STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Elk Grove, The	1920 Nerge Road Elk Grove Village, IL 60007

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to follow the Medication Storage Policy by failing to ensure medications are secured and by failing to ensure medications are labeled. This failure has the capacity to affect 20 residents reviewed for medications in a total sample of 31 and 1 cart of 7 reviewed for medication storage.Findings include: 1.On 12-17-25 at 4:56 AM, V3 (Registered Nurse) left the medication cart unlocked and unattended while passing R45's medication. At 5:15 AM, V3 left the medication cart unlocked and unattended while passing R12's medication. At 5:18 AM, V3 left the medication cart unlocked and unattended while passing R137's medication. On 12-17-25 at 5:34 AM, V3 (Registered Nurse) said the nurse is responsible for securing medication storage by locking the cart while passing medications. V3 said this prevent people from taking medications from the medication cart. On 12-18-25 at 3:49 PM, V2 (Director of Nursing) said all medication should be locked in medication cart to ensure only nurses have access to the medications. Medication Storage Policy reviewed 4-18-25 documents: B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications permitted to access medications. Medication rooms, carts, emergency kits/boxes, and medication supplies are locked when not attended by persons with authorized access. 2.On 12-17-25 at 6:34 AM, surveyor and V4 (Registered Nurse) were reviewing medication cart (for team 2 & 3). Surveyor observed a medication cup with unlabeled 7 tablets. The medication cup said 250mg Vit C with no other way to identify these tablets. V4 examined the cup and immediately disposed of the tablets. On 12-17-25 at 6:34 AM, V4 said she did not use this medication cart during her shift. V4 said she was not able to identify these medications, and the medications should be labeled. V4 said she will dispose of these medications immediately. On 12-18-25 at 3:49 PM, V2 (Director of Nursing) said unsecured unlabeled medications are to be discarded. V2 said she was made aware of the unlabeled medications, and it was determined the agency nurse used house stock Vitamin C 250 mg and placed in the medication cup. V2 said the responsible nurse should have retrieved a labelled bottle and mark the open date. V2 said this cart has medications for 16 residents currently. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Storage Policy reviewed 4-18-25 documents: F. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. 3. On 12/16/2025 at 10:08AM during unit rounds, a medicine cup with a total of 4 pills, an orange, a purple, a white and a red, in it was at R89's bedside table. On 12/16/2025 at 10:09AM, V12 (Registered Nurse) came in R89's room and stated that she was pulled for another resident and did not mean to leave the pills on R89's bedside table. R89 stated that V12 leaves R89's medications with her all the time. On 12/18/2025 at 12:45PM during interview with V2 (Director of Nursing), V2 stated that nurses are to stay with the resident for the duration of medication administration to ensure medications are completely taken by the resident. V2 stated that she is not aware of any resident in the facility that can self-administer their medications. Review of R89's Order Summary Report dated 12/28/2025 indicated admission date of 07/27/2024, and diagnoses of not limited to unspecified dementia, anxiety disorder and depression. It also indicated may leave at bedside for patient to self-administer only for PreserVision AREDS (Multiple Vitamins with Minerals) and TheraBreath Oral Rinse (Throat Liquid Mouthwashes). Review of facility's policy entitled Medication Administration reviewed 04/18/2025 indicated the following: Intent: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 17. Remain with the resident to ensure that the resident swallows the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow the Acute Respiratory Infection Policy when V3 (Registered Nurse) failed to wear a mask during a facility wide COVID outbreak and the facility failed to follow the Enhanced Barrier Precaution Policy when V3 was not wearing a gown when applying pain patch (direct physical contact) on a resident with Enhanced Barrier Precautions. This failure has the capacity to affect 4 residents in a total sample of 31.Findings include:On 12-16-25 at 9:00 AM, while entering the facility, front desk receptionist informed the survey team about facility outbreak of COVID and advised the survey team to wear a mask. Surveyor observed masks and hand sanitizer station in the lobby. Surveyor observed most staff and all visitors wearing masks and sanitizing their hands appropriately. V2 also told survey team about COVID outbreak status.On 12-17-25 at 4:56 AM, V3 was observed passing medications to R45 without wearing a mask. At 5:15 AM, V3 was observed passing medications to R12 without a mask. At 5:18 AM, V3 was observed passing medications to R137 without a mask. At 5:27 PM, V3 was observed providing direct patient care (applying pain patch) to R44 (orders of Enhance Barrier Precautions/ EBP) without wearing a gown.On 12-17-25 at 5:34 AM, V3 (Registered Nurse) said the facility is currently on COVID outbreak status and staff are to wear masks and wash their hands to prevent the spread of infection. V3 said R44 is on EBP but V3 said he did not directly touch R44 and said he touched the pain patch that touched R44.On 12-18-25 at 10:24 AM, V17 (Infection Preventionist) said they saw V3 working and not wearing a mask. V17 said she immediately provided 1:1 education and in-serviced V3 on wearing a mask and hand hygiene before and after patient contact. V3 said all staff who have direct patient contact (touching the patient) should wear a gown and gloves to prevent the spread of infection.On 12-18-25 3:49 PM V2 (Director of Nursing) said facility is currently at COVID Outbreak Status (more than 3 cases) and isolated to unit 300. V2 said staff, residents, and visitors are highly encouraged to use mask. V2 said residents have the right to refuse and staff and family were educated on using masks. V2 said V17 (IP Nurse) witnessed V3 on the floor without wearing a mask and immediately in-serviced V3 and provided PPE training and coaching.Physician Order Summary documents: Enhanced Barrier Precaution due to: wounds, indwelling urinary catheter, CRAB every shift.Enhanced Barrier Precautions reviewed 6-25 documents: Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S.aureus and Multidrug Resistant Organisms (MDRO). EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: wound or indwelling medical devices, regardless of MDRO colonization status, Infection or colonization with an MDRO.Acute Respiratory Illness Policy dated 11-14-25 documents: The facility will recommend masking for all healthcare personnel and visitors during a facility wide outbreak.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its Call Light Policy by not ensuring the call light was placed within easy reach of a resident. This deficient practice affected one resident (R83) out of three residents reviewed for accommodation of needs, within a total sample of 31 residents.R83 is a [AGE] year-old-female re-admitted to the facility on [DATE]. R83's medical diagnoses include, but not limited to Secondary parkinsonism, Alzheimer's disease, type 2 diabetes, anxiety, bipolar, hypertension, gout, hyperlipidemia, hypothyroidism. On 12/16/2025 at 9:54 AM during room rounds, R83 was observed in bed awake and resting. R83's call light string was noted on top of the bedside table and not within R83's reach. V5 (Certified Nursing Assistant/CNA) entered the room and was asked why R83's call light was positioned out of her reach; the CNA stated, It's because she always plays with the call light. When the CNA was asked how R83 could request assistance if the call light cord was positioned out of reach, no response was provided. On 12/17/2025 at 9:04 AM, R83 was observed in bed eating breakfast. The call light cord was observed positioned away from the resident, with the end of the string noted on the floor. V5 (CNA) entered the room and stated that R83 likely threw the call light onto the floor. When asked whether R83 uses the call light to request assistance, the CNA responded, Yes. V5 was also asked why floor mats were present on both sides of the bed and stated they were in place to prevent injury in the event of a fall. On 12/18/2025 staff was interviewed regarding call light use. At 9:14 AM, V9 (Registered nurse/RN) stated that staff needs to make sure that call light should be within the resident's reach. V9 said, We must put them close to the resident so that they can use it. If it's far, they won't reach it, and if the resident is at risk for fall then they might fall. So frequent rounds are necessary to make sure they are within reach. At 9:20 AM, V10 (Licensed Practical Nurse/LPN) said that call light should always be placed where residents can reach them so they can call for assistance when they need help. V10 also stated that if it's far, and they cannot reach it then falls may happen. At 9:54 AM, V11 (CNA), said that it is very important to place the call light within reach because you don't want any falls or anything like that to happen. She also said, clip it so they can reach it.R83's care plan for Activities of Daily Living (ADLs), revised on 3/12/2025, indicated that R83 had an ADL self-care deficit, as evidenced by an unsteady gait related to physical limitations, cognitive impairment, functional decline, and dependence on staff for ADLs and transfers.R83's care plan on Falls with a revised date of 9/22/2023 states that, R83 is high risk for falls, impaired mobility, cognitive deficit, dx/condition, potential s/e of meds and d/t poor safety awareness, cognitively impaired, poor communication and, unable to repositioned self, needing assistance from staff for ADL and dependent with transfer. On 4/21/2023 an intervention was added to her Fall care plan, which was Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. R83's Call Light Ability Screen-V1 assessment, completed by a nurse and dated 8/10/2024, indicated the following outcome:1. Instruction - #2 Resident is able to follow instruction on how to use call light? YES #3 Resident able to return demonstration on how to use call light immediately after instructions given? YES2. Ability - Resident is able to use the call lightThe facility's Call light Policy and Procedure, provided by V2 and last reviewed dated 2/25/2025, stated the following: Intent - Facility aims to meet resident's needs as timely as possible. Call light system is utilized to alert staff of resident's needs.Guideline:1. A call light ability screen will be completed for each resident on admission and with a significant change to determine the ability to use the call light.2. Residents capable of using the call light appropriately will have their call light accessible at all times.3. Residents incapable of using the call light will have alternative means or assistive devices based on functional ability.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the Fall Prevention and Management Policy by not completing post fall assessment dated [DATE] after a fall incident. This failure affected 1 resident (R3) of 3 residents reviewed for falls in a total sample of 31.Findings include:On 12-17-25 at 12:49 PM, V14 (Restorative Nurse) said R3's Fall Event dated 3-16-25 documents In Progress and nothing is entered. V14 said this event occurred before V14 was the Restorative Nurse. V14 said she does not have knowledge of this incident. V14 said the nurse on duty is responsible for completing the Fall Event form.On 12-18-25 at 10:46 Am, V2 (Director of Nursing) said the nurse on duty was an agency nurse who didn't complete the Fall Event form and did not enter any new interventions. V2 said the fall team completed a soft copy Fall Event form however did not enter the form in computer because she was not the nurse on duty at that time. V2 said the team decided to continue the current interventions however the date was not changed.R3's Fall Event dated 3-16-25 is not completed.Fall Prevention and Management Policy revised 3-31-25 documents: 3. Procedure for Post Fall Management. A. Post Fall Observation will be completed. B. Perform assessment to the cause and fall of the potential for injury. C. Perform physical assessment including head to toe assessment, vital signs, range of motion, neurological assessment as indicated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate the Level II PASRR (Preadmission Screening and Resident Review) process for residents identified with mental illness. This deficient practice affected 3 residents (R133, R12, and R9) reviewed for PASRR within a total sample of 31 residents. 1 -R9 is a [AGE] year-old female, admission record documents initial admission date to the facility was on 6/19/2019 with diagnosis of, not limited to, Dementia unspecified severity with other behavioral disturbance, onset date 10/01/2022. Major depressive disorder single episode unspecified, onset date 7/22/2020. Unspecified psychosis not due to substance or known psychological condition, onset date 7/29/2020. Personal history of other mental behavioral disorders, onset date 10/01/2020. Depression unspecified, onset date 5/20/2024. R9's OBRA I- Initial Screening dated: 6/26/2019, reads: based upon all information and data available to me for this person there is a reasonable basis for suspecting DD or MI, no was marked. On 12/17/2025 at 10:18AM V7 (Social Service Coordinator) said: R9 did not have any other PASARR (Pre-admission Screening and Resident Review) evaluation since the initial admission date to the facility. On 12/18/2025 at 11:32AM V8 (Social Service Director) stated, R9 should have been re-evaluated after new psych diagnoses were added after R9s admission date. V8 (Social Service) states a PASRR Level 1 should have been submitted before re-admission to facility. During record review of R9s census list, R9 was discharged from the facility on 2/8/2020 and admitted to the facility on [DATE]. Record reviewed R9s census list documents R9 was discharged from the facility on 11/23/2022 and readmitted to the facility on [DATE]. On 12/18/2025 at 11:33AM, V7 stated a PASRR was not completed after R9 was re-admitted into the facility. V7 stated he missed the opportunity to send a referral to the appropriate state authority when R9 had a new evident psych diagnosis. 2 - R12 is a [AGE] year-old male, admission record documents initial admission date 12/01/2023, admission date 6/12/2025 with diagnosis of, not limited to Post Traumatic Stress Disorder onset date 1/3/2024, anxiety disorder onset date 12/1/2023, unspecified psychosis not due to a substance or known physiological condition onset date 1/3/2024, major depressive disorder recurrent mild onset date 1/3/2024, bipolar disorder current episode mixed unspecified onset date 8/1/2024. R12's order summary documents Cymbalta Capsule Delayed Release Particles 60mg (Duloxetine HCl) give 1 capsule by mouth two times a day for depression, order date 10/21/2025. Diazepam oral tablet 5 mg (Diazepam) give 1 tablet by mouth at bedtime for anxiety, order date 6/12/2025. Olanzapine oral tablet 5 mg (Olanzapine) give 1 tablet by mouth at bedtime for psychosis, order date 7/10/2025. Seroquel Oral Tablet 25 mg (Quetiapine Fumarate) give 1 tablet by mouth at bedtime for psychosis, order date 7/10/2025. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review of R12's Review of Notice of PASRR (Pre-admission Screening and Resident Review) Level I screen Outcome, Notice Date: August 25, 2023 indicated R12's PASRR Level I Determination: Refer for Level II Onsite. R12's Review of Notice of PASRR Level II screen Outcome, Notice Date: August 28, 2023 indicated R12s PASRR Determination: Level II-Excluded from PASRR- No Diagnosis- No LOC. R12's PASRR Outcome Explanation documents, you don't' require further Level II screening unless you experience a significant change in status that suggest you have a serious mental illness, intellectual disability (ID), or developmental disability. In that case, the nursing facility must submit an updated Level I screening form to Maximus. On 12/18/2025 at 11:34AM V7 (Social Service Coordinator) stated that was the only PASRR (Pre-admission Screening and Resident Review) they had for R12, notice date 8/28/2023 and they did not make a referral to the state designated authority after diagnosis of Post Traumatic Stress Disorder, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder recurrent mild, bipolar disorder current episode mixed unspecified were identified. V7 stated he should have made the referral but missed it. On 12/18/2026 at 11:34 AM, V7 and V8 (Social Service Director) stated they receive the PASARR from the hospital when a resident is newly admitted to the facility. V7 and V8 stated a psychiatric nurse practitioner comes to the facility on Thursdays to assess residents and that is how V7 and V8 identify residents with new evident or possible MD (Mental Disorders), ID (Intellectual Disabilities), or related condition after admission. V7 and V8 stated the social service department is responsible for making referrals to the appropriate state-designated authority when a resident is identified as having an evident or possible Mental Disorder (MD), Intellectual Disability (ID), or related condition. 3 - R133 is a 79 -year-old female admitted in the facility on 12/8/2017. R133 has diagnoses of, but no limited to vascular dementia, COPD, major depressive disorder, bipolar, insomnia, hypothyroidism, anxiety, unspecified psychosis, hypertension, emphysema, sarcopenia. On 12/17/2025 at 11:27 AM, a record review for R133 showed that a PASRR (Preadmission Screening and Resident Review) Level I pre-screening was completed on 12/7/2017. The screening indicated that, based on all available information and data, there was a reasonable basis to suspect the presence of a developmental disability (DD) or mental illness (MI). The review also revealed that R133 was later identified with new diagnoses. Bipolar disorder was added on 7/12/2018, and Unspecified psychosis was added on 5/8/2024. R133's current physician's order list indicated that R133 is on the following medications: Ativan Tablet, Buspirone HCl Oral Tablet and Duloxetine HCl Capsule. On 12/17/2025 at 2:10 PM, V7 was interviewed regarding the facility's process for screening residents. V7 stated that the interdisciplinary team discusses any new diagnoses during the daily morning meeting. V7 further explained that once a new diagnosis for mental illness is identified, a PASRR II is required to be rerun, and the Social Services Department is responsible for completing this process. When asked whether R133 had a PASRR Level II screening completed, V7 stated, we do not have one. On 12/18/2025 at 11:41 AM, V8 confirmed that R133's PASRR Level I initial screen dated 12/7/2017 was marked Yes, indicating a reasonable basis to suspect the presence of a developmental disability (DD) or mental illness (MI). When V8 was asked whether R133 had a PASRR Level II screening (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed, V8 stated that if V7 indicated there was none, then no PASRR Level II screening existed. On 12/18 /2025 V2 (Director of Nursing) presented the facility's policy on admission criteria dated 11/18/2021 with the latest review date of 4/12/2025 states in the procedure: 9. All new admissions and readmissions are screened for mental disorders MD), intellectual disabilities (ID) or related disorder (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual may meet the criteria for a MD, ID or RD. b. If the level I screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. c. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a new Pre-admission Screening and Resident Review (PASRR) Level I and Level II screenings for 1 (R31) of 3 residents reviewed for PASRR screening in the sample of 31. R31 is a [AGE] year-old-male, admission record documents initial admission date 9/5/2025, with diagnosis of, not limited to anxiety disorder onset date 5/4/2020, bipolar disorder 1/27/2020, major depressive disorder recurrent moderate onset date 3/7/2018, unspecified psychosis not due to a substance or known physiological condition onset date 8/18/2013, unspecified dementia onset date 10/15/2010.On 12/18/2025 at 10:18AM, V7 (Social Service Coordinator) and V8 (Social Service Director) stated there was no Pre-admission Screening and Resident Review (PASARR) completed for R31 prior to admission. Review of Notice of PASRR Pre-admission Screening and Resident Review) Level I screen Outcome, Notice Date: December 17, 2025PASRR Level I Determination: No Level II Required- No SMI/ID/RCOn 12/18/2025 at 11:34AM, V7 confirmed the PASRR was not completed prior to admission.On 12/18/2026 at 11:34 AM, V7 and V8 stated they received the PASARR from the hospital when a resident is newly admitted to the facility. V7 and V8 stated a psychiatric nurse practitioner comes to the facility on Thursdays to assess residents and that is how V7 and V8 identify residents with new evident or possible MD (Mental Disorder), ID (Intellectual Disabilities), or related condition after admission. V7 and V8 stated the social service department is responsible for making referrals to the appropriate state-designated authority when a resident is identified as having an evident or possible Mental Disorder (MD), Intellectual Disability (ID), or related condition. V2 (Director of Nursing) presented Policy titled: admission Criteria, dated: 4/12/2025 reads: Policy: admission Criteria, reviewed on 4/12/2025 documents procedure:9. All new admissions and readmission are screened for mental disorder (MD)intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD.

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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 - 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 ensure common areas are free of accident hazards for one of three residents (R42) reviewed for accidents in a sample of 31. Findings include:On 12/16/2025 at 10:02AM during unit rounds, R42 was lying on bed with discoloration on left eyebrow area. R42 stated that R42 fell on [DATE] in the lounge area within the unit. R42 got up on his wheelchair, went with surveyor to the lounge area and showed the surveyor how he fell. R42 stated that R42 stood up from wheelchair to transfer to the regular chair by holding on the table in the middle of the room but the table was wobbly so R42 fell on his left side. R42 touched the table and the table was wobbling. R42 stated that the table was wobblier when R42 fell. On 12/16/2025 at 10:52AM during observation with V12 (Registered Nurse), V12 touched the table in the lounge area and was wobbling. On 12/16/2025 at 10:52AM during interview with V12, V12 stated that the wobbling table is not safe for anyone who would want to sit by it. On 12/18/2025 at 12:55PM, V12 stated that she did not check the table at the time R42 fell. V12 stated that she just visually checked the surroundings. V12 stated that she received a call from R42's wife asking if there was any broken furniture where R42 fell but she did not visually see any, so she said no. On 12/18/2025 at 1:00PM during interview with V18 (Housekeeping), V18 stated that whenever she cleans the table in the lounge area, the table in the middle of the room was wobbling, and she has informed maintenance about it. On 12/18/2025 at 1:10PM during interview with V19 (Maintenance Director), V19 stated that he was not aware that the table in the lounge area was wobbling until the morning of 12/16/2025. Review of R42's facility incident report dated 12/14/2025 indicated the following:Incident Description: R42 was observed on the floor sitting, trying to get into a chair in the lounge.Predisposing Environmental Factors: None of the Above is checked and Furniture is not checked. Review of R42's Order Summary Report dated 12/18/2025 indicated admission date of 12/06/2025, and diagnoses of not limited to unspecified fall, other abnormalities of gait and mobility, acquired absence of left leg below knee, acquired absence of right leg below knee, and abnormal posture. Review of facility's policy entitled Fall Prevention and Management last revised on 03/31/2025 indicated the following:Policy Statement: The facility is committed its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained.Procedures:3. Procedure for Post-Fall Managementd. Environmental/physical assessment to identify any environmental/physical risk factors.