

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056325		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER TAYLORVILLE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH HOUSTON , TAYLORVILLE, Illinois, 62568			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation: #2640507/#2714831 FRI of 7/25/25-#2690587		S0000			02/10/2026	
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and		S9999			02/10/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision and ensure residents at high risk for elopement were not able to leave the facility without the facility being aware the resident has left for one of five residents (R4) reviewed for elopement in the sample of 13. This failure resulted in R4 eloping from the facility on 7/25/2025. R4 was observed wandering in a ditch and found by a community member not affiliated with the nursing home. This community member contacted the assisted living facility who in turn notified the facility and asked if a resident was missing. The facility was unaware that (R4) had eloped. Due to R4's poor safety awareness, poor judgement, and need for ongoing supervision, this failure could result in serious harm, serious injury, impairment and/or death.		S9999				

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S9999	Continued from page 2 This past non-compliance occurred from 7/25/25 through 7/28/2025. Findings include: On 1/29/2026 during this survey the door alarm, went off on ten times form 9:30 AM to 1:30 PM. The door alarm went off at 9:39 AM, 10:03, 10:11 AM, 10:18 AM, 10:23 AM, 12:06 PM, 12:11 PM, 12:23 PM, 12:45 PM, and 1:11 PM. On 1/15/2026 at 1:51 PM, V1, Administrator stated, "We did have an elopement back in July. (R4) got out of the building". R4's Photo is in the green book at the nurse's station document, Elopement Book and was identified by the Facility as an elopement risk. R4's Physician Order Sheet (POS) for July 2025 documents a diagnosis of Unspecified Dementia w/o (without) behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, Unspecified Dementia with/Agitation, Depression, Metabolic Encephalopathy and Hypotension. R4's Minimum Data Set (MDS) dated 5/10/2024 documents R4 has a wander/elopement alarm that is used daily. R4 was severely impaired for cognition for activities of daily living. R4 is independent with ambulation and requires minimal assistance with care. R4's Care Plan edited on 11/26/2025 documents, "Resident is at risk for injuries d/t (related to) exit seeking behaviors: attempts to exit the building unattended: Resident had an elopement on 7/25/25. Problem Start Date: 05/03/2024 Behavioral Symptoms: exhibit wandering/exit seeking behaviors and at risk for elopement. I currently have a (wander management system) on. I am known for packing my things and attempting to leave the building. Long Term Goal Target Date of 2/28/2026 documents, "I will be free from wandering through next review date." R4's Elopement Assessment dated 7/6/2025 documents R4 is ambulatory of independent in wheelchair location, resident is cognitively impaired, poor decision-making			S9999			

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S9999	Continued from page 3 skills, and or pertinent diagnosis. Has a history of wandering unto unsafe areas and has a (wander management system). Resident is at risk for elopement. R4's Progress Notes dated 7/25/2025 at 4:30 PM, "Residents POA (Power of Attorney) and MD (Medical Doctor) notified of resident leaving the facility, safely returned to facility via a caregiver vehicle. Residents VS (vital signs) WNL (within normal limits). Skin checks negative for any new skin disruptions of baselines,(wander management system) checked for effectiveness." (Care giver was not from the facility but rather was from the assisted living facility). On 1/15/2026 at 1:02 PM, V17, Certified Nursing Assistant (CNA) stated, "(R4) got out of the facility a while ago. I can't tell you how long she was gone or how she got out of the building. I know she did not have any injuries when she returned. The assisted living next to us notified us that someone was walking around and we found it to be (R4). We did not know (R4) had gotten out. I can't tell you how she got out and/or how long she was gone. The alarms did go off earlier and we did a head count and (R4) was there. I don't remember why the alarms were going off and I don't remember them going off again. We got a call from the (assisted living) asking us if a resident got out and that's when we found out (R4) had gotten out. I do not remember any resident telling me (R4) had gotten out of the door." Statement by V17, dated 7/25/2025 documents, "I took two residents out for their smoke break. These two residents starting telling me that another resident was pushing on their wheelchair to try and get out the door. After I found out a resident had gotten out the door the two residents told me she had gotten out the door." (This statement does not document the names of the residents.) Statement by V22, Assisted Living Staff documents, "A man came to the front desk (assisted living) to tell me there was a lady that just went through the ditch in front of the parking lot. He was worried she came from our building. I came outside to see her walking down the road. I got into my truck to get to her she was on the side of the road, and she didn't know where she was, or her name. I put her in my truck and took her to (assisted living) to see if we could find out. Called (Facility), they came over the (assisted living) to see		S9999				

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S9999	Continued from page 4 if she belonged to their building. She did so I drove her over to the (Facility). She was closer to the front door to drop her off." On 1/16/2026 at 10:31 AM, V22 stated, "I remember the day I found the resident from the (facility). It was a very hot day and originally when I was notified by a man, I do not know his name, but he stopped by here because he said he was worried because there was a woman who looked confused that was in the ditch I thought it was one of our residents. I got in my truck because I could see the resident walking down the road. When I approached her, she was very confused, and she did not know her name, and I was worried that she got overheated. I could not tell you how long she had been outside, but she looked pale as if she had been outside for some time. I brought her back here and gave her some water to try and cool her down, and I knew she was not one of our residents, so I called the (facility) to see if they were missing any residents. At that time, they were not aware of any residents that were missing. Some of their staff came over her and identified her as being their resident. So I took her in my truck back to the (Facility)." Investigation Notes from R4's elopement on 7/25/2025 documents, (V18, Family of R6) stated (R4) did not follow behind them when they went outside. Residents (R8) and (R9) over sitting inside by smoker door and (R4) kept trying to push them out the door; they asked her to stop. (V17) took smokers out at around 4:15 PM." On 1/27/2026 at 12:52 AM, R8 stated she remembers (R4) was trying to push her and go outside but she is not supposed to go outside. She told the nurse. She does not remember (R4) ever going outside or seeing her leave through the gate by the gazebo by herself. She found out later (R4) got out, but this was when it was hot outside, but she did not see her get out and if she would have, she would have told somebody." Statement from R8 dated 7/26/2025 documents, "(R9) and I were seated at patio door waiting to go outside. (R4) was trying to push (R9's) WC (wheelchair) out of the way and through the door. I went to get (V19, Licensed Practical Nurse). She came and removed (R4) from the area. We were taken out then to smoke. I did see (R4) come through the door to the outside but not after that."			S9999			

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S9999	Continued from page 5 Statement from R9 dated 7/28/2025 documents, "She did push me out the door a little. The door alarm sounded. The nurse hollered and said 'you can't go out.' The nurse brought her away. Did not see (R4) go out the door into the courtyard. Did not see (R4) in the courtyard while smoking. (V7), (R8) and myself were outside." On 1/27/2026 at 11:09 AM, R9 stated, "I remember (R4) because she does not look like she is strong enough to push you, but she does have some strength. This was in the summer I believe. (R4) kept trying to push me and (R8) because she was trying to get outside. I went and got the nurse because I know she is not supposed to go outside without any staff. I never saw her go outside. I heard later she had gotten out, but I am not sure how she got out." Statement from V21, Former Assistant Director of Nursing (ADON) dated 7/25/2025 documents, "(V7, CNA) the CNA was sitting at the nurse station when I walked by during med (medication) pass and said that someone called from the (assisted living) said they may have one of our residents. We have to go over there right now. (V7) and I immediately went through the patio door and over to the (assisted living). We saw (R4) in a truck with one of the staff from (assisted living). Staff from the (assisted living) said she walked over there, and they put her in their truck and called us. (V7) and I came back and met them at the front door and assisted (R4) to building." On 1/27/2026 at 12:31 PM, V21, Former Assistant Director of Nursing (ADON) stated, "I remember when (R4) got out. This was back in the summer. I was on the C hall passing out my medications. The door alarm was sounding, and I went to the front desk to see what was happening. The door alarm will go off if the red button is not pushed before opening the door. Anytime we do not know what set off the alarm and or who went out we are supposed to do a head count. I know the DON was working the A hall and I was working the C hall and all of my residents were present. I did a head count and everyone on my hall was there. Later on, we got a call from the (assisted living) and they said they may have one of our residents. (V7) and I went over there, and it was (R4). We had done a head count earlier and nobody was missing. We are not sure how (R4) got out and I am not sure if anyone knew if she had gotten out."		S9999				

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S9999	Continued from page 6 R4's Investigation Report dated 7/28/2025 documents. "Administrator & Social Service Director spoke with (V18, Family member of R6) whose husband is here at the facility. She visits daily and often takes (R6 out to the patio area to visit. Staff reports that (V18) does know the code to the patio door and she can recite that to us during our conversation. (V18) stated that she is uncertain whether (R4) came out of the patio door when she was assisting her husband out to the patio. She believes that she wouldn't have let her out but is unsure. Family and staff report that (V18) does have memory loss and becomes more confused throughout the day." Side note in different handwriting documents "(wander management system) going off on return to building." On 1/27/2026 at 12:47 PM, V18, Family member of R6 stated, "I know back when it was warm they were asking me questions about if I had ever let anyone out. I think someone got out that was not supposed to get out. When it is warm, which is not now (R6) likes to go outside and sit by the gazebo. I would take him out and we would sit outside together. I did know the code and would take (R6) out. I never let anyone else go out with us or open the door for any resident. Sometimes there would be residents already outside smoking. I never saw any resident leave the area without staff and or leave through the gate." Statement from V13 (Certified Nursing Assistant, CNA) and V24 (CNA) documents, "were on C wing when the alarm went off around 4:30 PM, Said they needed a head count on all the halls, were clear on the C wing, come to find out a resident on the A hall had gotten out." On 1/27/2026 at 2:58 PM, V13 stated, "It has been some time since R4 got out. I remember a door alarm went off and I did a head count and all of my residents were here. If someone gets out the front door or the side door the alarms will go off with a (wander management system) and on the door it is supposed to always go off. I know (R4) got out and nobody knew how she got out." On 1/29/2026 at 10:25 AM, V19, Licensed Practical Nurse (LPN) stated, "I remember vaguely when (R4) got out. I know earlier (R8) and (R9) were complaining about (R4) trying to push them in their wheelchair so I went and		S9999				

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S9999	Continued from page 7 got (R4) and took her back to her room. There was a lot of stuff happening that day. I was looking for a kitchen employee. I remember the door alarms going off and doing a head count. Everyone on my hall was present. Then later when I was looking for the kitchen staff, I saw a truck pull up and drop off (R4). She had left the building, and nobody knew she was missing." V19's Statement dated 7/25/2025 documents, "I (V19) walked out deliver door near kitchen, and was walking around the facility looking for an employee. When I was walking up the front door a pickup truck pulled up with resident in her front seat. I assisted resident out of the vehicle and into the building. I looked over her resident body/skin Vitals etc, gave drink of water. When assisting resident into front door (wander management system) started to alarm. Resident was in place to ankle." Write up by V1 documents, "Approx (sic) 4pm: (V19) Licensed Practical Nurse (LPN) states she was in bathroom and heard front door alarm sounding. She went to the door and could not see anyone. She left alarm sounding and went out the door, checking perimeter to ensure no resident was outside. She did not determine why alarm was sounding and directed staff to start a 'head count' per policy. The (Weather History & Data Archive) website documents outside temperature on 7/25/2025 at 3:52 PM, 89 degrees Fahrenheit (F), and at 4:52 PM 89.0 F for the town where the Facility is located. 1/27/2026 at 1:34, V8, Medical Director stated, his expectation are residents with wandering tendencies should be monitored/supervised; exit doors for (wander management system) on residents should alarm and prevent unnoticed departures. Risk: Exposure to 89°F could cause dehydration, confusion, and possible harm or injury. The Facility Missing Resident Policy with a revision date of November 2017 documents, "It is the policy of (Facility) that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but are not limited to: door alarms, personal door alarm activation devices, staff intervention, staff education regarding response to door alarms, and individual resident intervention.		S9999				

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S9999	Continued from page 8 It is the policy (Facility) to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the event that a resident is deemed missing. Maintenance to check operations of all facility door alarms daily when on duty. Nurses to check door alarms each shift. "Key pad coded" door codes will be changed as needed by maintenance Kitchen door and all other hazardous doors are to be closed and locked at all times when staff not present. Staff to be in-serviced at orientation on door alarm policy and procedure. All alarms will be set at all times. Immediate response from staff when alarms are activated to secure situation and reset alarm. Once an alarm is signaled and if there is no witnessed cause of the signal, a resident search will be conducted. Each charge nurse is responsible to assure each resident is accounted for. All staff must respond and identify all residents. Once all residents are accounted for an all-clear announcement will be made. Should a resident be identified as missing, the policy and procedure for missing resident is initiated. (B) TWO OF TWO 300.610a) 300.1210b) 300.1210d)6) 300.2420j) 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 9 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. Section 300.2420 Equipment and Supplies j) A sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures shall be provided. Resident care equipment shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over-the-lap tables, foot cradles, footboards, under-the-mattress bed boards, trapeze frames, transfer boards, parallel bars, and reciprocal pulleys. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure equipment was in proper working order during transfers for 2 of 3 residents (R1 and R2) reviewed for mechanical transfers in the sample of 13. This failure resulted in R1 and R2 both being transferred with a mechanical lift and the slings ripped causing both residents to fall. Both residents were sent to the hospital. R2 substantiated a hairline fracture to her pelvis, black eye, bruised forehead and cheek, and required two sutures. R1 sustained three skin tears to his left arm with discoloration. Findings include: 1. On 1/13/2025 at 11:28 AM, R2 was in the dining room		S9999				

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S9999	Continued from page 10 sitting in her wheelchair. R2 has a yellowish purple faded bruise to her right forehead the size of medium size apple, a black faded yellow, purple bruise black eye to her right eye and band aid covering a small yellowish purple bruise that is exposed around the band-aid on her right cheek. R2's Physician Order Sheet for January 2026 documents a diagnosis of Paraplegia, unspecified; anxiety disorder, unspecified; Congenital hydronephrosis; Disorder of the skin and subcutaneous tissue, unspecified Irritable bowel syndrome, unspecified; Other neuromuscular dysfunction of bladder Note: neurogenic bladder; Scoliosis, unspecified; Spina bifida, unspecified Morbid (severe) obesity due to excess calories; Body mass index [BMI]40.0-44.9, adult. R2's Vitals dated 1/7/2026 documents R2 weighed 190.0 pounds, and her BMI (body mass index) was 45.08. Manufacturer directions for the mechanical sling documents this is within the guidelines for a safe transfer. R2's Minimum Data Set (MDS) MDS dated 10/4/2025 document R2 was cognitively intact for decision making of activities of daily living. R2 has no impairment on her upper or lower extremities, she uses a wheelchair and is dependent on staff for chair/bed transfer: the ability to transfer to and from a bed to chair (or wheelchair) in which staff completed all the activities for the resident for transfers. R2's Care Plan Category under Pain with a created date of 1/10/2026 documents, "Resident has pain/risk for pain related to recent pelvic fracture/chronic right hip dislocation following a fall. Under ADL's (Activities of Daily Living) Functions and dated 1/09/2026: Staff to ensure to utilize a mesh shower sling when transferring resident after a shower. Resident has bilateral lower extremity paraplegia from the waist down and requires a (mechanical Lift) for transfers." On 1/13/2025 at 2:00 PM, R2 stated, "I was born with scoliosis and spina bifida. I have never been able to walk. They have to use a (mechanical lift) to transfer me. There is a sling on the machine, and something was wrong with the sling because it broke when they were moving me, and I fell from the air and fractured my		S9999				

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S9999	Continued from page 11 pelvis. (V1, Administrator) came and told me she would investigate, and she said (V14, Laundry Supervisor) does inspections on the slings. I saw a picture of the sling and it was broken on one side on both the top and bottom. How could both sides break at the same time if there was not something wrong? They were transferring me from my shower chair back to my bed that day. There were two CNA's present in the room. I weigh around 195 pounds. When I was up in the air for about a minute the sling snapped and down I went. (V6) caught my head otherwise I am not sure what would have happened if I had hit my head. I have two stitches in my cheek and the bruising on my face and the fracture of my pelvis. I am afraid to be transferred now, and I know I need to get up and down. It's scary because it should have never happened to begin with. There was another man on my hall (R1) and he was being transferred and the sling broke on him too. This was about six months ago. Allegedly they got rid of all of those slings and got new ones. But, then why did it break again on me? I don't want anyone else to get hurt either." R2's Progress Notes dated 1/9/2026 at 4:45 PM, "This writer was down A wing starting med pass when staff was heard yelling "someone come quick, hurry". This writer began going to the yelling voices. A visitor of another resident pointed this writer down C wing. Upon coming to this resident's room, CNA (Certified Nursing Assistant) (V6) was on the floor with this resident, holding a towel to residents right side of her face. CNA (V7) was standing by resident's head talking to resident. Residents' legs were partially under her bed, with her right leg on top of the right leg of the (mechanical Lift), her left shoulder blade on top of the left leg of the (mechanical Lift), and the sling that had been under this resident for transfer was snapped and was hanging from the (mechanical) lift. This writer noted large amount of blood and yelled up the hall for someone to call 911. This writer, and CNAs (V6) and (V7) stayed with resident. Staff was able to safely remove the (mechanical lift) out from under the resident. A pillow was placed under resident's head, all the while pressure maintained to resident's right face. Resident alert and oriented x4, complains of pain to the right side of her face. Noted resident's right eye and area surrounding where pressure being applied to already be discolored. ROM (range of motion) WNL (within normal limits) for this resident. Resident stated to both the CNAs and this writer that she was ok. Resident continued to talk with staff. Call placed to residents POA (power of attorney) to notify of incident and of resident being transferred, and a call placed to (V5, MDS Coordinator) and on call manager to			S9999			

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S9999	Continued from page 12 come to the facility for this incident. Upon EMS arrival, resident was placed on a lift blanket and transferred from the floor to the stretcher via EMS (Emergency Medical service) personnel. EMS pulled the towel back from resident's face and revealed what appeared to be a puncture/laceration to right cheek. Resident was able to communicate with EMS, who began conducting a more thorough cognitive exam. Resident left facility to go to (Emergency Room) at approximately 5pm. (V8, Medical Doctor) was notified as well as (DON)." On 1/13/2026 at 2:28 AM, V7, CNA stated, "I was working the day (R2) fell from the (mechanical lift). (V6, CNA) came and got me and asked me to help transfer (R2). (R2) had just came back from the shower. Her sling was underneath her. We were transferring her from the shower chair to her bed. I was at the foot of her bed and (V6) was at the head. Once (R2) was in the air (R2) was crooked and I went to swing her around and the straps just snapped and (R2) fell. It happened so quickly. We did not pull on the straps or test them beforehand because the sling it was already underneath (R2)." Statement dated 1/13/2026 from V7 documents, "On 1/9/2026 I was helping (V6) transfer (R2) with the (mechanical lift) to her bed after her shower. Hooked her up (V6) guided her front, I was at the foot of the bed guiding her feet when the sling broke making her fall to the right side of her head, she was bleeding, (V6) kept pressure to her head as she landed hitting the (mechanical lift) legs. I could not get around to help. I yelled for a nurse like 'Now' (V4) came to assess the fall then yelled someone call 911. Then (V4) and I pulled the (mechanical lift) out from her. (R2) was talking to us the whole time. 911 arrived and took over." On 1/14/2026 at 1:34 PM, V6, CNA stated, "(R2) was in the shower chair and normally after her showers (R2) likes to go to bed. After her shower I got (V7) CNA, and we hooked up (R2), and the straps were on correctly, but when she was in the air the stitching on the loops came undone and (R2) went down. It happened so fast, and I grabbed her head as she was falling and (R2) hit her face on the base of the (mechanical lift) and it started bleeding. I yelled for help and (V4) arrived and I put a pillow behind (R2's) head and kept pressure on her face/cheek until the EMS arrived. I did not inspect the sling that morning because it was		S9999				

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S9999	Continued from page 13 already underneath (R2). Normally, laundry inspects the slings after they are washed, and they inspect and document. I personally only experienced issues with the sling breaking with (R2) but I am aware of (R1's) sling also breaking during a transfer. This was a regular sling underneath (R2)." R2's Initial Report dated 1/9/2026 (R2), a 55 year old female resident who resides at (Facility) with a history of paraplegia due to spina bifida, scoliosis depression, anxiety. Due to diagnosis, resident requires total assist from staff via (mechanical lift) for transferring. At approximately, 4:45 PM, on Friday, January 9, 2026, resident was given a shower, following the shower, 2 staff CNA's were transferring resident back to bed from the shower chair using the (mechanical lift) in resident's room. During the transfer, the (mechanical lift) sling loops came unattached, causing (R2) to fall, CNA was able to protect head from striking the floor. The CNA in room yelled for help from other staff and immediately held pressure to (R2's) right side of face where there apparated to be a laceration. Nurse (V4, LPN) immediately arrived to room to assess. (R2) remained conscious, alert and orientated, vital signs remained stable. EMS (emergency Medical Services) was called, staff remained with resident until arrival of EMT's (emergency medical team). Resident was taken to hospital for evaluation. Resident's son was notified of incident at this time as well and PCP (Primary Care Provider). Facility later received phone call from ED (emergency department) for evaluation." R2's Hospital Records dated 1/9/206 at 5:10 PM, documents, "chief complaint: Fall. Location of injuries right cheek, right periorbital area and head. Occurred at nursing home. Occurred 4:50 PM on 1/9/2026. Pt (patient) arrives per EMS (Emergency Medical Services), States the strap of the (mechanical lift) broke and patient fell face first. Patients face hit the base of the (mechanical lift). Pt (Patient) has pain to right side of face. Pt has bruising and swelling under R (right) eye. Pt has a small lac (laceration) on R (right) cheek. R2's Radiology Report dated 1/9/2026 documents, "Acute nondisplaced fracture through the anterior right ilia wing." 2. R1's POS documents a diagnosis of Unspecified dementia, mild, with mood disturbance; Constipation, unspecified; Pressure ulcer of left heel, unstageable; Laceration without foreign body of left upper arm, initial encounter; Generalized anxiety disorder;		S9999				

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S9999	Continued from page 14 Depression; and Pain. R1's MDS dated 6/14/2025 document R1 was severely impaired for cognition for activities of daily living. R1 has no impairments and uses a wheelchair and is dependent on staff for chair/bed transfer: the ability to transfer to and from a bed to chair (or wheelchair). Dependent: A helper completed all the activities for the resident. R1's Medical Records document R1 is currently on hospice. R1's Care Plan: Under Falls: Resident is at risk for falls due to: age related comorbidities. Start date 3/30/2024. Problem: I am cognitively impaired due to: Dementia, BIMS (Brief Interview for Mental Status) score previously was staff and remains staff due to nonsensical answers which is severely impaired." R1's Progress Notes dated 7/31/2025 at 11:02 AM, "Resident was being transferred by CNA (certified nursing assistant) & this nurse from his bed to the wheelchair to get up for lunch. Resident was in sling and properly fitted in, sling straps and hooks were intact with no noted fraying or breaks. When CNA lowered sling down to place in wheelchair the sling straps to the left side straps part of the sling snapped, dumping resident backwards. This nurse assisted resident to the floor breaking the fall by easing resident to floor as the right-side straps part of the sling and hooks were still intact on the lift. Resident did not hit his head, has no c/o pain, alert, orientated to baseline. Resident has 3 skin tears to the left arm and discoloration. Resident has a red spot to the left cheek where he bumped this nurse's knee when going down. Pillow placed under resident's head and sheet under arm to stop bleeding. EMS (Emergency Medical Service) called and they assisted resident to stretcher with a blanket sling. Resident has been sent to (Hospital) for an evaluation. POA (Power of Attorney) & MD (Medical Doctor) has been notified." R1's Progress Notes dated 7/31/2025 at 11:14 AM, "Writer called to resident room and found resident on the floor. ADON (Assisted Director of Nursing) and CNA were getting resident up for lunch and using (mechanical lift) and sling broke causing resident to go to the floor. Resident skin tear on left arm		S9999				

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S9999	Continued from page 15 resident also c/o (complained of) shoulder pain. Writer called 911 and also contacted son and left message. Ambulance here and transferred resident to (hospital) for evaluation. DON (Director of Nursing) and administrator aware of resident on floor." On 1/15/2025 at 10:07 AM, V2, Director of Nursing stated, "When (R1) fell during his transfer I was not working as the Director of Nursing. I only know there was something with the sling. I don't remember anything else and was not part of the management team at that time." On 1/13/2026 at 2:32 PM, V9, Licensed Practical Nurse stated, "I was not working when (R2) fell but I was working awhile back when they were transferring (R1) and his (mechanical lift) strap broke and he fell but he was okay. The strap broke and he fell." Employee Witness Statement by V11, CNA dated 7/31/2025 documents, "(V21, ADON) and myself were transferring (R1) to his w/c (wheelchair) with the (mechanical lift) when 2 of the straps on the (mechanical lift) sling snapped and he landed on the floor fell mostly on his shoulder." On 1/14/2026 at 10:39 AM, V14, Laundry Supervisor stated, "We in laundry are supposed to inspect every sling and throw away any sling that is damaged. I know we were not documenting in the log like we were supposed to and I did get written up for it. I guess it broke again and somebody fell during a (mechanical lift because the sling broke). I work five days a week." On 1/29/2026 at 1:33 PM, V1, Administrator stated (R1) did fall during a transfer and the sling broke. After (R1) fell from his sling we checked with laundry to make sure they were inspecting the slings, not using bleach on them and that they everyday they are supposed to check the slings, throw them out if they are damaged and document the sling condition. After (R2) fell we re-educated laundry again. No other interventions were put in place expect in-serving staff. The lift was a Invacare reliant 450." The (Mechanical Lift) Manufacture Instructions documents, "Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard them immediately.DO NOT alter the slings. Be sure to check the sling attachments each time the sling is		S9999				

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S9999	Continued from page 16 removed and replaced to ensure it is properly attached before the patient is removed from a stationary object (bed, chair, or commode).If the patient is in a wheelchair, secure the wheel locks in place to prevent the chair from moving forward or backward. When connecting slings equipped with color-coded straps to the patient lift, the shortest of the straps MUST be at the back of the patient for support. Using the long section will leave little or no support for the patient's back. The loops of the sling are color coded and can be used to place the patient in various positions. The colors make it easy to connect both sides of the sling equally. Make sure there is sufficient head support when lifting a patient." V14's Employee Disciplinary Form dated 1/12/2026, documents, "Verbal Warning documents, "Laundry Personal will ensure log is updated when slings are laundered and inspected for any sign tears, unthreading, fading or any type of wear and tear. Any slings found to be in disrepair will be thrown away and logged in binder as such. We wash slings daily and are supposed to document the conditions of the sling after every wash." The Sling Log for the past six months provided by the Facility does not document any slings were checked 1/6/2026-1/12/2026. On 1/14/2026 at 9:39 AM, V11, CNA and V12, transferred (R2) with the (mechanical lift). R2's sling was underneath her and the transfer was made without staff testing the straps, pulling on them and or ensuring all stitching was secure. On 1/30/2026 at 1:44 PM, V8, Medical Director stated he would expect staff to follow all protocol for transfers. The Facility Fall Policy dated 10/15/2021 documents, "It is the policy of (Facility) to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determines the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. We will develop a culture of safety to provide the Quality of Care and preventive services for each individual resident. Our Quality		S9999				

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S9999	Continued from page 17 Assurance Program will monitor the program to assure ongoing effectiveness. A Fall is an unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. (An intercepted fall occurs when the resident would have fallen if he or she had not caught him, /herself or had not been intercepted by another person-this is still considered a fall. Adherence to manufacturer's recommendation is use of medical devices and special care equipment: To be assigned by Administrator." (A)		S9999				