STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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TERRA VISTA OF OAKBROOK TERRACE, LLC	1635 S ARDMORE AVENUE OAKBROOK TER, IL 60181

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A 000	Initial Comment Annual Licensure Survey 295.2000 a) 295.2040 a) 5) e) h) 295.3000 a) b) 295.4010 d)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure residency requirements were met for one resident (R7) with multiple falls, with or without injury, and requiring supervision. This failure creates a substantial probability to cause severe harm to a resident. Findings include: According to R7's Electronic Health Record	A2000		

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A2000	Continued From page 1	A2000		

(EHR), R7's diagnoses include but not limited to Dementia in other diseases classified elsewhere with behavioral, Type 2 diabetes mellitus without complications, Hyperlipidemia, unspecified, Vascular Parkinsonism, Overactive bladder. R7's move in date was listed as 3/21/25.

R7's Mini- Mental State Examination score dated 3/17/25 is 12/30. A score of 10-20 indicates Clear impairment. May require 24-hour supervision. R7's Fall Risk Assessment score dated 1/3/26 was 30(>13 Total points=High Fall risk).

On 1/6/25at 9:43am, R7 was observed seated on a wheelchair in the dining room, unable to answer some of the questions. Stated he is okay, asked if he gets the assistance he needs, he said no, but cannot elaborate. A visual alert was posted on R7's apartment door (Video recording in progress).

An onsite visit was conducted on 1/5/26 to 1/6/26. R7's documents were reviewed including the fall incident log. According to these documents, in the span of 10 months of residency, R7 had 41 falls with and without injury. These falls were as follows:
3/28/25 8:30pm, room, no injury
4/19/25 9:30am, room, no injury
4/21/25 2:50pm, bathroom, no injury
4/21/25 6:00pm, room, no injury
5/1/25 5:10am, bathroom, no injury
5/10/25 6:23pm, bathroom, no injury
5/18/25 6:30pm, room, no injury
5/22/25 9:41am, room, no injury
5/22/25 1:22pm room, complained of hip pain
6/13/25 7:05pm, bedroom, no injury
6/24/25 11:30am, bathroom, no injury
6/27/25 9:37pm, bathroom, no injury
6/28/25 9:20am room, no injury

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A2000	Continued From page 2 7/2/25 12:15pm, bathroom, no injury 7/10/25 7:30pm, apartment, no injury 8/4/25 9:02pm, room, no injury 8/11/25 9:11pm, room, no injury 8/15/25 4:12pm, room, no injury 8/16/25 12:05pm, room, no injury 8/19/25 6:30pm, room, no injury 8/25/25 1:20pm, room, no injury 9/5/25 7:13pm, room, no injury 9/6/25 2:56pm room, no injury 9/6/25 5:53pm, bathroom, no injury 9/11/25 8:50pm, room, no injury 9/15/25 12:34pm room, no injury 9/24/25 6:00pm, room, no injury 9/24/25 7:02am, bedroom, no injury 9/26/25 7:20pm, with injury 9/28/25 4:42pm room, no injury 9/29/25 4:00pm, bedroom, no injury 10/12/25 7:01pm, room, no injury 10/22/25 5:45pm bedroom, no injury 10/26/25 8:00pm, bathroom, no injury 10/29/25 4:56pm bedroom, no injury 11/10/25 2:24pm apartment, no injury 11/18/25 5:30pm, bedroom, no injury 11/19/25 5:45pm, bathroom, abrasion 11/30/25 5:00pm, bedroom, no injury 12/14/25 7:23am, room, no injury 12/23/25 11:45pm-writer was in the nurse's office on the first floor and heard a loud boom noise at approximately 3:40pm. This writer and co-worker nurse went upstairs to the resident's room. This writer opened the door and observed the resident on the floor by his chair in front of bookcase. The resident was sitting upright on his buttocks...The daughter stated the resident was pulling his pants up and fell to the floor by the bookcase. 12/25/25 4:30pm bedroom, 9/29/25 4:00pm, bedroom, no injury. On 1/6/26 at 9:39am, E16 (Licensed Practical	A2000		

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A2000	Continued From page 3	A2000		

Nurse), said R7 self-transfers independently causing the falls. E16 said, R7 was not supposed to self-transfer.

On 1/6/26 at 10:30am, E15 (Registered Nurse) said, acknowledged R7 needs more supervision. There were distinct conversations with R7's family that R7 needs be out more to be monitored. The family was reluctant to change psychiatric medications to relieve anxiety and anger issues, refused to put thick fall mat on the floor.

On 1/6/26 at 12:01pm E2 (Director of Nursing) said, R7 does not remember that he requires assistance to transfer himself from bed to wheelchair, wheelchair to the toilet. The family believes he has the right to fall, and values R7's independence. The family indicated they watch R7 in the camera installed in R7's room. They support R7's choice, the right to transfer himself, and values independence over safety, insisted R7 will not get injured because they watch R7 in the camera. E2 said, it is only a matter of time before R7 gets injured, and this was explained to R7's family. E2 said, no one can prevent the fall, one on one supervision cannot prevent fall, it is part of his Dementia.

R7's Fall Risk Service Plan (dated 3/17/25) documented
Safety/Falls: Moderate Assist needed. Resident is a fall risk due to neurological limitations. Needs Supervision. To prevent falls.
On a separate sheet, it documented: 1 person assist for dressing, 1 person assist for showers and transferring, 1 person assist. Can stand and pivot. Uses a wheelchair for safety. But can use a wheelchair if assisted by staff. Please keep wheelchair next to his bed facing the window with wheels locked when he is in bed so he can

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A2000	Continued From page 4 transfer himself. Keep side mat in place... Can refuse care on occasion. 1 person assist for transfers to toilet ...Please put disposable bed pads on his bed, only use the fabric bed pads. He has slipped out of bed and fallen in the past due to disposable bed pads. Mobility/Transfer. Use gait belt for transfers. Revised 12.31. With R7's family's refusal to cooperate with interventions to prevent falls, there was no alternative interventions in place to ensure resident's safety.	A2000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative e) Drills shall include residents, establishment personnel, and other persons in	A2040		

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A2040	Continued From page 5 the establishment. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. These requirements were not met as evidenced by: Based on interview and record review, The establishment failed to complete an emergency and evacuation orientation which is signed by resident or resident representative within 10 days of move for two (R2, R4) of six residents reviewed for this disaster preparedness. The facility also failed to include residents and other person in the establishment during drills and failed to identify residents who received assistance for evacuation. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: On 1/5/26, sampled residents Emergency and evacuation orientation was requested. According to R2's Electronic Health Record (EHR), R2 moved into the community on 8/25/25. R2's document titled Responsible Party and Resident Orientation was signed on 11/8/25, more than the 10 days specified on this requirement. According to R4's Electronic Health Record (EHR), R4 moved into the community on 12/8/25. R4's document titled Responsible Party and	A2040		

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A2040	Continued From page 6 Resident Orientation was signed but NOT dated. Unknown when resident or resident representative received orientation to the emergency and evacuation plan. FIRE DRILLS 2/7/2025- 10AM-10:15AM- 15 mins- 1st shift- employee signature only 4/9/2025- 5:30PM- 5:45PM- 15 mins, 2nd shift- employee signature only 6/10/2025- 11:30PM- 11:45PM- 15 mins. 3rd shift- employee signature only 8/24/2025- 7:30AM- 7:40AM- 10 mins. 1st shift- employee signature only 10/10/2025- 2:30PM- 2:40PM- 10 mins- 2nd shift- employee signature only 12/17/2025- 11:30PM- 11:40PM- 10 mins- 3rd shift- employee signature only On 1/5/2026 at 12:55PM, E11 (Receptionist) said that E10 (Maintenance Director) is on vacation until tomorrow. On 1/5/2026 at 1:22PM, E12 (Customer Care Manager) said that E10 (Maintenance Director) stated that whatever is in the Emergency and Disaster Manual it's all they have.	A2040		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training	A3000		

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A3000	Continued From page 7 a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. These requirements are not met as evidenced by: Based on observation, record review and interview, the establishment: -Failed to use wheelchair foot/leg rest during resident transport resulting to one (R4) resident's fall. -Failed to provide adequate assistance during transfer resulting to skin tear for one (R6) resident. - failed to ensure at least one direct staff person was on duty at all times that had obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. This failure creates the substantial probability to cause severe harm to a resident or residents in the establishment. Findings include: An onsite visit was conducted on 1/5/26 and 1/6/26. According to R4's Electronic Health Record	A3000		

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A3000	Continued From page 8	A3000		

(EHR), R4 is 83 years old. R4 moved into the community on 12/8/25. R4's diagnoses include but not limited to Dementia in other diseases classified elsewhere, Anxiety Disorder, unspecified, Vertigo of central origin, Arthritis due to other bacteria, unspecified joint, and Osteoarthritis of hip, unspecified.

R4's nursing notes dated 12/18/25 entered by E15 (Registered Nurse) stated in part; "(R4) was laying on her left side on the floor outside room 140. She was laying directly in front of her wheelchair. She was being pushed by Caregiver (E14- Certified Nursing Assistant). Fall was also witnessed by (two Caregivers) ...All state that she was riding in the wheelchair that did not have leg lifts on the chair. She put her feet down on the floor and was flung forward out of the chair onto the floor."

On 1/6/26 at 10:30AM, E15 said, the leg lifts needed to be used when transporting a resident.

On 1/6/26 at 12:01PM, E2 (Director of Nursing) said, R4's feet should have been on the wheelchair's footrest.

On 1/6/26 at 9:04AM, R4 was observed seated on a wheelchair in the TV area. The wheelchair had no foot or leg rest on. R4's feet were on the floor.

R4's Service plan documented; 12/18/25 "Remind caregivers to use footrest."

According to R6's EHR, R6 is 77 years. R6's diagnoses include but not limited to Alzheimer disease, Belching symptom, chronic kidney disease stage 3A (disorder), and Reactive depression. R6 moved to the community on

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A3000	Continued From page 9 3/14/23. R6's clinical notes dated 12/29/25 documented; "Resident was being transferred by caregiver (E13- Caregiver) from bed up to wheelchair. (E13) was holding (R6) by the hands to steady her, she began to lose balance, in his attempt to steady her, (R6) sustained a skin tear to her right upper hand." On 1/6/26 at 2:02PM, E13 said, "I was getting her up for breakfast to start the date. To be honest I don't know when it did happen, I only noticed it when she was already on the chair, she already had a wheelchair. I am guessing I was trying to get her up, she was heavy and tall. So, I hold her on the hands and stood her up. Sometimes I need to hold her from the back. She used to be Hoyer lift; they took her off Hospice. From the wheelchair to toilet, she grabs the bar. One person can do it. If from the bed, there is no grab bar to hold on, so from bed she needs Hoyer lift as safer form to transfer. Either that or Two person assist. She is tall and heavy. At the time of incident, she was being transferred from bed to wheelchair. At that time, she needed two persons to transfer her." On 1/6/26 at 12:56PM, R6 was observed being assisted to the bathroom by E17 (Caregiver). E17 instructed R6 to hold onto the grab bar. R6 hold onto the grab bar and slowly hoist up and sat on the toilet. There was no Hoyer lift inside R6's apartment. R6's Service Plan dated 11/24/25 stated in part. Transferring: Moderate Assistance. Description of Assistance and Preferences: Staff to use a Hoyer lift x2 assist for transfers. According to R6's notes; R6 has been discharged	A3000		

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A3000	Continued From page 10 from Hospice care since 6/9/25. On 1/5/26 at 2:43PM, E2 (Director of Nursing) Confirmed R6 uses mechanical lift to transfer. "The family is leasing it. She was previously on Hospice, but she became stable. She is off hospice." On 1/5/2026 Customer Care Manager provided this surveyor with a folder with nurses CPR. Per establishment's employee roster, there are 28 nurses and 19 Caregivers/Certified Nursing Assistants with CPR Certification. Out of 28 nurses, 16 completed CPR without return demonstration, seven nurse completed CPR after surveyor requested CPR documents. Out of 19 Caregivers/Certified Nursing Assistants who have CPR, 13 completed CPR online without returned demonstration. On 1/5/2026 at 2:42PM, E2 (Director of Nursing/DON) said that she completed CPR Online today, E2 said that E1 (Executive Director) sends a link to the nurses/staff to complete CPR Online when they need re-certification.	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 Service Plan d) The service plan, which shall be reviewed	A4010		

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A4010	Continued From page 11	A4010		

annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act)

This requirement is NOT MET as evidenced by:

Based on observation, interview and record review the establishment failed to revise and implement individualized fall interventions to prevent multiple falls, with or without injury for four (R1, R3, R7, R9) of five residents reviewed for falls. This deficient practice casused harm to a residents and has the probability to cause severe harm to a resident or residents.

Findings include:

According to R1's Electronic Health Record (EHR), R1 moved to the community on 4/4/25. R1's diagnoses include but not limited to Alzheimer's disease with early onset, Low back pain, Unspecified abnormalities of gait and mobility. R1 moved to the community on 4/4/25. R1's Mini Mental State Examination (MMSE) score, is 17/30 (0-17= Severe Cognitive impairment. Day to day functioning: Marked impairment. Likely to require 24-hour supervision.)
On 1/6/26 at10:12AM, R1 was observed on a wheelchair in the dining room. R1 was alert. Stated no issues with care.
Establishment's documents titled "Incident Reports Summary" indicated R1 had 25 falls in the span of 9 months of residency. These falls are as follows:
4/28/25 2:50pm- room, no injury
5/10/25 3:49pm- hallway, no injury
5/11/25 5:00pm- resident's room, no injury

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A4010	Continued From page 12	A4010		

5/23/25 10:45am- dining room, no injury
5/26/25 3:32pm- bedside, no injury
5/29/25 8:08pm -resident's room, no injury
5/29/25 6:17am -resident's room, c/o pain. witnessed, slipped to the floor
5/29/25 7:45pm -resident's room, injury abrasion
6/10/25 8:20am- hallway, no injury
6/17/25 9:21 am- room, injury abrasion
7/8/25 11:40am- dining area with injury
7/12/25 6:00pm- hallway, no injury
7/17/25 10:14pm- hallway, no injury
7/27/25 10:14pm- TV area, injury small red spot to forehead
8/19/25 7:55pm- resident's room, no injury
8/24/25 1:16pm- hallway, no injury
9/4/25 11:48pm- hallway, no injury
9/26/25 1:56pm- room, no injury
10/15/25 10:00am- room, no injury
10/25/25 7:35am- room, no injury
10/30/25 7:46pm- by bed, no injury
11/2/25 7:24pm- hallway, no injury
11/5/25 9:30pm- bedroom slight redness from kneeling
11/15/25 2:28pm- Northside hallway, injury hematoma
11/21/25 5:55pm- hallway, injury hematoma
R1's Service plan (Annual) dated 11/20/25 stated in part.
Safety/Falls: Resident at high risk for falls. Has history of multiple falls. Falls have occurred 4/28/25, 5/10/25, 5/11/25, 5/23/25, 5/26/25, 5/28/25, 5/29/25, 6/10/25, 6/17,25, 7/8/25, 7/12/25, 7/17/25, 7/27/25, 8/19/25, 8/24/25, 9/4/25, 9/26/25, 10/15/25, 10/16/25, 10/25/25, 10/30/25, 11/2/25, 11/5/25, 11/15/25, and 11/21/25. Encourage resident to use wheelchair for longer distances and when feeling tired. Resident sleeps on queen size bed with one rail for repositioning. Round on resident every two hours and as needed. Ask resident if she needs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRA VISTA OF OAKBROOK TERRACE, LLC	1635 S ARDMORE AVENUE OAKBROOK TER, IL 60181

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A4010	Continued From page 13	A4010		

help using the bathroom. Keep room well lit. Keep personal items and needs within reach such as tv remote. Keep pathway clear of clutter. No rugs. Give reminders to use walker or to ask for help when needed.
Additional fall intervention found a separate sheet indicated: Encourage to go the bathroom every two hours, stay in common area during waking hours for supervision, when possible, caregiver to provide reminders and transfer assistance (R3 was assessed as independent on this areas), encourage to participate in activities, put slipper boots.
On 1/6/25 at 10:30am, E15 (Registered Nurse), said R1 gets upset when told what to do. With the Dementia, resident also forgets instructions provided.
Despite all these interventions in place R1 continued to fall.

According to R3's EHR, R3 is 77 years old. R3 moved into the community on 2/10/25. R3's listed diagnoses were Malignant neoplasm of frontal lobe, Unspecified dementia without behavioral disturbance, Delirium due to known physiological condition, Parkinson's disease, Alzheimer's disease, unspecified, Epilepsy. R3's Hospice notes indicated, R3 was admitted to Hospice care on 11/24/25 with a diagnosis of Parkinson's Disease.
On 1/6/26 at 9:18am, R3 was observed in the TV area, seated on a high back wheelchair. R3 said was alert, oriented and pleasant upon approach. Able to verbalize needs.
Establishment's documents titled "Incident Reports Summary" indicated R3 had 14 falls in the span of 11 months of residency. These falls are as follows:
2/21/25-in room, no injury
3/19/25- bedroom, injury to right hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A4010	Continued From page 14 6/9/25- apartment, injury- skin tear 7/20/25 7:07pm room, bedroom, no injury 7/29/25 3:30pm, hallway, skin tear 8/13/25 7:35am- room, skin tear 8/15/25 7:21am- bedroom, no injury 10/2/25 12:47pm- observed lying on the floor, bedroom, no injury 10/4/25 8:51pm- found the resident seen on the floor sitting upright with head leaning on the mattress. 10/5/25 11:30pm hip injury- observed the resident laying on the floor by the wall next to his dresser. 10/9/25- laceration. resident was found on the floor with bleeding noted from the left hand due to a skin tear. observed upon palpation of left hip the resident c/o slight pain. 10/15/25-skin tear- At 7:30pm this writer was informed by caregiver that the resident had an unwitnessed fall in his bathroom and was bleeding. 11/2/25 10:30pm, resident was on the floor at 10:30pm, unwitnessed fall, no injury. 11/20/25 7:40pm, in room, laceration - At approximately 7:40PM, this writer found the resident on the floor behind the room door, lying on his left side. Resident was noted to have active bleeding from a laceration to the head and a skin tear to the left elbow. Resident stated, "I came to the door to turn on the light and I fell on my left side. My hip is hurting a lot." R3's Service plan dated 11/30/25 indicated the following interventions: Safety/falls- Keep in common area, waking hours, self-propels in wheelchair at times, rounding every two hours. There were no indicated dates when these interventions were put into place. Uknown if these interventions were revised, as the R3 had several falls with injury. Every two hour of resident rounding not sufficient to prevent the falls. The fall incidents occurred	A4010		

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A4010	Continued From page 15 mostly inside R3's apartment. According to R7's EHR, R7 is 83 years old. R7's diagnoses include but not limited to Dementia in other diseases classified elsewhere with behavioral, Type 2 diabetes mellitus without complications, Hyperlipidemia, unspecified, Vascular Parkinsonism, Overactive bladder. R7's move in date was listed as 3/21/25. R7's Mini- Mental State Examination score dated 3/17/25 is 12/30. A score of 10-20 indicates Clear impairment. May require 24-hour supervision. R7's Fall Risk Assessment score dated 1/3/26 was 30(>13 Total points=High Fall risk). On 1/6/25at 9:43am, R7 was observed seated on a wheelchair in the dining room, unable to answer some of the questions. Stated he is okay, asked if he gets the assistance he needs, he said no, but cannot elaborate. A visual alert as posted on the door (Video recording in progress). An onsite visit was conducted on 1/5/26 to 1/6/26. R7's documents were reviewed including the fall incident log. According to these documents, in the span of 10 months of residency, R7 had 41 falls with and without injury. These falls were as follows: 3/28/25 8:30pm, room, no injury 4/19/25 9:30am, room, no injury 4/21/25 2:50pm, bathroom, no injury 4/21/25 6:00pm, room, no injury 5/1/25 5:10am, bathroom, no injury 5/10/25 6:23pm, bathroom, no injury 5/18/25 6:30pm, room, no injury 5/22/25 9:41am, room, no injury 5/22/25 1:22pm room, complained of hip pain 6/13/25 7:05pm, bedroom, no injury 6/24/25 11:30am, bathroom, no injury 6/27/25 9:37pm, bathroom, no injury 6/28/25 9:20am room, no injury 7/2/25 12:15pm, bathroom, no injury	A4010		

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A4010	Continued From page 16	A4010		

7/10/25 7:30pm, apartment, no injury
8/4/25 9:02pm, room, no injury
8/11/25 9:11pm, room, no injury
8/15/25 4:12pm, room, no injury
8/16/25 12:05pm, room, no injury
8/19/25 6:30pm, room, no injury
8/25/25 1:20pm, room, no injury
9/5/25 7:13pm, room, no injury
9/6/25 2:56pm room, no injury
9/6/25 5:53pm, bathroom, no injury
9/11/25 8:50pm, room, no injury
9/15/25 12:34pm room, no injury
9/24/25 6:00pm, room, no injury
9/24/25 7:02am, bedroom, no injury
9/26/25 7:20pm, with injury
9/28/25 4:42pm room, no injury
9/29/25 4:00pm, bedroom, no injury
10/12/25 7:01pm, room, no injury
10/22/25 5:45pm bedroom, no injury
10/26/25 8:00pm, bathroom, no injury
10/29/25 4:56pm bedroom, no injury
11/10/25 2:24pm apartment, no injury
11/18/25 5:30pm, bedroom, no injury
11/19/25 5:45pm, bathroom, abrasion
11/30/25 5:00pm, bedroom, no injury
12/14/25 7:23am, room, no injury
12/23/25 11:45pm-writer was in the nurse's office on the first floor and heard a loud boom noise at approximately 3:40pm. This writer and co-worker nurse went upstairs to the resident's room. This writer opened the door and observed the resident on the floor by his chair in front of bookcase. The resident was sitting upright on his buttocks...The daughter stated the resident was pulling his pants up and fell to the floor by the bookcase.
12/25/25 4:30pm bedroom, 9/29/25 4:00pm, bedroom, no injury.
On 1/6/26 at 9:39am, E16 (Licensed Practical Nurse), said R7 self-transfer independently causing fall. E16 said, R7 was not supposed to

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A4010	Continued From page 17	A4010		

self-transfer.
On 1/6/26 at 10:30am, E15 (Registered Nurse) said, acknowledged R7 needs more supervision. There were distinct conversations with R7's family that R7 needs be out more to be monitored. The family was reluctant to change psychiatric medications to relieve anxiety and anger issues, refused to put thick fall mat on the floor.
On 1/6/26 at 12:01pm E2 (Director of Nursing) said, R7 does not remember that he requires assistance to transfer himself from bed to wheelchair, wheelchair to the toilet. The family believes he has the right to fall, and values R7's independence. The family indicated they watch R7 in the camera installed in R7's room. They support R7's choice, the right to transfer himself, and values independence over safety, insisted R7 will not get injured because they watch R7 in the camera. E2 said, it is only a matter of time before R7 gets injured, and this was explained to R7's family. E2 said, no one can prevent the fall, one on one supervision cannot prevent fall, it is part of his Dementia.
R7's Fall Risk Service Plan (dated 3/17/25) documented
Safety/Falls: Moderate Assist needed. Resident is a fall risk due to neurological limitations. Needs Supervision. To prevent falls.
On a separate sheet, it documented: 1 person assist for dressing, 1 person assist for showers and transferring, 1 person assist. Can stand and pivot. Uses a wheelchair for safety. But can use a wheelchair if assisted by staff. Please keep wheelchair next to his bed facing the window with wheels locked when he is in bed so he can transfer himself. Keep side mat in place... Can refuse care on occasion. 1 person assist for transfers to toilet ...Please put disposable bed pads on his bed, only use the fabric bed pads. He has slipped out of bed and fallen in the past due

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	ASL510362	A. BUILDING: _____ B. WING _____	01/07/2026

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A4010	Continued From page 18	A4010		

to disposable bed pads. Mobility/Transfer. Use gait belt for transfers. Revised 12.31.
With R7's family's refusal to cooperate with interventions to prevent falls, there was no alternative interventions in place to ensure resident's safety.

According to R9's EHR, R9 moved in the community on 3/4/23. R9's diagnoses include but not limited to Dementia, Anemia, Cataracts, Muscle Weakness, Spinal Stenosis, Bradycardia, Unsteadiness. R9 has been admitted to Hospice care since12/31/24.
On 1/6/26 at 8:55am, R9 was observed in the TV area, seated on a Specialized chair, did not respond to basic questions. E18 (Certified Nursing Assistant-CNA) was with R9. E18 said, R9 gets agitated, doesn't want to be touched, fights during care, slurred speech, cannot get the word out, confused, cannot walk, cannot stand up, and needs mechanical lift for transfer.
Establishment's documents titled "Incident Reports Summary", and EHR notes indicated R9 had 34 falls since January 2024 to current.
These falls are the following:
1/13/25 fall, dining room, with injury- bruise
2/2/2025 - Redness on back of head
2/13/2025- No injury; 2/13/2025 3:20pm, hallway- Laceration to right inner elbow
2/14/2025 6:25pm dining room, injury Abrasion
2/21/2025, 2/27/2025, 2/28/2025- No injury
3/5/2025; 3/6/2025; 3/12/2025- no injury
3/14/25 - bathroom floor, no injury, 3/15/2025- bedroom floor, noted some redness to her back; 3/16/2025- no apparent injury
4/4/2025- hallway, 4/7/2025; 4/13/2025; 4/26/2025- no injury
5/4/2025; 5/5/2025; 5/7/2025; 5/9/2025; 5/20/2025; 5/28/2025; 5/29/2025- No apparent injury

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A4010	Continued From page 19 5/30/2025- on the floor, sitting beside chair, laceration to scalp, hematoma 6/1/2025 dining room, no injury. 6/24/2025- TV area. No apparent injury 7/29/2025- observed the resident lying next to her bed with (specialized) chair in front, no injury 8/7/2025- lying on floor mat, bleeding to the right arm, injury was reopened. 8/17/2025- redness on the forehead and small bump to the R lateral side of the head. 8/18/2025- The resident was observed laying on the side of her body on the floor next to her (specialized) chair... small bump on the Right side of her head and redness on the forehead... 8/25/2025- injury, bumped to the side of the head... 11/1/2025- Resident noted on floor in the dining room next to (specialized) chair. 11/3/2025- resident slid down from Broda chair. No injury. 12/2/2025- The resident was observed sitting on the foot of her (specialized) chair. observed no injury. R9's Service plan dated 12/3/25 stated in part; Safety/Falls: Unable to remember she cannot stand or walk without assistance. Keep in common area while wake, round every two hours, routine toileting. With all these fall incidents there was no sufficient resident supervision in place to decrease fall occurence. Two hours of rounding is not sufficient to supervise a resident who is a high risk for fall. Establishment's Fall Policy and Procedure stated in part; Policy: To help ensure the safety of the resident by monitoring and tracking falls, providing appropriate documentation, performing fall risk assessments, and implementing precautionary	A4010		

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A4010	Continued From page 20 fall interventions. Procedure: The Director of Nursing shall oversee the service plan of each resident and update accordingly fall safety interventions.	A4010		