999		

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S9999	Continued from page 7 300.1210b) 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 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. 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 EVIDENCED BY: Based on observation, interview, and record review the facility failed to ensure a resident with a high fall risk, diagnoses of Dementia and Muscle Weakness, and who was dependent on staff assistance for transferring, was transferred safely with a gait belt while toileting for one of one resident (R24) reviewed for falls in the sample of 38. This failure resulted in R24 falling in	S9999		

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S9999	Continued from page 8 the bathroom and hitting her head causing pain and requiring an emergent hospital transfer and resulting in a diagnosis of a closed head injury and a single contusion with a soft tissue hematoma to R24's scalp. The facility's Gait Belt Policy and Procedure, dated 6/15/09, documents "It is the policy of this to provide a safe environment for all residents. Using gait belts enables the facility to better provide security for the resident during standard non-mechanical assisted weight bearing transfers and assisted weight bearing ambulation. Gait belt use reduces the potential for injury to both the resident and staff and allows the most effective use of correct body mechanics. This belt is used as an assistive and safety device during non-mechanical assisted weight bearing transfers and assisted weight bearing ambulation. Procedure: 1. The gait belt should be placed at waist level with the buckle forward whenever possible. 6. Transfer the resident smoothly and move at the resident's pace. Avoid jerking or rushing the resident. 7. Use good body mechanics. Use an underhand grip on the belt. When assisting with transfers, place your hands at the resident's sides. Lift with your legs bent and straight back to avoid self-injury and assist the resident to a weight bearing standing using a smooth movement. When assisting with ambulation, use an underhand grip and grasp the belt at the back. Walk on the resident's weaker side, if possible." The facility's Safe Resident Handling Program Policy, dated 3/18/18, documents "The Safe Handling Program exists to ensure a safe working environment for resident handlers. The policy is to be reviewed and signed by all staff that perform or may perform resident handling. This policy will be reviewed annually with changes made accordingly. Gait belt usage is mandatory for all resident handling with the exception of mechanic lift use, bed mobility and medical contraindications. The gait belt will be considered a part of the certified nursing assistant's uniform. Resident transfer status will be listed on the resident plan of care." The facility's Fall Assessment and Management Policy, dated 6/2024, documents "Policy: It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be address and care planned." R24's Admission Record documents R24 is a 99-year-old female who admitted to the facility on 8/25/2023 with the following, but not limited to, diagnoses: Alzheimer's Disease, Spinal Stenosis, Idiopathic Peripheral Autonomic Neuropathy, Osteoarthritis, Generalized Muscle weakness,	S9999		

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S9999	Continued from page 9 Unsteadiness on Feet, Abnormal Posture, Dementia with Psychotic disturbance, and Depression. R24's Care Plan dated 5/9/25, documents "Focus: (R24) is at risk for falls related to History of Falls, Dementia, Osteoarthritis, Depression, Need for Assistance with all Mobility and Transfers, Use of Anti-Depressants, and Incontinence of Bladder." This same Plan of Care documents "Focus: (R24) is at risk for ADL (Activity of Daily Living) Self Care Performance Deficit related to Dementia. Interventions: Transfers- (R24's) usual performance for transfers is partial to moderate assistance with a gait belt, two wheeled walker and assist of one staff. (R24) uses a two wheeled walker with supervision/touch assistance for ambulation. Date Initiated- 9/6/2025." R24's MDS (Minimum Data Set) Assessment, dated 7/11/25, documents R24 is severely cognitively impaired and requires partial/moderate assistance with transfers. (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort). R24's Fall Risk Scale, dated 7/11/25, documents R24 is at high risk for falls. R24's Final Report to Illinois Department of Public Health, dated 7/31/25, documents R24 sustained a fall on 7/24/25 during a transfer in R24's bathroom from R24's wheelchair to the toilet with staff assistance, resulting in R24 being sent to the emergency room and sustaining a closed head injury and single contusion with a soft tissue hematoma to R24's scalp. R24's Event Note, dated 7/24/25, documents R24 had a witnessed fall in her bathroom resulting in R24 hitting her head significantly hard on the ground. This same Event Note documents a golf ball size goose egg was observed to the back left side of R24's head and R24 complained of pain to her head and the middle of her back. R24's Fall Management Review Note, dated 7/25/25, documents "Assessment: (R24) sent to the local emergency room for an evaluation of a raised area to the back of (R24's) head. Complaint of a headache/head pain and middle back pain. Returned to the nursing home with a diagnoses of minor closed head injury and a single contusion, with a soft tissue hematoma to (R24's) scalp." R24's Local Emergency Room Note, dated 7/24/25, documents "History of Present Illness- Chief Complaint: Fall. (R24) with a history of Dementia presents after ground level fall while transferring to toilet with (facility staff). (R24) hit the back of her head." This same Emergency Room Note documents, "Clinical Impression: Minor closed head injury. No loss of consciousness. Single contusion with soft tissue hematoma to the scalp." On 12/14/25 at 9:40 AM R24 was sitting in her recliner in her room. R24 presented as pleasantly confused and was unable to provide appropriate responses to questions. On 12/17/25 at 10:44 AM on V24/CNA (Certified Nursing Assistant)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054890	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARA'S REHAB & SENIOR CARE	1450 CASTLE MANOR DRIVE , LINCOLN, Illinois, 62656

(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
S9999	Continued from page 10 stated, “On 7/24/25 wheeled (R24) to her room after lunch to use the restroom. I wheeled (R24) into her bathroom, put my gait belt around (R24), and then stood (R24) up while (R24) was holding on the toilet grab bars. After I stood (R24) up, I let go of (R24’s) gait belt because I was standing behind (R24’s) wheelchair and could barely reach (R24) so I had to move (R24’s) wheelchair out of the way. As soon as I let go of the gait belt and place my hands on (R24’s) wheelchair handles, (R24) pulled down her pants, started to turn around on her own, tripped over her pants and fell backwards hitting the back of her head on the bathroom floor. I tried to catch (R24), but I could not since the wheelchair was in between us and I did not have ahold of (R24’s) gait belt. (R24) was crying out in pain, so I immediately yelled for assistance. (R24) was sent out to the (local emergency room) for evaluation.” V24 stated R24 requires assistance of one staff member and gait belt for transfers. V24 verified she should not have taken her hands off R24’s gait belt when transferring (R24) to the toilet. On 12/17/25 at 11:44 AM V2/Director of Nursing verified R24 required staff assistance times one and a gait belt for transfers. V2 stated, “Ideally, (V24/CNA) should have set (R24) back down in her wheelchair and repositioned (R24’s) wheelchair instead of letting go of (R24’s) gait belt to reposition the wheelchair. If a resident requires assistance with a gait belt, the staff should not let go of the gait belt while transferring any resident who requires staff assistance. On 12/17/25 at 11:53 AM V21/Facility Medical Director stated staff should not let go of a resident’s gait belt while transferring a resident who requires assistance with transferring. (B)	S9999		