STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylorville Care Center	600 South Houston Taylorville, IL 62568

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Failures at this level required more than one deficient practice statement. A-Based on observation, interview and record review the facility failed to provide supervision and ensure residents at high risk for elopement were not able to leave the facility without the facility being aware the resident has left for one of five residents (R4) reviewed for elopement in the sample of 13. This failure resulted in R4 eloping from the facility on 7/25/2025. R4 was observed wandering in a ditch and found by a community member not affiliated with the nursing home. This community member contacted the assisted living facility who in turn notified the facility and asked if a resident was missing. The facility was unaware that (R4) had eloped. Due to R4's poor safety awareness, poor judgement, and need for ongoing supervision, this failure could result in serious harm, serious injury, impairment and/or death. This past non-compliance occurred from 7/25/25 through 7/28/2025. B. Based on observation, interview and record review the facility failed to ensure equipment was in proper working order during transfers for 2 of 3 residents (R1 and R2) reviewed for mechanical transfers in the sample of 13. This failure resulted in R1 and R2 both being transferred with a mechanical lift and the slings ripped causing both residents to fall. Both residents were sent to the hospital. R2 substantiated a hairline fracture to her pelvis, black eye, bruised forehead and cheek, and required two sutures. R1 sustained three skin tears to his left arm with discoloration.Findings include: a. The Immediate Jeopardy began on 7/25/2025 when R4 eloped from the facility at around 4:15 PM. R4 was observed wandering in a ditch and found by a community member not affiliated with the nursing home. This community member contacted the assisted living facility who in turn notified the facility and asked if a resident was missing. The facility was unaware that (R4) had eloped from the facility. The facility was notified of the Immediate Jeopardy on 1/28/26. The surveyor confirmed by observation, interview, and record review, that the immediacy was removed, and the deficient practice was corrected, on 7/28/2025. On 1/29/2026 during this survey the door alarm, went off on ten times form 9:30 AM to 1:30 PM. The door alarm went off at 9:39 AM, 10:03, 10;11 AM, 10:18 AM, 10:23 AM, 12:06 PM, 12:11 PM, 12;23 PM, 12:45 PM, and 1:11 PM. On 1/15/2026 at 1:51 PM, V1, Administrator stated, We did have an elopement back in July. (R4) got out of the building. R4's Photo is in the green book at the nurse's station document, Elopement Book and was identified by the Facility as an elopement risk. R4's Physician Order Sheet (POS) for July 2025 documents a diagnosis of Unspecified Dementia w/o (without) behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, Unspecified Dementia with/Agitation, Depression, Metabolic Encephalopathy and Hypotension. R4's Minimum Data Set (MDS) dated [DATE] documents R4 has a wander/elopement alarm that is used daily. R4 was severely impaired for cognition for activities of daily living. R4 is independent with ambulation and requires minimal assistance with care. R4's Care Plan edited on 11/26/2025 documents, Resident is at risk for injuries d/t (related to) exit seeking behaviors: attempts to exit the building unattended: Resident had an elopement on (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/25/25. Problem Start Date: 05/03/2024 Behavioral Symptoms: exhibit wandering/exit seeking behaviors and at risk for elopement. I currently have a (wander management system) on. I am known for packing my things and attempting to leave the building. Long Term Goal Target Date of 2/28/2026 documents, I will be free from wandering through next review date. R4's Elopement assessment dated [DATE] documents R4 is ambulatory of independent in wheelchair location, resident is cognitively impaired, poor decision-making skills, and or pertinent diagnosis. Has a history of wandering unto unsafe areas and has a (wander management system). Resident is at risk for elopement. R4's Progress Notes dated 7/25/2025 at 4:30 PM, Residents POA (Power of Attorney) and MD (Medical Doctor) notified of resident leaving the facility, safely returned to facility via a caregiver vehicle. Residents VS (vital signs) WNL (within normal limits). Skin checks negative for any new skin disruptions of baselines,(wander management system) checked for effectiveness. (Care giver was not from the facility but rather was from the assisted living facility). On 1/15/2026 at 1:02 PM, V17, Certified Nursing Assistant (CNA) stated, (R4) got out of the facility a while ago. I can't tell you how long she was gone or how she got out of the building. I know she did not have any injuries when she returned. The assisted living next to us notified us that someone was walking around and we found it to be (R4). We did not know (R4) had gotten out. I can't tell you how she got out and/or how long she was gone. The alarms did go off earlier and we did a head count and (R4) was there. I don't remember why the alarms were going off and I don't remember them going off again. We got a call from the (assisted living) asking us if a resident got out and that's when we found out (R4) had gotten out. I do not remember any resident telling me (R4) had gotten out of the door. Statement by V17, dated 7/25/2025 documents, I took two residents out for their smoke break. These two residents starting telling me that another resident was pushing on their wheelchair to try and get out the door. After I found out a resident had gotten out the door the two residents told me she had gotten out the door. (This statement does not document the names of the residents.) Statement by V22, Assisted Living Staff documents, A man came to the front desk (assisted living) to tell me there was a lady that just went through the ditch in front of the parking lot. He was worried she came from our building. I came outside to see her walking down the road. I got into my truck to get to her she was on the side of the road, and she didn't know where she was, or her name. I put her in my truck and took her to (assisted living) to see if we could find out. Called (Facility), they came over the (assisted living) to see if she belonged to their building. She did so I drove her over to the (Facility). She was closer to the front door to drop her off. On 1/16/2026 at 10:31 AM, V22 stated, I remember the day I found the resident from the (facility). It was a very hot day and originally when I was notified by a man, I do not know his name, but he stopped by here because he said he was worried because there was a woman who looked confused that was in the ditch I thought it was one of our residents. I got in my truck because I could see the resident walking down the road. When I approached her, she was very confused, and she did not know her name, and I was worried that she got overheated. I could not tell you how long she had been outside, but she looked pale as if she had been outside for some time. I brought her back here and gave her some water to try and cool her down, and I knew she was not one of our residents, so I called the (facility) to see if they were missing any residents. At that time, they were not aware of any residents that were missing. Some of their staff came over her and identified her as being their resident. So I took her in my truck back to the (Facility). Investigation Notes from R4's elopement on 7/25/2025 documents, (V18, Family of R6) stated (R4) did not follow behind them when they went outside. Residents (R8) and (R9) over sitting inside by smoker door and (R4) kept trying to push them out the door; they asked her to stop. (V17) took smokers out at around 4:15 PM. On 1/27/2026 at 12:52 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	AM, R8 stated she remembers (R4) was trying to push her and go outside but she is not supposed to go outside. She told the nurse. She does not remember (R4) ever going outside or seeing her leave through the gate by the gazebo by herself. She found out later (R4) got out, but this was when it was hot outside, but she did not see her get out and if she would have, she would have told somebody. Statement from R8 dated 7/26/2025 documents, (R9) and I were seated at patio door waiting to go outside. (R4) was trying to push (R9's) WC (wheelchair) out of the way and through the door. I went to get (V19, Licensed Practical Nurse). She came and removed (R4) from the area. We were taken out then to smoke. I did see (R4) come through the door to the outside but not after that. Statement from R9 dated 7/28/2025 documents, She did push me out the door a little. The door alarm sounded. The nurse hollered and said 'you can't go out.' The nurse brought her away. Did not see (R4) go out the door into the courtyard. Did not see (R4) in the courtyard while smoking. (V7), (R8) and myself were outside. On 1/27/2026 at 11:09 AM, R9 stated, I remember (R4) because she does not look like she is strong enough to push you, but she does have some strength. This was in the summer I believe. (R4) kept trying to push me and (R8) because she was trying to get outside. I went and got the nurse because I know she is not supposed to go outside without any staff. I never saw her go outside. I heard later she had gotten out, but I am not sure how she got out. Statement from V21, Former Assistant Director of Nursing (ADON) dated 7/25/2025 documents, (V7, CNA) the CNA was sitting at the nurse station when I walked by during med (medication) pass and said that someone called from the (assisted living) said they may have one of our residents. We have to go over there right now. (V7) and I immediately went through the patio door and over to the (assisted living). We saw (R4) in a truck with one of the staff from (assisted living). Staff from the (assisted living) said she walked over there, and they put her in their truck and called us. (V7) and I came back and met them at the front door and assisted (R4) to building. On 1/27/2026 at 12:31 PM, V21, Former Assistant Director of Nursing (ADON) stated, I remember when (R4) got out. This was back in the summer. I was on the C hall passing out my medications. The door alarm was sounding, and I went to the front desk to see what was happening. The door alarm will go off if the red button is not pushed before opening the door. Anytime we do not know what set off the alarm and or who went out we are supposed to do a head count. I know the DON was working the A hall and I was working the C hall and all of my residents were present. I did a head count and everyone on my hall was there. Later on, we got a call from the (assisted living) and they said they may have one of our residents. (V7) and I went over there, and it was (R4). We had done a head count earlier and nobody was missing. We are not sure how (R4) got out and I am not sure if anyone knew if she had gotten out. R4's Investigation Report dated 7/28/2025 documents. Administrator & Social Service Director spoke with (V18, Family member of R6) whose husband is here at the facility. She visits daily and often takes (R6 out to the patio area to visit. Staff reports that (V18) does know the code to the patio door and she can recite that to us during our conversation. (V18) stated that she is uncertain whether (R4) came out of the patio door when she was assisting her husband out to the patio. She believes that she wouldn't have let her out but is unsure. Family and staff report that (V18) does have memory loss and becomes more confused throughout the day. Side note in different handwriting documents (wander management system) going off on return to building. On 1/27/2026 at 12:47 PM, V18, Family member of R6 stated, I know back when it was warm they were asking me questions about if I had ever let anyone out. I think someone got out that was not supposed to get out. When it is warm, which is not now (R6) likes to go outside and sit by the gazebo. I would take him out and we would sit outside together. I did know the code and would take (R6) out. I never let anyone else go out with us or open the door for any resident. Sometimes there would be residents (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	already outside smoking. I never saw any resident leave the area without staff and or leave through the gate. Statement from V13 (Certified Nursing Assistant, CNA) and V24 (CNA) documents, were on C wing when the alarm went off around 4:30 PM, Said they needed a head count on all the halls, were clear on the C wing, come to find out a resident on the A hall had gotten out. On 1/27/2026 at 2:58 PM, V13 stated, It has been some time since R4 got out. I remember a door alarm went off and I did a head count and all of my residents were here. If someone gets out the front door or the side door the alarms will go off with a (wander management system) and on the door it is supposed to always go off. I know (R4) got out and nobody knew how she got out. On 1/29/2026 at 10:25 AM, V19, Licensed Practical Nurse (LPN) stated, I remember vaguely when (R4) got out. I know earlier (R8) and (R9) were complaining about (R4) trying to push them in their wheelchair so I went and got (R4) and took her back to her room. There was a lot of stuff happening that day. I was looking for a kitchen employee. I remember the door alarms going off and doing a head county. Everyone on my hall was present. Then later when I was looking for the kitchen staff, I saw a truck pull up and drop off (R4). She had left the building, and nobody knew she was missing. V19's Statement dated 7/25/2025 documents, I (V19) walked out deliver door near kitchen, and was walking around the facility looking for an employee. When I was walking up the front door a pickup truck pulled up with resident in her front seat. I assisted resident out of the vehicle and into the building. I looked over her resident body/skin Vitals etc, gave drink of water. When assisting resident into front door (wander management system) started to alarm. Resident was in place to ankle. Write up by V1 documents, Approx 4pm: (V19) Licensed Practical Nurse (LPN) states she was in bathroom and heard front door alarm sounding. She went to the door and could not see anyone. She left alarm sounding and went out the door, checking perimeter to ensure no resident was outside. She did not determine why alarm was sounding and directed staff to start a 'head count' per policy. The (Weather History & Data Archive) website documents outside temperature on 7/25/2025 at 3:52 PM, 89 degrees Fahrenheit (F), and at 4:52 PM 89.0 F for the town where the Facility is located. 1/27/2026 at 1:34, V8, Medical Director stated, his expectation are residents with wandering tendencies should be monitored/supervised; exit doors for (wander management system) on residents should alarm and prevent unnoticed departures. Risk: Exposure to 89 F could cause dehydration, confusion, and possible harm or injury. The Facility Missing Resident Policy with a revision date of November 2017 documents, It is the policy of (Facility) that reasonable precautions are taken to minimize the risks of resident elopement attempts. Reasonable precautions include, but are not limited to: door alarms, personal door alarm activation devices, staff intervention, staff education regarding response to door alarms, and individual resident intervention. It is the policy (Facility) to demand immediate response to elopement attempts, door alarm activation and participation in search attempts in the event that a resident is deemed missing. Maintenance to check operations of all facility door alarms daily when on duty. Nurses to check door alarms each shift. Key pad coded door codes will be changed as needed by maintenance Kitchen door and all other hazardous doors are to be closed and locked at all times when staff not present. Staff to be in-serviced at orientation on door alarm policy and procedure. All alarms will be set at all times.Immediate response from staff when alarms are activated to secure situation and reset alarm. Once an alarm is signaled and if there is no witnessed cause of the signal, a resident search will be conducted. Each charge nurse is responsible to assure each resident is accounted for. All staff must respond and identify all residents. Once all residents are accounted for an all-clear announcement will be made. Should a resident be identified as missing, the policy and procedure for missing resident is initiated. The Immediate Jeopardy that began on 7/25/2025 was corrected/removed on 7/28/2025 after the facility took the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	following actions to correct the noncompliance prior to the start of current survey: Resident returned to facility safely, skin assessment and vital signs completed upon. Resident placed on 15-minute checks, (wander management system) checked for proper functioning, code to patio door changed, and all door alarms checked for proper functioning. 7/25/2025. All residents could be affected by deficient practice. Measures put in place include staff education re: elopement policy, DON/ADON to audit (wander management system) on MAR (Medical Administration Records /TAR (Treatment Administration Records 5x/week x 3 weeks and monthly x 3 months. R3, R4, R10, R11, and R12's Care Plan, Elopement Assessments, MAR and TAR were all reviewed and document they were being checked and documented. Audits were being completed as described with no issues, Code yellow book reviewed by SSD (Social Service Director) to ensure completeness. Care plans for residents at risk for elopement reviewed and updated as needed. Code yellow drills performed weekly x 4 weeks on each shift. Administrator to review audits to ensure compliance. Trends reported to QA (Quality Assurance) committee review with any identified deficiencies to have further corrective action implemented as needed. Completed on 7/26/2025. Code Yellow book was located at the nurse's station and all residents identified as high risk for elopement photo was in the book and a description of the residents was present in the book. Book was reviewed on 1/29/2026. Inservice dated 7/28/25 documents all staff were in-serviced by V1 re: resident supervision, redirecting exit seeking residents, alarms response, no sharing of door codes with non-staff members. 58 signatures. Additional 6 names of new employees starting after 7/28/25 were documented as receiving the training before working on the floor. All staff working on 1/29/2026 were verified as receiving the trainings. This task was documented as being completed on 7/28/2025. b. 1- On 1/13/2025 at 11:28 AM, R2 was in the dining room sitting in her wheelchair. R2 has a yellowish purple faded bruise to her right forehead the size of medium size apple, a black faded yellow, purple bruise black eye to her right eye and band aid covering a small yellowish purple bruise that is exposed around the band-aid on her right cheek. R2's Physician Order Sheet for January 2026 documents a diagnosis of Paraplegia, unspecified; anxiety disorder, unspecified; Congenital hydronephrosis; Disorder of the skin and subcutaneous tissue, unspecified Irritable bowel syndrome, unspecified; Other neuromuscular dysfunction of bladder Note: neurogenic bladder; Scoliosis, unspecified; Spina bifida, unspecified Morbid (severe) obesity due to excess calories; Body mass index [BMI]40.0-44.9, adult. R2's Vitals dated 1/7/2026 documents R2 weighed 190.0 pounds, and her BMI (body mass index) was 45.08. Manufacturer directions for the mechanical sling documents this is within the guidelines for a safe transfer. R2's Minimum Data Set (MDS) MDS dated [DATE] document R2 was cognitively intact for decision making of activities of daily living. R2 has no impairment on her upper or lower extremities, she uses a wheelchair and is dependent on staff for chair/bed transfer: the ability to transfer to and from a bed to chair (or wheelchair) in which staff completed all the activities for the resident for transfers. R2's Care Plan Category under Pain with a created date of 1/10/2026 documents, Resident has pain/risk for pain related to recent pelvic fracture/chronic right hip dislocation following a fall. Under ADL's (Activities of Daily Living) Functions and dated 1/09/2026: Staff to ensure to utilize a mesh shower sling when transferring resident after a shower. Resident has bilateral lower extremity paraplegia from the waist down and requires a (mechanical Lift) for transfers. On 1/13/2025 at 2:00 PM, R2 stated, I was born with scoliosis and spina bifida. I have never been able to walk. They have to use a (mechanical lift) to transfer me. There is a sling on the machine, and something was wrong with the sling because it broke when they were moving me, and I fell from the air and fractured my pelvis. (V1, Administrator) came and told me she would investigate, and she said (V14, Laundry Supervisor) does inspections on the slings. I saw a picture of the sling and it was broken on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was in the shower chair and normally after her showers (R2) likes to go to bed. After her shower I got (V7) CNA, and we hooked up (R2), and the straps were on correctly, but when she was in the air the stitching on the loops came undone and (R2) went down. It happened so fast, and I grabbed her head as she was falling and (R2) hit her face on the base of the (mechanical lift) and it started bleeding. I yelled for help and (V4) arrived and I put a pillow behind (R2's) head and kept pressure on her face/cheek until the EMS arrived. I did not inspect the sling that morning because it was already underneath (R2). Normally, laundry inspects the slings after they are washed, and they inspect and document. I personally only experienced issues with the sling breaking with (R2) but I am aware of (R1's) sling also breaking during a transfer. This was a regular sling underneath (R2).R2's Initial Report dated 1/9/2026 (R2), a [AGE] year old female resident who resides at (Facility) with a history of paraplegia due to spina bifida, scoliosis depression, anxiety. Due to diagnosis, resident requires total assist from staff via (mechanical lift) for transferring. At approximately, 4:45 PM, on Friday, January 9, 2026, resident was given a shower, following the shower, 2 staff CNA's were transferring resident back to bed from the shower chair using the (mechanical lift) in resident's room. During the transfer, the (mechanical lift) sling loops came unattached, causing (R2) to fall, CNA was able to protect head from striking the floor. The CNA in room yelled for help from other staff and immediately held pressure to (R2's) right side of face where there apparated to be a laceration. Nurse (V4, LPN) immediately arrived to room to assess. (R2) remained conscious, alert and orientated, vital signs remained stable. EMS (emergency Medical Services) was called, staff remained with resident until arrival of EMT's (emergency medical team). Resident was taken to hospital for evaluation. Resident's son was notified of incident at this time as well and PCP (Primary Care Provider). Facility later received phone call from ED (emergency department) for evaluation. R2's Hospital Records dated 1/9/206 at 5:10 PM, documents, chief complaint: Fall. Location of injuries right cheek, right periorbital area and head. Occurred at nursing home. Occurred 4:50 PM on 1/9/2026. Pt (patient) arrives per EMS (Emergency Medical Services), States the strap of the (mechanical lift) broke and patient fell face first. Patients face hit the base of the (mechanical lift). Pt (Patient) has pain to right side of face. Pt has bruising and swelling under R (right) eye. Pt has a small lac (laceration) on R (right) cheek. R2's Radiology Report dated 1/9/2026 documents, Acute nondisplaced fracture through the anterior right ilia wing. b. 2 - R1's POS documents a diagnosis of Unspecified dementia, mild, with mood disturbance; Constipation, unspecified; Pressure ulcer of left heel, unstageable; Laceration without foreign body of left upper arm, initial encounter; Generalized anxiety disorder; Depression; and Pain.R1's MDS dated [DATE] document R1 was severely impaired for cognition for activities of daily living. R1 has no impairments and uses a wheelchair and is dependent on staff for chair/bed transfer: the ability to transfer to and from a bed to chair (or wheelchair). Dependent: A helper completed all the activities for the resident.R1's Medical Records document R1 is currently on hospice.R1's Care Plan: Under Falls: Resident is at risk for falls due to: age related comorbidities. Start date 3/30/2024. Problem: I am cognitively impaired due to: Dementia, BIMS (Brief Interview for Mental Status) score previously was staff and remains staff due to nonsensical answers which is severely impaired.R1's Progress Notes dated 7/31/2025 at 11:02 AM, Resident was being transferred by CNA (certified nursing assistant) & this nurse from his bed to the wheelchair to get up for lunch. Resident was in sling and properly fitted in, sling straps and hooks were intact with no noted fraying or breaks. When CNA lowered sling down to place in wheelchair the sling straps to the left side straps part of the sling snapped, dumping resident backwards. This nurse assisted resident to the floor breaking the fall by easing resident to floor as the right-side straps part of the sling and hooks were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylorville Care Center	600 South Houston Taylorville, IL 62568

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	still intact on the lift. Resident did not hit his head, has no c/o pain, alert, orientated to baseline. Resident has 3 skin tears to the left arm and discoloration. Resident has a red spot to the left cheek where he bumped this nurse's knee when going down. Pillow placed under resident's head and sheet under arm to stop bleeding. EMS (Emergency Medical Service) called and they assisted resident to stretcher with a blanket sling. Resident has been sent to (Hospital) for an evaluation. POA (Power of Attorney) & MD (Medical Doctor) has been notified. R1's Progress Notes dated 7/31/2025 at 11:14 AM, Writer called to resident room and found resident on the floor. ADON (Assisted Director of Nursing) and CNA were getting resident up for lunch and using (mechanical lift) and sling broke causing resident to go to the floor. Resident skin tear on left arm resident also c/o (complained of) shoulder pain. Writer called 911 and also contacted son and left message. Ambulance here and transferred resident to (hospital) for evaluation. DON (Director of Nursing) and administrator aware of resident on floor.On 1/15/2025 at 10:07 AM, V2, Director of Nursing stated, When (R1) fell during his transfer I was not working as the Director of Nursing. I only know there was something with the sling. I don't remember anything else and was not part of the management team at that time.On 1/13/2026 at 2:32 PM, V9, Licensed Practical Nurse stated, I was not working when (R2) fell but I was working awhile back when they were transferring (R1) and his (mechanical lift) strap broke and he fell but he was okay. The strap broke and he fell.Employee Witness Statement by V11, CNA dated 7/31/2025 documents, (V21, ADON) and myself were transferring (R1) to his w/c (wheelchair) with the (mechanical lift) when 2 of the straps on the (mechanical lift) sling snapped and he landed on the floor fell mostly on his shoulder. On 1/14/2026 at 10:39 AM, V14, Laundry Supervisor stated, We in laundry are supposed to inspect every sling and throw away any sling that is damaged. I know we were not documenting in the log like we were supposed to and I did get written up for it. I guess it broke again and somebody fell during a (mechanical lift because the sling broke). I work five days a week. On 1/29/2026 at 1:33 PM, V1, Administrator stated (R1) did fall during a transfer and the sling broke. After (R1) fell from his sling we checked with laundry to make sure they were inspecting the slings, not using bleach on them and that they everyday they are supposed to check the slings, throw them out if they are damaged and document the sling condition. After (R2) fell we re-educated laundry again. No other interventions were put in place expect in-serving staff. The lift was a Invacare reliant 450.The (Mechanical Lift) Manufacture Instructions documents, Bleached, torn, cut, frayed, or broken slings[TRUNCATED]