STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145160	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care on the Hill	555 West Carpenter Springfield, IL 62702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to send the results of a urinalysis and urine culture in a timely manner to resident's urologist for 1 (R3) of 3 residents reviewed for quality of care in the sample of 3. This failure resulted in a nonverbal resident (R3) being transferred to the emergency room and diagnosed with a UTI and received IV hydration and intramuscular shot of an antibiotic and put on oral antibiotics. Using the reasonable person approach, this failure caused pain, discomfort and invasive interventions during a hospital visit. The facility also failed to reassess (R3) after readmission for warning signs of sepsis on multiple days prior to having a change in condition on 2/20/2024 which he was transferred to the emergency room where he received IV hydration and was diagnosed with a UTI, sepsis, a PICC line insertion for multiple IV antibiotic administration. R3 coded due to the sepsis infection and had to have emergent cardiopulmonary resuscitation (CPR). Additionally, facility staff failed to complete change in condition documentation which included current vital signs and assessment of the residents (R3, R7) of 3 residents reviewed for change in condition in the sample of 3. These residents were transferred to the emergency room and received IV hydration and other medications.Findings include: 1. R3's Face Sheet documents he was initially admitted to the facility on [DATE] with diagnoses including hemiplegia, hemiparesis, stroke, respiratory failure, prostate cancer, neuromuscular dysfunction of bladder, epilepsy, heart disease, high blood pressure, high cholesterol and aphasia. R3's Quarterly Minimum Data Set (MDS), dated [DATE] documents R3 is severely cognitively impaired, no indwelling catheter, incontinent of urine, no urinary toileting program, no urinary tract infections (UTI) last 30 days, dependent on staff for toileting, mobility device: wheelchair. R3's Care Plan Report, dated 12/8/2023, documents resident has an indwelling catheter for diagnosis: neurogenic bladder. Goal: resident will show no signs or symptoms of UTI through review date 1/31/2024. Interventions dated 12/8/2023: position catheter bag and tubing below the level of the bladder, check tubing for kinks, monitor and document intake and output as per facility policy, monitor for s/sx (signs and symptoms) of discomfort of urination and frequency, monitor/document for pain/discomfort due to catheter, monitor/record/report to MD (physician) for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, depending of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. R3's Physician's Order Sheet (POS) dated 12/6/2024 through 1/7/2024 documents a new physician's order drink enough fluids to keep urine clear for 4-6 weeks. Twice a day for 6 weeks. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R3's Electronic Medical Record (EMR) dated 12/6/2024 through 1/7/2024 no documentation of resident being able to drink enough fluids or if urine was clear for 4-6 weeks per physician's order dated 12/6/2024. Further review no documentation on R3's Care Plan Report to note physician's order either. R3's Care Plan Report did not reflect the physician's order to drink enough fluids to keep urine clear for 4-6 weeks starting on 12/6/2024. R3's POS dated 12/8/2023 documents foley catheter 16F 10 cc diagnosis: urinary retention. R3's Nursing Note, dated 1/16/2025 at 1:11 PM staff documented writer changed foley without complications. 18F (French) placed with 10 cc. No assessment of R3's urine documented. R3's Electronic Medical Record (EMR) dated 1/16/2024 V21, R3's Physician ordered obtain urinalysis and urine culture if indicated. R3's Urine Culture dated 1/23/2024 at 9:12 AM documents V18, Nurse Practitioner reviewed R3's urine culture results. R3's EMR dated 1/23/2024 no documentation of assessment of R3 or antibiotic ordered after V18 reviewed urine culture results. R3's Health Status Note, dated 1/30/2024 at 1:01 PM, documents R3's family said the nurse at the urologist's office wants res (resident) sent to ER (emergency room.) Writer asked for name and number of urologist to speak with nurse. R3's family also said urologist wants most recent UA results. R3's family said the nurse just and spoke with V19 (urologist nurse) and she said not to send res to ER and she wants UA results faxed to office. Writer faxed results. NP (Nurse Practitioner) aware as well she said just spoke to urology as well. No S/S (signs and symptoms) of pain or discomfort at this time. R3's Health Status Note, dated 1/30/2024 at 1:02 PM, documents R3's urology nurse said she will have urologist review UA results, and she will call writer back. R3's family is aware. R3's Health Status Note, dated 1/30/2024 at 1:10 PM, documents R3's family said res (resident) in pain and wants to lay down. Writer and NP went to see res. NP asked res if he was in pain, res shook head no. NP asked res again if he was in pain, res shook head yes. NP asked res if he wanted to lay down, res shook his head yes. Writer asked CNA to please lay res down in bed writer administered PRN (when needed) Ibuprofen. R3's Health Status Note, dated 1/30/2024 at 2:19 PM, documents writer spoke with V19, Urology Nurse. Urologist reviewed UA and wants res sent to ER. Family present and would like res sent to local ER. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/9/2025 at 12:40 PM V18, R3's Nurse Practitioner stated when a urine culture is indicated she expects the urine culture results to be communicated with the facility within 24 hours of the results being available. V18 stated R3's urologist prefers to oversee all things urine with R3, so she would've expected staff to forward the urine culture dated 1/20/2024 to his urologist's office and follow his orders. V18 recalled the day R3's family insisted he be sent to the hospital in 1/2024 and she assessed him herself that day and asked if he was in pain and at first, he replied no then he expressed to his family he was in pain, so staff lay him in bed. V18 stated there was a mix up and a lot of back and forth between facility staff and R3's urologist's office but at the end of it R3's urologist's office ordered R3 to be sent to the local ER. V18 stated she didn't recall if she assessed R3's urine that day and the nursing staff would have assessed R3's vital signs and if they were abnormal, they would have reported that to her, but she didn't recall R3's vital signs being abnormal that day and it was a long time ago so she wouldn't recall that information. On 10/16/2025 at 11:22 AM V18, R3's NP stated she recalled reading R3's urine culture results January 2024 and she sent the results to R3's urologist office because he wants to handle R3's urine issues. V18 stated she didn't assess R3's urine that day because she knew facility staff would send the urine culture to his urologist's office and V20, R3's urologist would handle it from there. On 10/10/2025 at 2:31 PM V20, R3's Urologist stated he recalled R3 having multiple UTIs over the last year and he was concerned about it. V20 stated anytime R3 had a UA and urine culture results he expected the facility to send those test results to his office so he could review them and let them know what new orders to implement but he checked his medical records, and the facility didn't send the UA, or the urine culture results in 1/2024. V20 stated R3 had a UTI and the urine culture results were available on 1/20/2024 but the facility didn't send the urine culture results to his office, if he would have received the urine culture on 1/20/2024 he would have ordered an antibiotic to treat the UTI and ordered to increase R3's fluids to flush the infection out and then the facility called his office 1/30/2024 and they were back and forth with his nurse regarding sending R3 to the ER. The facility sent his office the UA results dated 1/16/2024 on 1/30/2024 and he ordered R3 be assessed at the ER because he knew he had a UTI, and he had it and wasn't treated for over 10 days and that means he was almost septic at that time and wanted to ensure R3 received antibiotics to treat the UTI. R3's Health Status Note, dated 1/30/2024 at 2:35 PM, documents res left facility via ambulance to local hospital at this time. R3's EMR dated 1/30/2024 no documentation of vital signs or assessment of R3's urine prior to R3 being transferred to the emergency room. No documentation in change in condition documented. R3's Health Status Note, dated 1/30/2024 at 11:52 PM, documents resident came back from hospital around 11 pm transported by ambulance resident has a UTI (Urinary Tract Infection) and low potassium. The orders have been put in and waiting for pharmacy. R3's Hospital After Visit Summary, dated 1/30/2024 documents he was diagnosed with a UTI and received Ceftriaxone 1 gram injection and IV (intravenous) fluids in the hospital. New physician's order for Bactrim DS 800 milligrams (mg) -160 mg twice a day (BID) for 7 days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R3's Medication Administration Record (MAR) dated 1/31/2024 through 2/8/2025 documents antibiotic for UTI administered per physician's orders. Staff document the last antibiotic for UTI was administered on 2/8/2024. R3's [NAME]-Infection Antibiotic Charting Note, dated 2/14/2024 at 3:07 AM documents sediment noted in urine, no mental status changes noted. Staff documented infection type: UTI, treatment/orders: R3 is receiving oral antibiotics, vital signs documented: blood pressure on 2/13/2024 at 8:05 AM 112/60, temperature 98.0 dated 2/12/2024 at 10:55 PM, heart rate 94 dated 2/5/2024 at 11:46 AM, Respirations 18 dated 2/5/2024 at 11:46 AM and pulse ox 98% dated 2/5/2024 at 11:47 AM room air, no pain. Resident condition is stable, no distress noted. No documentation of current vital signs of temperature, heart rate, respirations and temperature and pulse ox were documented and no assessment of R3's urine other than nurse documented sedimentation present. R3's POS, dated 2/14/2024 no documentation R3 was on an antibiotic to treat a UTI at this day. R3's Health Status Note, dated 2/14/2024 at 9:03 AM documents Res refused breakfast multiple times. He kept shaking his head no when staff offered bites of food. R3's [NAME]-Infection Antibiotic Charting Note, dated 2/14/2024 at 12:04 PM documents. Staff documented infection type: UTI, treatment/orders: R3 is receiving Bactrim DS 800-160 mg two times a day, vital signs documented: blood pressure on 2/14/2024 at 9:35 AM 128/81, temperature 98.0 dated 2/12/2024 at 10:55 PM, heart rate 94 dated 2/5/2024 at 11:46 AM, Respirations 18 dated 2/5/2024 at 11:46 AM and pulse ox 98% dated 2/5/2024 at 11:47 AM room air, no pain. Staff documented resident condition is stable, no distress noted. No documentation of current vital signs of temperature, heart rate, respirations and temperature and pulse ox were documented. No assessment of R3's urine documented at that time. R3's MAR dated 2/17/2024 at 2:00 PM, documents blood pressure 97/66, temperature 97.1, heart rate 96, respirations 16 and pulse ox 97%. R3's EMR dated 2/17/2024 no further documentation of nurse assessment of R3's vital signs documented at 2:00 PM on his MAR and no assessment of his urine at that time. R3's Nursing Note, dated 2/20/2024 at 7:58 AM documents, writer went in to check AM vitals and noted that resident looked very lethargic and was cold to touch vital signs were low for this resident, resident seems to be breathing with his belly. Resident has had a major decline in health over the last several months. Writer attempted to give resident a sip of water from a straw and resident unable to sip from his straw. Writer held all am medication. notified facility NP. NP wants resident to be sent to ER for further evaluation. R3's Nursing Note, dated 2/20/2024 at 8:36 AM documents two EMTs here to transport resident to local hospital, resident's family aware and agreed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R3's Change in Condition Evaluation dated 2/20/2024 staff documented change in condition started in the morning. Staff documented R3 had abnormal vital signs blood pressure 100/48 on 2/20/2024 at 7:47 AM, heart rate 96 on 2/17/2024 at 3:24 PM, respirations 16 on 2/17/2024 at 3:24 PM, temperature 97.1 on 2/17/2024 at 3:24 PM, pulse ox 97% on room air on 2/17/2024 at 3:24 PM, blood glucose 99 on 11/2/2023 at 5:53 PM. Staff also documented decreased level of consciousness, general weakness, abnormal lung sounds, reported change in condition to provider at 8:10 AM ordered to send resident to the ER. No current vital signs of heart rate, respirations, temperature, pulse ox or blood glucose was documented. R3's Nursing Note, dated 2/20/2024 at 12:23 PM documents admitting diagnosis mental status changes. R3's Nursing Note, dated 2/22/2024 at 7:06 AM documents resident in ICU (intensive care unit) and intubated. R3's Hospital Paperwork, dated 2/21/2024 documents R3 received critical care, intubation and a central line at the hospital. History of present illness documents the patient is a [AGE] year-old male with a PMH and hemiparesis following CVA (stoke), prostate cancer and bladder dysfunction, epilepsy, multiple contractures including left lower extremity, right upper extremity, neck. EMS stated resident was found to be unresponsive, hypotensive at facility today. EMS was unable to obtain access in route as patient is a difficult stick. Patient had a pulse and was full code. Unresponsive to questioning with no gag reflux so decision was made to intubate patient. IO was started and central line was started after intubation for delivery of medications and better access. 2/20/2024 at 9:42 AM emergent situation resident was intubated. Patient became bradycardia and dropped his pressure became hypoxic and arrested. CPR was performed with epinephrine and bicarbonate. We were able to restore pulses, but bedside ultrasound shows a diminished ejection fraction. Despite being on 50 of Levophed and 20 of dopamine his pressure systolic 50 diastolic 30. Starting Vasopressin and Solu-Cortef. Clinical impressions: respiratory failure, septic shock, UTI, AKI (acute kidney infection) and right lower lobe pneumonia. R3 was discharged from the hospital and readmitted to the facility on [DATE]. R3 was prescribed two IV antibiotics at that time to be administered per physician's orders. On 10/9/2025 at 12:40 PM V18, R3's Nurse Practitioner stated she recalled R3 had multiple UTIs within the last year. V18 stated she expects nurses to assess and document the assessment when a resident has a change in medical condition including the resident's current vital signs blood pressure, heart rate, temperature, respirations, pulse ox and lung/heart depending on the change in medical condition the resident is experiencing at that time and if it's an emergent situation. If the resident is transported to the hospital, she expects the nurses to document the entire assessment in the resident electronic medical record in the nursing progress notes and wherever they are required to document a change in medical condition. V18 stated she was aware of staff documenting previous vital signs during a resident's change in medical condition and that wouldn't be appropriate because it doesn't paint an accurate picture of how the resident was doing during the current change in medical condition. (continued on next page)

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Arcadia Care on the Hill	555 West Carpenter Springfield, IL 62702

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/10/2025 at 2:31 PM V20, R3's Urologist stated after R3 was readmitted to the facility at the end of January 2024 with a UTI he expected staff to assess and document R3's urine to ensure the UTI was resolving. Knowing R3 has a long history of having UTIs V20 expected staff to do a more thorough assessment when staff noted he refused to eat breakfast and sediment was in his urine on 2/14/2024, what did R3's urine look like that day, was it dark and odorous, if so, those are warning signs of an impending UTI. When staff documented R3's blood pressure was 97/66 on 2/17/2024 that was another warning sign that R3 could be in trouble medically and knowing R3 has a history of UTIs he expected the nurse would assess his urine and document the assessment at that time. V20 stated the facility staff should have called his office on 2/14/2024 when he had sediment in his urine and wasn't eating breakfast and on 2/17/2024 when his blood pressure read 97/66. V20 stated he checked R3's medical record at his office and no facility staff called or sent documentation of his medical status on 2/14/2024 or 2/17/2024. V20 stated he would have informed the nurse to do a further assessment of the resident and would have ordered a urinalysis or sent R3 to the ER if the assessment documented R3's urine was dark and/or odorous because those are signs of a UTI. V20 stated R3 had a change in medical condition starting on 2/14/2024 and again on 2/17/2024 and facility staff didn't document current vital signs when he had a change in condition on 2/20/2024. V20 stated he expected the nurse to obtain current vital signs during a change in medical condition not to document vital signs from days before because that is no good when a resident is having a change in medical condition. V20 stated R3 was transferred to the local hospital and was admitted and was diagnosed with UTI which led to sepsis which made R3's heart work harder due to sepsis which caused R3 to go into cardiac arrest which resulted in the hospital staff having to do emergent living saving cardiopulmonary resuscitation (CPR) and R3 had to get a PICC line placed which is a surgical procedure for the strong antibiotics to treat the UTI, per V20 all of this was avoidable if the facility staff would have assessed R3's warning signs on 2/14/2024 and 2/17/2024. On 10/14/2024 at 1:45 PM V1, Administrator stated she expected staff to communicate with outside physicians when that is the understanding and send those physicians labs i.e. urinalysis and urine cultures to a urologist's office. V1 also expected staff to follow the facility's policies and procedures and to document what the resident's current vital signs where when a resident experienced a change in medical condition. On 10/8/2025 at 12:40 PM R3 was observed lying in bed. R3's eyes were open, but he didn't respond to IDPH surveyor's questions. On 10/14/2025 at 9:30 AM R3 was observed lying in bed. R3's eyes were open, but he didn't respond to the IDPH surveyor's questions. V22, LPN entered R3's room at that time and uncovered him, no indwelling catheter was observed, R3 had an incontinence brief on at that time. V22 stated she didn't know R3 well, but she knew he didn't have a catheter, and he is incontinent of urine. 2. R7's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including atrial fibrillation and high blood pressure. R7's Nurse's Note, dated 10/7/2025 at 4:23 AM documents admission to local hospital with pneumonia. No nurse assessment or vital signs documented in this nurse's note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R7's In Progress Change in Condition Evaluation, dated 10/6/2025 at 9:53 PM documents current vital signs included blood pressure 91/59, current respiration 13, current temperature 97.3 and vitals dated 10/6/2025 at 1:31 PM were heartrate 74 and pulse ox 95% oxygen via nasal cannula. No documentation of what current heart rate or pulse ox was. No documentation of lung sounds or if R7 was in respiratory distress. This document was not completed and reads in progress in R7's electronic medical record (EMR.) On 10/10/2025 at 10:35 AM V2, Director of Nurses (DON) stated she expects nurses to assess a resident from head to toe when a resident has a change in medical condition and this assessment included basic vital signs including blood pressure, heartrate, pulse ox and respirations per minute. V2 stated nurses can either document the assessment in the resident's nurse's notes or on the change in condition assessment document but the assessment of the resident should be documented in one place or the other and V2 stated if the nurses documented the not current vital signs as part of the change in condition assessment, then that would defeat the purpose of the nurse documenting the change in current medical condition. V2 stated it's important to document the resident's current vital signs so future readers can clearly see the resident had a change in medical condition and the nurse assessed the resident and followed physician's orders including sending the resident to the emergency room if medically necessary. On 10-9-2025 at 12:40 PM V18, NP stated when a resident has a change in condition, she expects the nurse to assess the resident and document the assessment in the resident's medical record. V18 stated she wasn't aware nurses were documenting previous vital signs when a resident experienced a change in condition, that of course would need to be addressed immediately because the provider needs to know the current state of the resident to make an informed clinical decision on whether or not to start a new medication of send the resident to the emergency room. The Facility's Physician Notification of Laboratory Results Policy, last revised 11/2019, documents: purpose to assure physician ordered diagnostic test are performed and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the resident's care. A licensed nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them. The licensed nurse is responsible for documenting the notification of results in the clinical record. The Facility's Physician Change in Condition Policy, revised 11/13/2018, documents: purpose to ensure that medical care problems are communicated to the attending physician or authorized designee in a timely, efficient and effective manner. Guidelines: the facility will inform the resident; consult with the resident's physician or authorized designee such as nurse practitioner when there is a significant change in the resident's physical status. Clinical complications are such things as development of recurrent urinary tract infection.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement, and document fall interventions for 1 (R7) of 3 residents who was newly admitted to the facility with hospital documentation of multiple vertebral fractures from a previous fall prior to being admitted to the facility of 3 residents reviewed for falls. This failure resulted in an alert resident (R7) falling twice at the facility and being transferred to the emergency room where she received IV fluids and narcotic pain medication. She sustained 2 skin tears from falls and was transferred to the emergency room due to post fall lethargy. Findings include:R7's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including compression fractures of second and fourth lumbar vertebra, burst fractures of T11-T12 vertebra, falls, low back pain, abnormalities of gait and mobility, muscle wasting and atrophy and lack of coordination.R7's Hospital Discharge Plan, dated 9/30/2025 documents she was in the hospital because: falls and weakness. R7's Baseline Care Plan, dated 9/30/2025 documents safety risks: resident does have a history of falls and has fell within the last month prior to admission, has had a fall within last 2-6 months prior to admission. Focus: the resident is at risk for falls r/t (related to) history of falls. No goal or interventions to prevent falls was documented on R7's baseline care plan. R7's admission Assessment, dated 9/30/2025 documents R7 was at risk for fall r/t history of falls, but no goal or interventions were documented. Staff documented resident has a history of 1-2 falls in the past 3 months. R7's Nurse's Note, dated 9/30/2025 at 9:28 PM documents patient arrived at facility via wheelchair with facility's transportation. Patient wanted to get in bed body brace was removed when placed in bed. patient has T3, T5, T6, T10 & L1 fracture. Patient educated on how to properly use call light when needing assistance. Patient A&0 x3. Will continue to monitor patientR7's Nursing Note, dated 10/5/2025 at 5:05 AM documents heard someone yell for help and then a crash as was going down hall to find who had yelled. R7 was only in depend lying on floor across the room from the bed in front of the TV and the bedside table was on its side between her and the bed. Currently VS returning to baseline, family notified by voice mail. Order obtained for treatment of skin tear.R7's Unwitnessed Fall Report, dated 10/5/2025 at 4:35 AM documents resident stated, I was going to the bathroom. Skin tear to left elbow, no other injuries noted. Assisted to toilet. Staff documented resident was alert and ambulatory with assistance. No intervention documented on fall report to prevent future falls. R7's Nursing Note, dated 10/6/2025 at 12:39 AM documents CNA answered call light to find resident on floor next to bed. She came for me (R7) for help. Assessed in place to find skin tear on right elbow this time. Cleansed and dressed. Lifted into bed. Resident was not as alert as normal. Called MD (physician) and got order to send to ED (emergency department.) Called for transport, notified family and administrator. Resident sent to local emergency room via ambulance.R7's Unwitnessed Fall Report, dated 10/6/2025 at 12:00 AM documents CNA came to get me reporting the resident had fallen again. Resident on floor up against bedframe. Resident stated, I don't know, I don't know why I'm doing this. Resident assessed in place, cleansed and dressed skin tear, lifted to bed, discussed with MD. Skin tear: right elbow. Resident lethargic post fall. Wheelchair bound. Staff documented resident was taken to hospital. No intervention documented on fall report to prevent future falls. R7's Nursing Note, dated 10/6/2025 at 8:25 AM documents Resident returned from ED visit. Dx of Hypokalemia. IV fluids 500 ml (milliliters) administered at ED. R7's Hospital Discharge Paperwork, dated 10/6/2025 documents R7 received IV fluids and a narcotic pain medication, hydrocodone/acetaminophen. R7's Electronic Medical Record (EMR) dated 10/5/2025 and 10/6/2025 no documentation fall interventions or precautions to prevent falls were implemented upon admission to the facility on 9/30/2025 or after these two falls.On 10/10/2025 at 10:35 AM V2, Director of Nurse (DON) stated when residents are initially admitted to the facility, they don't really know the resident other than what the hospital medical discharge paperwork documents. V2 stated if a resident had a history of falls, and the facility staff were aware of that there should be interventions documented on the resident's baseline care plan and admission assessment. All residents have low bed and are orientated to their call light to ask for assistance from staff when needed. V2 stated staff ensure residents always have proper footwear on, their call light within reach and are orientated to the facility. The Facility's Fall Prevention Program, revised 5/2022 purpose: to assure the safety of the residents in the facility, when possible. The program will include measures which determine 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. Quality Assurance Programs will monitor the program to assure ongoing