STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145452	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Dwight	300 East Mazon Avenue Dwight, IL 60420

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect a resident's (R14) right to be free from sexual abuse by another resident (R15), protect a resident's (R12) right to be free from verbal/mental abuse by another resident (R11), protect a resident's (R8) right to be free from physical abuse by another resident (R3), and protect residents' (R2, R3) right to be free from physical abuse by another resident (R3, R2). These failures affect seven residents (R2, R3, R8, R11, R12, R14, R15) of 12 residents reviewed for abuse in the sample list of 15. Findings include: The facility's Abuse Prevention and Reporting policy dated December 2025 documents the facility affirms the residents' right to be free from abuse, including physical abuse, sexual abuse, and verbal abuse. This policy documents physical abuse is the infliction of injury on a resident that does not occur by accidental means, sexual abuse includes unwanted intimate touching of any kind including the breasts, and verbal/mental abuse includes yelling, mocking, insulting, and ridiculing.1.) The facility's Preliminary 24 Hour Abuse Investigation Report documents on 2/26/26 at 6:30 PM it was reported that R14 was in R15's room holding up her gown and R15 touched R14's breasts. V14 Certified Nursing Assistant (CNA) Staff Interview form dated 2/16/26 documents V14 walked past R15's room and noticed R14 was in R15's room, as V14 entered R15's room V14 witnessed R14 holding up her gown and R15 had his hand on R14's breast. R14's Minimum Data Set (MDS) dated [DATE] documents R14 has severe cognitive impairment, has hallucinations, and wandering behavior noted 1-3 days during the 7 day look back period. R14's Capacity for Sexual Consent assessment dated [DATE] documents R14 has no awareness of who is initiating sexual contact, R14 does not have the capacity to consent to sexual relationships, and R14 did not recall the incident with R15. R15's MDS dated [DATE] documents R15 has moderate cognitive impairment. R15's Care Plan initiated on 4/22/24 and revised on 2/18/26, documents R15 has a history of displaying a lack of boundaries including sexually inappropriate behavioral symptoms towards others, including inappropriate, sexually oriented and suggestive remarks. Due to dementia R15 displays poor internal control and self regulation skills. R15's Capacity for Sexual Consent assessment dated [DATE] documents R15 has the capacity to consent to sexual relationships but did not recall touching R14. On 3/4/26 at 10:55 AM R15 stated R15 does not recall this, but staff told R15 that a female resident came into R15's room, put her feet on his bed and lifted her gown. R15 denied touching R14 but did not recall this incident. On 3/4/26 at 11:15 AM R14 was interviewed but did not recall the incident with R15. On 3/4/26 at 10:48 AM V14 CNA stated at approximately 6:30 PM V14 came out of another resident room and saw R14 in R15's room with her feet on the edge of R15's bed and R14 was holding up her night gown. V14 stated R14 was not wearing a bra and R15 was touching R14's bare breast with R15's hand. V14 stated V14 asked R14 and R15 what they were doing and neither resident replied. V14 stated R15 has grabbed staff's buttocks before. V14 stated both R14 and R15 have memory impairment. On 3/4/26 at 11:04 AM V13 Licensed Practical Nurse stated at approximately 7:00 PM V14 CNA reported R14's/R15's abuse allegation. V13 stated R15 has a history of inappropriate sexual touching of other residents, but it has been about a year and half ago since the last incident. V13 stated R15 has intermittent confusion and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 145452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's cognition varies between being alert and oriented to person, place, time and situation to just person and place. V13 stated R14 is alert and oriented to person only and did not recall the incident with R15.On 3/4/26 at 12:25 PM V21 Social Services Director stated V21 completes the capacity for sexual consent assessments and R14 does not have the capacity to consent. V21 stated R15 has the capacity to consent. V21 stated R14 did not recall the incident with R15. 2.) On 3/3/26 at 11:35 AM V6 Housekeeper stated V6 has witnessed R11 and R12 curse at each other a couple times and V6 witnessed them saying f*** (expletive) you to each other at approximately 7:00 AM today. V6 stated R11 does not like R12 since R12 has Alzheimer's and forgets things. On 3/3/26 at 11:57 AM V7 CNA stated R11 and R12 [NAME] back and forth, R11 gets upset with R12 being confused and forgetful. V7 stated V7 has heard R11 call R12 a f****** (expletive) dummy. V7 stated this has been going on for a couple of weeks, V7 has reported this to the nurses and mentioned that a room change should be considered. On 3/4/26 at 8:48 AM V17 Housekeeper stated R11 yells a lot at R12 saying things like you (R12) just asked that God d*** (expletive) it. R11's MDS dated [DATE] documents R11 has moderate cognitive impairment. R12's MDS dated [DATE] documents R12 has severe cognitive impairment. On 3/3/26 at 12:16 PM R11 and R12 were sharing a room. R12 stated R11 and R12 have been roommates for about a month and they [NAME] back and forth and curse at each other at times. R12 did not feel that this was abuse. On 3/4/26 at 8:44 AM R12 did not recall any yelling or cursing from R11. 3.) The facility's Preliminary 24 hour Abuse Investigation Report documents on 11/28/25 at approximately 10:00 AM it was reported that a resident (R3) had touched R8's nose. The facility's Final Report dated 12/4/25 documents R8 pushed R3's wheelchair. R3 told R8 not to push R3. R8 told R3 I'll (R8) do what I (R8) want. R3 then grabbed R8's nose and R8 grabbed R3's arm and pushed R3 away. R3's Abuse Allegation Interview dated 11/28/25 documents R3 reported R8 pushed R3's wheelchair so R3 grabbed R8's nose and then R8 grabbed R3's hand to push R3 away. R8's Abuse Allegation Interview dated 11/28/25 documents R8 reported trying to help R3 and R3 grabbed R8's nose so R8 pushed R3's hand away. R8 reported it hurt at first, but R8 was fine. V18 CNA undated Interview documents V18 heard R8 yell out for help, R8 was sitting in the hallway near the nurse's station and R3 was pedaling her wheelchair away. V18 asked R8 to show V18 what happened and R8 reached out and grabbed/twisted V18's nose. V19 Registered Nurse was also present. R3's MDS dated [DATE] documents R3 as cognitively intact and R3 had verbal behaviors towards others 1-3 days out of the 7 day review. R8's MDS dated [DATE] documents R8 has moderate cognitive impairment. On 3/3/26 at 1:02 PM R8 was interviewed but did not recall the incident with R3. On 3/4/26 at 10:30 AM R3 stated several months ago R8 bumped R3's wheelchair in the hallway near the dining room, so R3 touched R8's nose and told R8 not to do that. R3 stated R8 then told R3 not to do that and R3 went on her way. On 3/4/26 at 9:00 AM V19 stated V19 heard yelling and R3 and R8 had already separated themselves from each other. V19 stated R3 said R8 tried to push R3's wheelchair from behind so R3 grabbed R8's nose. V19 stated R8 is confused but reenacted the nose grab to the CNA. V19 stated R3 is alert and oriented to person, place and time.4.) The facility's Preliminary 24 Hour Abuse Investigation Report documents on 1/17/26 at 12:40 PM it was reported that R2 was observed in the front lobby yelling that someone was trying to kill R2's son and R2 made contact with R3.R7's Abuse Allegation Interview dated 1/23/26 documents R7 was present in the lobby when R2's/R3's incident occurred, R2 bumped R3's wheelchair, R3 bumped R2 back and then R2 grabbed R3's arm. R7's MDS dated [DATE] documents R7 as cognitively intact. R3's Abuse Allegation Interview dated 1/19/26 documents R2 was anxious and grabbed R3's wrist without causing injury. On 3/3/26 at 8:53 AM R3 stated about a month ago R2 was trying to slap at R3, so R3 grabbed R2's wrist, and then R2 grabbed R3's wrist. R3 stated R3 didn't get hurt.On 3/3/26 at 10:28 AM R7 stated he witnessed R2's/R3's altercation and there was no staff present. R7 stated R2 seemed upset prior, R2 bumped into R3's wheelchair, R3 yelled at R2, and R2 yelled at R3. R7 stated R3 grabbed R2's wrist then R2 grabbed R3's wrist. R7 stated R3 gets upset with staff and yells at them.

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NAME OF PROVIDER OR SUPPLIER Arc at Dwight		STREET ADDRESS, CITY, STATE, ZIP CODE 300 East Mazon Avenue Dwight, IL 60420	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report allegations of resident-to-resident abuse to the administrator for four (R9, R10, R11, R12) of 12 residents reviewed for abuse in the sample list of 15. Findings include:The facility's Abuse Prevention and Reporting policy dated December 2025 documents verbal abuse includes oral and gestured communication towards residents, verbal abuse can be considered mental abuse and includes yelling, mocking, insulting, and ridiculing. This policy documents to consider resident to resident altercations as potential situations of abuse that should be investigated. This policy documents employees are required to report any incidents, allegations or suspicions of abuse immediately to the administrator or to an immediate supervisor who must immediately report to the administrator.1.) On 3/3/26 at 11:35 AM V6 Housekeeper stated V6 has witnessed R11 and R12 curse at each other a couple times and V6 witnessed them saying f*** (expletive) you to each other at approximately 7:00 AM today. V6 stated R11 does not like R12 since R12 has Alzheimer's and forgets things. V6 stated V6 had not reported this to V1 Administrator since nursing staff were aware of this, including V7 Certified Nursing Assistant (CNA). V6 stated abuse is reviewed in the monthly meetings and staff are to report suspected abuse immediately to V1. V6 was asked if V6 would consider R11 and R12 cursing at each other as abuse. V6 stated I (V6) guess but was unsure since these residents are prone to it due to their illnesses. On 3/3/26 at 11:57 AM V7 CNA stated R11 and R12 [NAME] back and forth, R11 gets upset with R12 being confused and forgetful. V7 stated V7 has heard R11 call R12 a f****** (expletive) dummy. V7 stated this has been going on for a couple of weeks, V7 has reported this to the nurses and mentioned that a room change should be considered. V7 stated V7 would consider this as verbal abuse and had not reported this to V1 or V2 Director of Nursing since the nurses were aware. On 3/4/26 at 8:48 AM V17 Housekeeper stated R11 yells a lot at R12 saying things like you (R12) just asked that God d*** (expletive) it. V17 stated V17 did not report this to V1 since the CNAs were aware. On 3/3/26 at 12:16 PM R11 and R12 were sharing a room. R12 stated R11 and R12 have been roommates for about a month and they [NAME] back and forth and curse at each other at times. The facility's abuse log does not include an allegation of abuse between R11 and R12. On 3/3/26 at 12:22 PM V1 was not present in the facility. V2 Director of Nursing stated no one has reported any concerns between R11 and R12, and V2 would consider the yelling/cursing as abuse. V2 stated staff should report this so that it can be investigated. V2 stated V2 will report this to V1 and will follow up to look into a room change. On 3/4/26 at 9:33 AM V1 stated staff should have reported R11's/R12's yelling and cursing to V1, and V1 was not made aware until notified yesterday by V2. 2.) On 3/3/26 at 11:35 AM V6 Housekeeper stated a couple months ago V6 heard yelling between R9 and R9's roommate (R10), V6 witnessed R9 give R9's roommate (R10) the middle finger, and their rooms were changed. V6 stated V6 did not report this as there was an unidentified CNA in the room at the time. V6 was asked if V6 would consider this to be abuse. V6 stated I (V6) guess but was unsure since these residents are prone to it due to their illnesses. R9's Minimum Data Set, dated [DATE] documents R9 has moderate cognitive impairment. The facility's abuse log does not include an allegation of abuse involving R9. On 3/3/26 at 12:22 PM V2 stated there have been no abuse allegations involving R9 or roommate. V2 stated R9's former roommate, R10, asked for a room change due to R9 getting in R10's personal space. V2 stated V2 was aware of R9 giving staff the middle finger, but not residents. V2 stated V2 will report this to V1.On 3/4/26 at 9:33 AM V1 confirmed staff should have reported the allegation of R9 giving R10 the middle finger. V1 stated this was just reported to V1 yesterday by V2.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to implement measures to prevent further abuse during an abuse investigation for three (R2, R3, R8) of 12 residents reviewed for abuse in the sample list of 15. Findings include: The facility's Abuse Prevention and Reporting policy dated December 2025 documents the facility will take steps to prevent potential abuse during the investigation and residents who allegedly abuse another resident will be assessed to determine the most suitable therapy, care approaches, and placement while considering the resident's safety and the safety of other residents. This policy documents the facility will take all necessary steps to ensure the safety of residents, including but not limited to separating the residents involved. 1.) The facility's Preliminary 24 hour Abuse Investigation Report documents on 11/28/25 at approximately 10:00 AM it was reported that a resident (R3) had touched R8's nose. The facility's Final Report dated 12/4/25 documents R8 pushed R3's wheelchair. R3 told R8 not to push R3. R8 told R3 I'll (R8) do what I (R8) want. R3 then grabbed R8's nose and R8 grabbed R3's arm and pushed R3 away. R3's Abuse Allegation Interview dated 11/28/25 documents R3 reported R8 pushed R3's wheelchair so R3 grabbed R8's nose and then R8 grabbed R3's hand to push R3 away. This incident happened near the nurse's station. R8's Abuse Allegation Interview dated 11/28/25 documents R8 reported trying to help R3 and R3 grabbed R8's nose so R8 pushed R3's hand away. R8 reported it hurt at first, but R8 was fine. V18 Certified Nursing Assistant undated Interview documents V18 heard R8 yell out for help, R8 was sitting in the hallway near the nurse's station and R3 was pedaling her wheelchair away. V18 asked R8 to show V18 what happened and R8 reached out and grabbed/twisted V18's nose. V19 Registered Nurse was also present. There is no documentation that the facility implemented 15 minute checks or one to one supervision of R3 and R8 during the investigation of this abuse allegation.On 3/4/26 at 9:00 AM V19 stated V19 heard yelling and R3 and R8 had already separated themselves from each other. V19 stated R3 said R8 tried to push R3's wheelchair from behind so R3 grabbed R8's nose. V19 stated R8 is confused but reenacted the nose grab to the CNA. V19 stated R3 is alert and oriented to person, place and time. V19 stated sometimes 15 minute checks are done for abuse allegations, but that is based on directive from V1 Administrator and V19 could not recall if 15 minute checks were implemented after the incident. V19 stated 15 minute checks are documented on a paper form that is uploaded into the resident's electronic medical record. On 3/4/26 at 12:20 PM V1 stated 15 minute checks or one to one monitoring was not implemented during the investigation of R3's/R8's altercation. V1 stated staff were just checking on these residents every two hours and monitoring their behaviors. 2.) The facility's Preliminary 24 Hour Abuse Investigation Report documents on 1/17/26 at 12:40 PM it was reported that R2 was observed in the front lobby yelling that someone was trying to kill R2's son and R2 made contact with R3. The facility's Final Abuse Investigation Report for this allegation is dated 12/4/25. R7's Abuse Allegation Interview dated 1/23/26 documents R7 was present in the lobby when R2's/R3's incident occurred, R2 bumped R3's wheelchair, R3 bumped R2 back and then R2 grabbed R3's arm. R3's Abuse Allegation Interview dated 1/19/26 documents R2 was anxious and grabbed R3's wrist without causing injury. There is no documentation in R2's or R3's medical records that 15 minute checks or one to one supervision was implemented during the investigation of this abuse allegation.On 3/4/26 at 12:20 PM V1 stated 15 minute checks or one to one monitoring was not implemented during the investigation of R2's/R3's altercation. V1 stated staff were just checking on these residents every two hours and monitoring their behaviors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a care plan with problem, goals, and interventions to address behaviors of disrobing for one (R14) of 12 residents reviewed for abuse in the sample list of 15. Findings include: R14's Minimum Data Set, dated [DATE] documents R14 has severe cognitive impairment. R14's Behavior Tracking dated 2/3/26-3/4/26 documents R14 had behaviors of disrobing on 2/3/26, 2/5/26, 2/19/26, 2/20/26, 2/23/26 and 2/24/26. The facility's Preliminary 24 Hour Abuse Investigation Report documents on 2/26/26 at 6:30 PM it was reported that R14 was in R15's room holding up her gown and R15 touched R14's breasts. V14 Certified Nursing Assistant Staff Interview form dated 2/16/26 documents V14 walked past R15's room and noticed R14 was in R15's room, as V14 entered R15's room V14 witnessed R14 holding up her gown and R15 had his hand on R14's breast. R14's Nursing Note dated 2/24/2026 at 10:24 PM documents R14 had increased confusion with hallucinations and R14 took her gown off while sitting in the hallway with incontinence brief halfway off. R14 was assisted with dressing. R14's Care Plan dated as revised 2/25/26 documents R14 wanders into other resident rooms and has pulled her top up in a male resident's room. This care plan does not include a problem, goals and interventions to address R14's behaviors of disrobing in public areas. On 3/4/26 at 1:43 PM V2 Director of Nursing stated R14 is not aware of R14's surroundings, R14 will change R14's gown in the hallway or comes out of R14's room while putting R14's top on. V2 stated this is not a new behavior for R14. At 1:51 PM V2 confirmed R14's care plan does not include a problem, goal, and interventions to address R14's public disrobing behaviors, only the incident involving R15. The facility's Abuse Prevention and Reporting policy dated December 2025 documents staff will identify residents with increased vulnerability for abuse, including residents who have needs, triggers and behaviors that might lead to conflict. This policy documents staff will identify problems, goals, and interventions that will be care planned to reduce the chances of abuse.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement fall interventions and thoroughly investigate falls for two (R5, R6) of three residents reviewed for falls in the sample list of 15. Findings include: The facility's Fall Prevention Program dated January 2026 documents nursing staff are responsible for implementing and maintaining resident safety precautions, residents will be observed every two hours and provided care as care planned, residents will be transferred according to their care plan and fall interventions will be documented on the care plan. The facility's Transfers-Manual Gait Belt and Mechanical Lifts policy dated December 2025 documents to use a gait belt for one and two person transfers and the use of a gait belt is mandatory for all physical assisted transfers. 1.) R5's Minimum Data Set (MDS) dated [DATE] documents R5 has severe cognitive impairment and requires substantial/maximal staff assistance for bed mobility and transfers. R5's Care Plan documents an intervention dated 1/6/26 that R5 requires one assist for transfers. R5's Fall Report dated 2/18/26 at 6:30 PM documents R5 was lowered to the floor by a Certified Nursing Assistant (V16 CNA) and R5 bumped her head on the trash can. The facility's fall investigation for this fall does not include an interview or statement from V16 regarding this fall or documentation if a gait belt was utilized for this transfer. The documented root cause is weakness due to recent COVID-19 illness, and the post fall intervention is to encourage fluids for three days and physical therapy. On 3/3/26 at 6:11 PM V16 stated V16 was transferring R5 from the wheelchair to the bed, R5 became weak and lost balance, and V16 had to grab the waist band of R5's pants and lower R5 to the floor. V16 stated R5 landed on her bottom and bumped R5's head on the trash can. V16 stated R5 had COVID-19 and was a one assist for transfers at that time. V16 stated V16 did not use a gait belt for this transfer but should have since gait belts should be used for one person transfers. On 3/4/26 at 1:06 PM V2 Director of Nursing stated a gait belt should be used for all non-mechanical lift transfers, including one assist transfers. V2 was not aware that a gait belt was not used during R5's staff assisted transfer and fall. At 1:43 PM V2 confirmed all of R5's fall investigation documentation was provided and does not include whether a gait belt was used.2.) R6's MDS dated [DATE] documents R6 has severe cognitive impairment, R6 requires partial/moderate staff assistance for chair/bed/toilet transfers, R6 is always incontinent of urine and frequently incontinent of bowel. R6's Care Plan dated 10/25/24 documents interventions for bed in low position with landing strip (mat) 1/5/26 and revised toileting plan 2/23/26. R6's Care Plan dated 12/12/24 documents R6 is incontinent of urine and to remind/cue R6 to go to the bathroom. New intervention added 2/23/26 to toilet ever two hours and as needed. R6's Unwitnessed Fall Report dated 1/4/26 at 9:30 PM documents R6 was found on the floor of her room lying on her left side at the foot of the bed. R6 had a large skin tear to her left arm. R6 stated R6 thought she saw a dog, went to look for it and tripped over the floor mat. The facility's fall investigation for this fall does not document when R6 was last checked on or provided toileting/incontinence cares. R6's Unwitnessed Fall Report dated 2/22/26 at 3:15 PM documents R6 was sitting on the floor between the foot pedals of her wheelchair. R6 stated R6 was trying to put pants on. The facility's investigation for this fall does not document when R6 was last checked on or provided toileting/incontinence cares. The root cause is listed as attempted to self-toilet and R6 was on isolation for COVID-19. The intervention is listed as revised toileting plan to include toileting at 3:15 PM. On 3/3/26 at 10:04 AM R6 was sitting in her wheelchair in her room. There was no fall mat noted in R6's room. R6 did not recall having any falls or what fall interventions are used. On 3/3/26 at 2:38 PM R6 was in bed with bed low to the floor. There was no fall mat beside R6's bed. At 2:40 PM V2 stated a landing strip is a fall mat placed beside the bed. V2 confirmed R6 did not have a fall mat beside her bed. V2 stated V2 would have to check R6's care plan. At 3:25 PM V2 confirmed R6 should have a fall mat on the floor when R6 is in bed. On 3/3/26 at 11:57 AM V7 CNA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was working on R6's hallway. V7 stated R6 had a fall recently, R6's door was closed due to COVID-19, and V7 had been in another resident room. V7 stated V7 heard yelling, R6 was trying to put her pants on or off, R6 slid down to the floor onto her knees, and R6 was incontinent at that time. V7 stated R6 was in the wheelchair prior to the fall, V7 had just changed R6 prior and dressed R6 in a clean gown because R6 wanted to go to bed. V7 stated R6 attempts to self-transfer. V7 was unsure of R6's specific fall interventions and stated V7 refers to the resident care plans for fall interventions. On 3/3/26 3:09 PM V22 Registered Nurse stated a CNA came to report that R6 was on the floor and R6 had a skin tear on her arm. V2 stated R6 said R6 was looking for a dog, lost balance and fell. V22 stated R6 is checked on every couple of hours at night and would have been toileted around 8:00-8:30 PM. V22 stated R6 does not usually try to self-transfer during the night. On 3/4/26 at 1:43 PM V2 confirmed R6's fall investigations do not include staff interviews or statements documenting when R6 was last toileted or checked on prior to the falls. V2 stated R6 was on a standard every two-hour toileting schedule prior to the fall which was changed to add toileting at 3:15 PM.