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PORTER PLACE	17833 HARLEM AVE TINLEY PARK, IL 60477

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A 000	Initial Comment FACILITY REPORTED INCIDENT SURVEY IL00200141, IL00200258, IL00200843 - 295.1100 e) 295.2040 b) 5) 295.4000 a) 295.4010 a) b) 1) 2) 3) c) d) e) 295.4050 295.4060 a) 3) A) 6)	A 000		
A1100	Section 295.1100 Alzheimer's and Related Dementias Special Car This Regulation is not met as evidenced by: VIOLATION Section 295.1100 Alzheimer's Disease and Related Dementias Special Care Disclosure An establishment that offers, advertises or markets to provide care for persons with Alzheimer's disease and related dementias through an Alzheimer's special care program shall disclose to the Department and to a potential or actual resident of the establishment the following information in writing: e) The establishment's minimum and maximum staffing ratios, specifying the general licensed health care provider to resident ratio and the trainee health care provider to resident ratio;	A1100		

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A1100	Continued From page 1 This requirement was not met as evidenced by: Based on record review and interview the establishment failed to ensure general licensed health care provider to resident ratio was listed on Alzheimer's Disease and Related Dementias Special Care Disclosure. Findings include: Alzheimer's Disclosure Statement documents in part: Staffing: Staffing patterns and ratios are dependent upon then needs of the resident population. At a minimum we are staffed by one full time and awake care giver 24 hours a day, an Executive Director 40 hours per week, and supplemented by the following Department leaders that are available for the entire community: Clinical Services Director, Dining Services Director, Environmental Service Director, Life Engagement Director, Community Relations Director, licensed 24-hour nurses. We shall have caregiving 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. Shift Minimum 1:13 1:13 1.5:25 Maximum 3:13 3:13 2.5:25 Per surveyor review, Alzheimer's Disclosure does not show ratios of licensed staff to resident ratio. On 4/24/2026, at 9:38 am, E1 Executive Director/ED stated our Alzheimers Disclosure	A1100		

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A1100	Continued From page 2 does not specify staffing ratios of licensed staff, it has an all-inclusive staff ratio breakdown. If I am reading this the staffing ratios listed just speaks to bodies per my interpretation, not licensed health care personnel. On 4/23/2026, 2:16 pm, E3 Licensed Practical Nurse/LPN stated we have 49-50 residents in the whole building right now. We have 2 nurses that work the floor and we have the Director and Executive Director/ED as well that are nurses. Afternoons is 2 nurses and overnights is one nurse. On days we have like 5 resident care assistants, afternoons is 5 and nights is 4. I do feel like there is enough staff to care for these residents. I know it can be done. I can't speak for other people and I don't have very many falls. So, I know it can be done. I think it depends on the leader. I think anywhere more staff would prevent falls	A1100		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: VIOLATION Section 295.2040 Disaster Preparedness b) Each establishment shall: 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.	A2040		

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A2040	Continued From page 3 This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to orient residents to emergency and evacuation plans within 10 days after resident's arrival for three (R1, R2, and R3) of three residents reviewed. Findings include: R1 is an 85-year-old resident admitted to the establishment on 8/29/25 with diagnoses including but not limited to essential hypertension, dementia and dysphagia. R2 is a 76-year-old resident admitted to the establishment on 3/13/25 with diagnoses including but not limited to Alzheimer's Dementia with behavioral disturbance and hyperlipidemia. R3 is a 95-year-old resident admitted to the establishment on 9/29/19 with diagnoses including but not limited to Alzheimer's Dementia and gout. The document that was provided to surveyor when resident orientation was requested for R1 was page 9 of contract and Resident Handbook Acknowledgment that documents in part: Fire Safety. The establishment has a fire and smoke alarm system and fire sprinkler systems that meet all fire codes required by the Illinois Department of Public Health/IDPH and the Area Fire District. Because establishment is a secure community and locking devices used to secure community egress doors and egress access doors, shall be in compliance with the pertinent NFPA Life Safety Code. Residents will be directed to participate in periodic fire drills in accordance with he Life	A2040		

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A2040	Continued From page 4	A2040		

Safety Code and the IDPH. Resident Handbook Acknowledgement contains a signature of power of attorney for R1.

The document that was provided to surveyor when resident orientation was requested for R2 was page 4 and 10 of 18 page contract that documents in part: Security, Emergency Response and Fire Protection. Your suite is equipped with a motion detection system and sprinkler system. The outside doors leading to unsecured areas of the Community are alarmed and released upon fire alarm sounding. All residents and responsible parties must sign the Resident log book when leaving and returning to the Community. Page 10 of 18 contains a signature of power of attorney for R2.

The document that was provided to surveyor when resident orientation was requested for R3 was page 5 and 9 of 25 page contract that documents in part: Security, Emergency Response and Fire Protection. Your suite will be equipped with an emergency call button, motion detection system, and sprinkler system. In order to protect the residents, the outside doors leading to unsecured areas of the Community are alarmed with delayed egress. All residents and/or responsible parties are required to sign the resident log book when both leaving and returning to the Community. Page 9 of 25 contains a signature of power of attorney for R3.

No other documents were provided regarding orientation to emergency and evacuation plans for R1, R2, or R3.

On 4/23/2026, at 11:56 am, E2 Clinical Service Director stated I believe all we go over with the resident and families regarding emergency exits

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A2040	Continued From page 5 is these contract pages addressing fire safety. I can go ask if we have anything else. On 4/23/2026, at 12:47 am, E2 Clinical Service Director stated regarding orientation I did talk to the marketing director regarding the resident orientation the only thing we have is the part of the contract that I gave you. We do a round table prior to a resident coming to the facility. We talk to families and then when a resident comes in, department heads come in and meet and greet with residents talking about safety such as pull cords in bathrooms, etc. That is not documented or signed by anyone.	A2040		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: VIOLATION Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. This requirement was not met as evidenced by:	A4000		

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A4000	Continued From page 6 Based on record review and interview the establishment failed to ensure physician assessments were completed by a physician for two (R1 and R2) of three residents reviewed. Findings include: R1 is an 85-year-old resident admitted to the establishment on 8/29/25 with diagnoses including but not limited to essential hypertension, dementia and dysphagia. R1's physician assessment dated 8/27/2025 is completed by an Advanced Practice Nurse Practitioner/APRN and not a physician. R2's physician assessment dated 3/12/25 is completed by a Nurse Practitioner/NP and not a physician. R2 is a 76-year-old resident admitted to the establishment on 3/13/25 with diagnoses including but not limited to Alzheimer's Dementia with behavioral disturbance and hyperlipidemia. On 4/23/2026, at 12:47 pm, E2 Clinical Service Director stated the primary physician is the person who completes the physician assessment. I am not sure if nurse practitioner's/NPs can complete. For R2 her physician certification is done by an NP. On 4/23/2026, at 1:32 pm E1 Executive Director/ED stated I am aware that an NP can cosign a physician assessment but should not sign alone. R1 is a newer admit and (physician assessment) should definitely be signed by a physician. I do see that it is signed by an APRN and not a physician.	A4000		

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A4010	Continued From page 7	A4010		
A4010	Section 295.4010 Service Plan	A4010		

This Regulation is not met as evidenced by:
VIOLATION

Section 295.4010 Service Plan

a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan.

b) The service plan shall be developed by:

1) The resident, resident's representative or any individual requested by the resident;

2) The manager or manager's designee; and

3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care.

c) The service plan shall be signed and dated by all individuals involved in its development.

d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery

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A4010	Continued From page 8 contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). This requirement was not met as evidenced by: Based on record review and interview the establishment failed to: ensure service plans were reviewed annually for one (R3) of three residents reviewed, Ensure service plans are signed by a registered nurse and a manager or managers designee for one (R1) of three residents reviewed, And ensure that service plans were reviewed and revised immediately after a significant change for three (R1, R2, and R3) of three residents reviewed. Findings include: R1 is an 85-year-old resident admitted to the establishment on 8/29/25 with diagnoses including but not limited to essential hypertension, dementia and dysphagia. R1's Care Plan with Power of Attorney/POA signature dated 4/23/26 has no signature of a registered nurse/RN and no signature of manager or manager designee and was signed after initiation of survey. Care Plan did not have fall prevention interventions for falls on 1/26/26 and 16 other falls between 8/30/25 and 11/4/25.	A4010		

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A4010	Continued From page 9 R2 is a 76-year-old resident admitted to the establishment on 3/13/25 with diagnoses including but not limited to Alzheimer's Dementia with behavioral disturbance and hyperlipidemia. R2's Care Plan, dated 5/8/25, had all appropriate signatures. R2's falls from 11/14/25, 10/26/25, 10/8/25, 10/2/25, 8/10/25, 7/28/25, and 7/26/25 are not listed on Care Plan and does not document fall prevention interventions related to these falls. R3 is a 95-year-old resident admitted to the establishment on 9/29/19 with diagnoses including but not limited to Alzheimer's Dementia and gout. R3's Care Plan dated 5/22/23 is the most updated signed care plan the establishment was able to provide and is over 2 years old. R3's injury of unknown origin from 1/26/26 that resulted in a broken arm is not listed on care plan or interventions on how to care for broken arm were listed on care plan. On 4/23/2026, at 11:56 am, E2 Clinical Services Director stated for R1's service plan, his wife signed today as she was here. I can get you the one that was signed previous to that. For R3 the service plan signed in 2023 is the only service plan I have with signatures. On 4/23/2026, at 12:47 am, E2 Clinical Services Director stated I have not been able to find R1's previously signed service plan. The only one I have is the one that was signed by wife today. We did meet, but I must have misplaced it or tossed it. That would have been R1's initial service plan. We do document an intervention for every fall. I do not see that there is an intervention	A4010		

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A4010	Continued From page 10 on service plan for fall he had on 1/26/26 or the falls from 8/30/25-11/4/25. On 4/23/2026, at 1:32 pm, E1 Executive Director/ED came in and asked to take E2's place as E2 had an interview and E1 stated I am a nurse as well. When asked if E1 could show me on service plan for R2 the fall documentation for falls on 11/14/25, 10/26/25, 10/8/25, 10/2/25, 8/10/25, 7/28/25, and 7/26/25 she stated they are not on service plan, but I have fall risk assessments for every fall. E1 ED stated interventions should be on the service plan for every fall/incident.	A4010		
A4050	Seciton 295.4050 Tuberculin Skin Test Procedures This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.4050 Tuberculin Skin Test Procedures Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696). This requirement was not met as evidenced by: Based on record review and interview, the establishment failed to ensure Tuberculin (TB) skin tests were completed and results available in chart for two (R2 and R3) of three residents reviewed. This failure has the substantial probability to	A4050		

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A4050	Continued From page 11 cause harm to a resident. Findings include: R2 is a 76-year-old resident admitted to the establishment on 3/13/25 with diagnoses including but not limited to Alzheimer's Dementia with behavioral disturbance and hyperlipidemia. R2's initial physician assessment dated 3/12/25 does not document any TB test result or the presence or absence of TB. R3 is a 95-year-old resident admitted to the establishment on 9/29/19 with diagnoses including but not limited to Alzheimer's Dementia and gout. R3's initial physician assessment dated 9/10/19 documents in part: TB QuantiFERON gold done 9/10/19 but does not document result. Establishment could not provide TB test results. No TB test results were provided for R2 and R3. On 4/23/2026, at 12:47 am, E2 Clinical Service Director stated I looked everywhere, and I am not finding an initial TB for R3 and R2, just what was documented on the physician certification. E2 stated for R2, I could not find her initial TB. R2 admitted right before I started. I started July 2025. I was not the one to review R2's admit. On 4/23/2026, at 1:32 pm, E1 Executive Director/ED stated my expectation regarding TB test is that they are completed prior to admission, annually and if an outbreak.	A4050		

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A4060	Continued From page 12	A4060		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times; This requirement was not met as evidenced by: Based on record review and interview the establishment failed to ensure the continued safety of three (R1, R2, and R3) of three	A4060		

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A4060	Continued From page 13	A4060		

residents reviewed and failed to provide staff sufficient in number, with qualifications, adequate skills, education and experience to meet the 24-hour scheduled and unscheduled needs of three (R1, R2, and R3) of three residents reviewed.

This failure resulted in R1 having a total of 32 falls in less than 9 months, R2 having 16 falls since 3/13/25, and R3 breaking her arm from an injury of unknown origin. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 is an 85-year-old resident admitted to the establishment on 8/29/25 with diagnoses including but not limited to essential hypertension, dementia and dysphagia.

R1's Incident/Accident Report documents that R1 had 2 falls in August 2025, 8 falls in September 2025, 5 falls in October 2025, 5 falls in November 2025, 4 falls in December 2025, 3 falls in January 2026, 3 falls in February 2026, and 2 falls in April 2026. This is a total of 32 falls in less than 9 months.

R1's Initial Physician Assessment dated 8/27/2025, it documents based on assessment resident's condition warrants assistance with the following services: Eating, Dressing, Toileting, Transferring, and Bathing.

R1's Initial Care Plan dated 8/29/25 documents: R1 needs cueing/standby assistance for ambulation, physical assistance with bathing, physical assistance of 1 for getting in and out of bed, physical assist of 1 for dressing/undressing,

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A4060	Continued From page 14	A4060		

reminders for grooming, physical assistance of 1 for toileting, and physical assistance of 1 for transfers.

R2 is a 76-year-old resident admitted to the establishment on 3/13/25 with diagnoses including but not limited to Alzheimer's Dementia with behavioral disturbance and hyperlipidemia.

R2's Incident/Accident Report documents that R2 has had 16 falls since 3/13/2025.

R2's Initial Physician Assessment dated 3/12/2025 documents based on assessment resident's condition warrants assistance with the following services: Eating, Dressing, Toileting, Transferring, and Bathing.

R2's Initial Care Plan documents: R2 requires physical assistance of 1 for ambulation, physical assist of 1 for bathing, set up assistance for bed mobility, reminders of meal times, set up assistance for dressing, reminders for grooming, and physical assist of 1 for transfers.

R3 is a 95-year-old resident admitted to the establishment on 9/29/19 with diagnoses including but not limited to Alzheimer's Dementia and gout.

R3's Incident/Accident Report documents that R3 had an injury of unknown origin on 1/20/2026 which was later discovered was an error and should read 1/26/26.

R3's Care Plan documents: R3 requires physical assistance of 1 for mobility since 10/24/24, physical assistance of 1 for grooming since 10/24/24, physical assistance of 1 for toileting since 10/24/24, assistance of 2 people with

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A4060	Continued From page 15 mechanical lift since 2/12/26. R3's Care Plan dated 5/22/23 documents: R3 requires assistance of 1 for dressing, bathing assistance of 1, and toileting assistance of 1. R3's hospital after visit summary dated 1/26/26 documents diagnosis: broken arm. No other hospital records were able to be obtained by establishment. On 4/23/2026, at 12:47 pm, E2 Clinical Service Director stated R1 has had frequent falls. They have decreased. I think he is now on the correct medication, he also uses a wheelchair for mobility now. R1 is active with the community program and extra supervision. Any of R1's falls have been related to him not using his assistive devices like getting up and walking off not using his walker. R1 can still stand and pivot transfer but has balance issues and Parkinson's. When R1 first moved in he was a standby assist for transfers and originally was independent for mobility. When we started seeing the falls we started to give R1 more assistance for transfers and got R1 on therapy. I can look in the computer and see when R1 was changed to assistance with mobility. R1's service plan states he has been physical assistance since moving in with verbal queueing and standby assistance. When asked how R1 is having all these falls with assistance, E2 stated R1 would just stand up and try to walk on his own. We try to make sure there is always someone in the common areas to watch all the residents. R1 was just pretty quick with these events. We do document an intervention for every fall. When asked if R1 still having falls as 2 falls this month were noted to be documented on service plan. E2 stated yes, R1 had 2 falls this month. I think the reason is for his	A4060		

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falling is that R1 is pretty impulsive. We are seeing a decrease and I don't want to overly sedate R1. I think we may be due for a medication increase. I think our interventions are effective, but I think we need to reevaluate medications and that may be helpful. R1 is in the common area and we are engaging him, R1 is just impulsive. R1 does not have a one-to-one supervision. I do not think more staffing would help. R1 is a very social guy so a lot of R1's interventions are keeping R1 engaged and supervised. R1 is very redirectable, if you tell R1 to sit back down he will. When asked if an intervention you have in place is engage with resident while awake how is resident still having falls, E2 stated I do see that some staff are engaging with R1 while awake. I do see some staff keeping R1 very close. Maybe some staff are not keeping R1 that close during groups and that is why R1 is falling. I can look into staff training on that aspect.

On 4/23/2026, 2:16 pm, E3 Licensed Practical Nurse/LPN stated I was here when R1 had a fall on 12/19/25. R1 was sitting on the couch in the common area and R1 said was trying to get up and he lost his balance and fell. R1 had an abrasion on his forehead so I sent him out 911. I can't recall if there were any caregivers in the common area when that happened. R1 is alert and oriented, R1 knows his name and faces. R1 is just a busy body. R1's thing is that he just wants to learn to get stronger and walk. I just tell him he has to ask for help. I really was drilling it into R1 to ask for help. R1 will tell us if he needs anything. R1's wife is here a lot. We keep R1 in activities so R1 is engaging. I let R1 call bingo. R1 will tell us if he needs to use the bathroom. R1 is a bit calmer now. There is staff around R1 at all times. Sometimes R1 just jumps up real quick. I

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can only speak for when I am here. I know who all the fallers are, I make sure the fall risks are set up and engaging in activities in close range of me and other staff. We have 49-50 residents in the whole building right now. We have 2 nurses that work the floor and we have the Director and ED as well that are nurses. PM is 2 nurses and overnights is one nurse. Days we have like 5 resident care assistants, pms is 5 and nights is 4. I do feel like there is enough staff to care for these residents. I know it can be done. I cant speak for other people and I don't have very many falls. So, I know it can be done. I think it depends on the leader. I think anywhere more staff would prevent falls. On 3/16/26 R2 had a fall that she had a laceration. That was after dinner. There were 3 Resident Care Assistants/RCAs with R2 and transferring her. I was mad because there were 3 of them with her. They said R2 leaned forward while they were pushing R2 in the wheelchair taking R2 to the washroom and R2 fell out of the wheelchair with 3 assistants. There were 2 regular RCA's and one orientee. It was E5, the orientee girl was E6 and E4 was the other RCA. E5 and E4 are here today and both get off at 10:30pm.

On 4/23/2026, at 2:34 pm, E4 Resident Care Assistant/RCA stated I was working when R2 had a fall. It was 3 of us. We were on the way to get R2 dressed, E5 RCA was pushing the wheelchair. We stopped at R2's room, me or E6 RCA opened the door, as we stopped to open the door R2 leaned forward and fell out of the wheelchair. I do not know how R2 fell out of the chair with 3 of us standing there. It happened so fast. I knowR2's knees hit the floor and then her head. I do not think E5 was pushing the wheelchair too fast, I don't really remember. None of us reached out to catch her. We are not supposed to try to catch

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them are we. When asked if it was her child, mom, grandma would E4 want someone to try to catch them and break the fall and E4 stated yes. E4 stated it happened so fast. I do think because there were 3 of us, we could have prevented that fall. Someone could have stood at R2's side and made sure R2 doesn't lean while someone else was pushing her. Even while she is sitting too, making sure someone is standing by R2's side. If something like this happens again, I will try to reach out and catch them. I do not know what caused the fall. Maybe R2 trying to get up while we were trying to open the door. Me and E6 were kind of in front of her with our backs to her. E5 was behind the wheelchair and could not get in front of her quick enough. I was not here when E3 or E1 has had a fall. There is a language barrier with E5, I can go get E5 for you.

On 4/23/2026, at 2:50 pm E5 Resident Care Associate stated I was working when R2 had a fall with E4 RCA. R2 was leaning over and fell out of the chair when we stopped to open the door. I was pushing the wheelchair. It was me, E4 RCA and E6 RCA. E6 is not here today. R2 did not want to sit in the wheelchair and R2 fell. This day R2 was very aggressive and R2 fell. The wheelchair was not moving when R2 fell. I stopped the wheelchair so we could open the door and R2 fell. I think E4 opened the door. I don't remember exactly. When R2 fell, I did not try to grab her, I called the nurse. E4 had her back to R2 as she was opening the door. I was behind the wheelchair. I don't remember where exactly E6 was. Nobody thought R2 was going to fall. Before I was at the door Ellen was moving and aggressive. She just fell. I don't know exactly. I think so her leg somehow got under the chair, and she fell. Exactly. The chair was stopped when she fell. I think her leg got under the chair

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A4060	Continued From page 19 and she fell. I remember exactly. On 4/24/2026, at 12:50 pm, E2 Clinical Services Director stated for R2 she has had 16 falls since last March. I did not realize it was that much. Since October R2 has only had 4. R2 does not like to use her assistive device, R2 does not like to come in the common areas. R2 likes to do circles around the unit. R2 will get up out of her wheelchair and try to push it like a walker and loses her balance. We try to keep a close eye on R2 and redirect her to sit down. When R2 is in her chair I try to direct her to use the rails to help propel herself. The last intervention, we put (non-slip pad) in her chair to help prevent R2 from sliding out. R2 requires physical assist of one for ambulation and transfers like stated in R2's care plan. R2 is able to self-propel even though it is not documented in her initial care plan. I am also not seeing her ability to self-propel in her updated care plan. Her current care plan documents she should be a physical assist of one for transfers and ambulation/mobility as well. Staff is not following current care plan as the care plan does not specify R2 is able to self-propel in the wheelchair. It only states that for ambulation R2 needs a physical assist of one. I agree that if R2 continues to have falls, R2 should require a physical assist of one for mobility. I am really hopefully with the (non-slip pad) since 2 of the last 4 falls were from R2 sliding out of the chair. R2 does not like to use her wheelchair and gets up and tries to walk by herself and use the wheelchair as a walker. R2 is very redirectable and will follow orders. For R3's fall with the ulna fracture, that was not on the care plan because we did not have any record of a fall and R3 is not one who could self-recover if R3 had a fall. So, we would have known if R3 fell because someone would have had to get her up. I really	A4060		

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have no idea how that happened. R3 does lean to that side. R3 previously was in a regular wheelchair and had poor core strength and would lean to the left. We thought a reclining wheelchair with the side cushions would help from leaning and putting pressure on the upper extremities. I have no real clear guess. Maybe R3 rolled on it, maybe R3 leaned on it. I am just not sure. I can try to have staff request the actual hospital records for her visit to see if noted or identified a cause. Staff denied any falls or bumping or any difficulty dressing or transferring her. Staff even said at breakfast R3 was feeding herself and lunchtime R3 was unable to. No noted events in between these times.

On 4/24/2026, at 2:05 pm, E6 Resident Care Assistant/RCA stated I do recall working the day R2 fell out of the wheelchair. That was actually one of my days I was training. It really kind of happened so fast. It was me and two other people with R2 when she fell. It was my second day of training. Me and the young girl (E4 RCA) came into the room first. E5 RCA was pushing R2 in the wheelchair behind us. R2 did not want to go in the room. I know me and E4 walked in first. E5 said R2 was giving E5 trouble. As we got to the door, E4 had the key and unlocked the door, and I was in the middle and came in behind E4. We did not even fully make it in the room because R2 fell out of the wheelchair in the doorway. With R2 giving E5 trouble to go in the room the only thing I can think happened is that E5 pushed the wheelchair when R2 was trying to stop E5 from pushing R2 in the wheelchair into the room as R2's feet were down. That was really scary to me. R2 fell right on her face. So, we heard the fall and heard R2 scream and me and E4 turned around. When we tried to pick R2 up but R2's feet were a little trapped under the wheelchair. It was hard to

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A4060	Continued From page 21 get R2 up because of that. It was a little struggle. When asked if there was anything that we could have done differently to prevent this from happening, E6 stated me personally if R2 did not want to go in the room, we should not have pushed R2 in the room. It was R2's day to shower, and I was just learning how to do everything, this is my first time working in a facility. It happened so fast, I couldn't really prevent anything myself from happening. I have learned so far that R2 doesn't really like being in her room sometimes. If R2 is not ready to go in there we usually just let R2 be.	A4060		