STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare at Stearns	3900 Stearns Avenue Granite City, IL 62040

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review the facility failed to maintain a comfortable and good repair environment for 1 of 3 (R3) residents reviewed for bed mobility in a sample of 59.Findings include:1. On 6/22/2026 at 2:19 pm observed R3's mattress sunken in the middle. Observed a hole in the mattress. Observed V6, Licensed Practical Nurse, and V22, Certified Nurse Assistant, transfer R2 into bed.On 6/23/2026 at 3:40 PM V18, R3's family, stated that R3 has a hole in her mattress and she has notified the facility repeatedly. V18 stated that this is ridiculous. V18 would not live like that. When the mattress is worn or has a hole you replace it. On 6/29/2026 at 9:35 AM a mattress observed sunken in the middle with a hole in mattress.On 6/29/2026 at V16, Certified Nurse Assistant, stated that she doesn't usually work the hall. V16 verified that R3's mattress was sunken in the middle with a hole in the mattress. V16 stated that she is not sure how long the hole has been there. V16 stated that laying the sunken mattress and the hole would be uncomfortable.The facility's Resident Rights policy, dated 6/1/2025, documents that Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems, and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. It also documents that Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. The facility will not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility practices designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion.

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 0677 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to ensure dependent residents received assistance with nail care and shaving for 1 of 3 (R3) residents reviewed activities of daily living in a sample of 59. This failure resulted in R3 being embarrassed about her appearance. A reasonable person, who was not a dirty person, would likely feel embarrassed about their appearance when their nails are dirty and has long facial hair.Findings include:On 6/22/2026 at 1:50 PM R3 observed sitting in wheelchair with head down. R3 had long facial hair and dirty nails. On 6/23/2026 at 9:00 AM R3 observed sitting in chair with long facial hair to chin. R3's nails were long and dirty.On 6/23/2026 at 10:09 AM R3 sitting in room facing window. Long facial hair remains to chin.On 6/23/2026 at 3:04 PM V58, R3's family, stated that R3 was not a dirty person. V58 stated that R3 did not have facial hair, and her nails were never dirty. V58 stated that R3 would be embarrassed if she saw herself.On 6/30/2026 at 10:30 AM V2, Director of Nursing, stated that she was aware of R3's facial hair and dirty nails. V2 stated that R3 is particular with who does the care. V2 stated that she is working with the family to get it done. The facility's Activities of Daily Living (AOL), Supporting policy, dated 7/15/2025, documents that Policy StatementResidents will be provided with care, treatment and services as appropriate to maintain or improve their abilityto carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation: 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) does not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with a. hygiene (bathing, dressing, grooming, and oral care); b. mobility (transfer and ambulation, including walking); 4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, observation, and record review, the facility failed to Implement fall interventions to reduce falls for 2 of 5 residents (R3, R7) reviewed for resident safety in the sample of 59. The findings include:1. R7's admission Record, dated 6/25/26, documents R7 was admitted to the facility on [DATE] with diagnosis of Dementia, Alzheimer's Disease, Generalized anxiety disorder, Bipolar disorder, Major depressive disorder, Seizures, Metabolic encephalopathy, Type 2 Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), Hypertension (HTN) Asthma, Osteoarthritis, and Obesity. R7's Care Plan, dated 5/28/26, documents R7 is at risk for falls and has experienced falls related Poor Balance, Unsteady gait and failure to use her assistive device. Interventions: 1/5/26: Encourage resident to propel in wheelchair (w/c) independently. If resident requests assistance, encourage use of bilateral foot rests during staff assisted propulsion in wheelchair. 10-15-25: Staff to assist resident with repositioning in wheelchair when resident is not sat back into the chair as resident tolerates. 10/23/25: Medication and lab review- resident to be on enhanced monitoring when noted to have an infection. 11-8-25: Staff to offer resident a snack in the night if noted awake and encouraged resident to utilize call light and ask for assistance with getting something to eat. 11/20/25: Ensure call light and personal items are within easy reach to reduce unsafe reaching or leaning. 5/6/26: (non-slip pad) to wheelchair. 6-8-25: The bed was adjusted so wheels not touching the floor. Staff to ensure that the bed is in this position as much as possible and only to have wheels down when moving the bed. 6/12/26: Staff to assist resident with diversional activities of choice between mealtimes. 8/23/25: Staff to assist resident to preferred destination as she tolerates when resident does not get what she wants and appears to be upset about the situation. resident is independent with transfers. Toileting schedule: Offer to assist resident to the bathroom Q3H (every 3 hours) at night between 8p-7a. Toileting schedule: Staff to offer to assist resident to restroom Q4H (every 4 hours) as tolerated 6a-8p daily. R7's MDS, dated [DATE], documents R7 has a moderate cognitive impairment and is dependent on staff for most ADLs and for sit-to-stand transfers. Facility's Fall Log for the past six months documents R7 had falls on 1/5/26, 5/6/26, and 6/12/26. On 6/23/26 at 10:27 AM, R7 seen asleep in her wheelchair with no foot rests on the chair. On 6/24/26 at 2:20 PM, R7 stated she has had a few falls. R7 stated she has fallen out of her bed when trying to get into her wheelchair, and she has fallen out of her wheelchair. Unable to see if there is a non-slip pad in her wheelchair at this time. On 6/25/26 at 8:10 AM, R7 was assisted by staff to stand up. R7's wheelchair has a cushion on the seat with no (non-slip pad) seen on top of the cushion or under it. R7's Nursing Note, dated 1/5/26 at 2:26 PM, documents Resident was refusing to let CNA (Certified Nursing Assistant) push her to her room to change her soiled clothes when she put her legs out while being pushed towards her room when she fell forward out of her chair landing face down causing a nosebleed with a small laceration across the top of her nose. Resident was still alert and oriented during body assessment, no other complaints of pain or injury to any other parts of her body. Nose (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immediately stopped bleeding once pressure was applied. Resident was given Tylenol and PRN (as needed) Xanax for pain. R7's Fall Investigation, dated 1/7/26, documents (R7) 64 y/o (year old) female, wheelchair bound, alert with confusion. Dx. (diagnosis) Alzheimer's disease, Bipolar disorder, COPD, Asthma, severe obesity, Type 2 DM, anxiety, mood disorders, developmental disorders, HTN, insomnia, osteoarthritis, vitamin deficiencies, depression, and anxiety. Monday 1/5/26 resident had a fall with slight pain and small cut to bridge of nose noted upon assessment, MD (medical doctor) notified, and PRN treatment initiated along with fall protocol. Resident c/o (complain of) increased pain to the area on 1/6/26 MD notified, and x-ray obtained. Results 1/7/26 revealed a fx. (fracture) MD updated. Please find this as the initial report with final to follow. Incident Summary: On the afternoon of Monday 1/5/26, while attempting to assist the resident (R7) to change her clothing after an incontinent episode staff was propelling the w/c (wheelchair) when the resident started having behaviors about not wanting to change and slammed her feet down onto the floor. The staff propelling the resident could not anticipate the abrupt stop at which time the resident went forward from the w/c landing in a prone position on the floor. Staff immediately initiated the fall protocol, and this DON (Director of Nursing) was notified. This DON assessed the resident at which time a small laceration was noted to the bridge of the resident's nose, some bleeding was present easily stopped without concern. The resident was offered treatment further and refused stating she was fine and going to bingo. The facility house NP (Nurse Practitioner) present was notified. The resident has no RP (representative person) but was aware herself of the fall and her decisions to forgo an x-ray post fall. Neuro checks were initiated as tolerated, fall f/u (follow-up) in place, staff provided Tylenol PRN for discomfort reported and resident proceeded to participate in the scheduled activity. The resident reported increased pain and was noted with increased swelling to the facial area on 1/6/26 during fall follow up assessments. No neurological changes identified and therefore an in-house x-ray was initiated when provider was updated on progression of edema and pain. The resident remained on fall f/u and assessments while awaiting completion of mobile radiology. PRN Tylenol and ice offered as needed with no major COCs (changes of condition) noted. This AM 1/7/26 the facility was informed via fax of a positive nasal bone fracture. The MD has been updated, resident care plan reviewed and revised. Based on all evidence and information available the resident behavior leading to the fall from w/c was the root cause of this fall with fracture. Staff education and care plan updates completed as resident to be encouraged to self-propel and when requests for assistance are made or assistance is needed foot pedals to be provided on w/c to ensure safety during assisted propulsion in w/c. The resident will continue to be monitored in house r/t (related to) the nasal bone fracture with no acute concerns noted at this time. Please find this as the initial reporting as well as the final investigation findings for this fall with fracture. Several in-service sheets with documented staff signatures were included in this investigation. R7's Fall Investigation, dated 5/6/26, documents Resident was sitting on the floor between the two beds with w/c behind her. Resident has a small, raised area to right forehead. Resident stated that she slid out of her w/c and she hit her head, but she doesn't know what she hit it on. 5/6/26-IDT (interdisciplinary team) met to discuss resident and (non-slip pad) added to w/c. 5/8/26: No post fall negative outcomes noted. Care plan interventions remain in place and resident is tolerating well. No concerns noted at this time. Refusal of VS (vital signs) continues to encourage resident to allow full assessments. 5/9/26: Fall f/u completed. No late injuries or concerns noted at this time. Fall interventions in place and resident tolerating well. No concerns at this time. R7's Nurse Note, dated 5/6/26 at 7:25 AM, documents VS 36.3, 90, 22, 137/67. I was called to this resident room by the CNA, and I found resident sitting on the floor between the 2 beds with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair behind her, the lighting is good, the bathroom floor was wet from resident attempting to get on toilet and wet the floor. There is no change in medications and no change in medication. Resident does AROM (active range of motion) at command without difficulty. The resident also has an abrasion to right forehead. Call placed to Dr. (doctor) and orders received to monitor resident; the MD was informed that resident does take Aspirin 81 MG (milligrams) 1 tablet every day. M.D. stated she will be ok. R7's Fall Investigation, dated 6/12/26, documents Heard resident yelling out upon entering room resident was noted on floor laying on her right side. Resident states she was trying to get in her w/c from her bed and missed the chair and fell down. 6/12/26: IDT completed review of the incident with care plan implemented per orders. Care plan reviewed. Staff to assist resident to participate in diversional activity of choice between meals. Resident and MD in agreement with plan of care. On 6/29/26 at 9:05 AM, V49, LPN, stated Any resident on fall precaution may have a sign posted on their wall, they are discussed in report, they will have fall precaution equipment in their room, and we can always review the resident's care plan. On 6/29/26 at 9:10 AM, V50, CNA, stated If a resident is on fall precautions, I makes sure the bed is low, I review the fall interventions in the care plan, and sometimes we will talk about that resident in report. On 6/29/26 at 9:17 AM, V51, CNA, stated For residents who are on fall precautions, I look at the resident's Kardex or care plan, sometimes the report sheet, and/or the report sheet to find out what interventions that resident has. On 6/30/26 at 9:30 AM, V2, DON, stated I would expect all staff to follow all fall interventions put in place to help keep the resident safe. The facility's Fall Evaluation and Prevention Policy, dated 6/1/25, documents in part To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. 2. R3's Care Plan, dated 6/16/2026, documents that I am at increased risk for skin issues r/t (related to) dx (diagnosis) dementia, incontinence of bowel and bladder. I am at increased risk for bruising r/t use of anticoagulant/ASA (aspirin). I have active skin tears to my BUE (bilateral upper extremities) with treatments in place. 6/5/26 (R3) is at risk for falls and has a history of actual falls r/t Confusion, Gait/balance problems, Psychoactive drug use, Unaware of safety needs, impulsivity and wandering. 2/4/2026 IDT MEETING: DYCEM WILL PLACE IN RESIDENT'S WHEELCHAIR UNDER CUSHION. 6-25-25-Anti thrust cushion to wheelchair to assist resident to define the edge of the wheelchair seat when scooting in wheelchair seat. This is an enabler for positioning not a restraint and resident is able to transfer in and out of the w/c if she chooses to do so. 6/16/2026 (R3) at risk for skin impairment r/t fragile skin, poor skin integrity. 5/27/26 Left hand 5/31/26 Right leg 6/16/26 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resolved 6/5/26 left breast 06/15/26 resolved 6/9/26 Right arm. 4/23/26-discuss moving from high stimulated area to less stimulated area to decrease physical contact with objects 4/24/26-daughter and resident agreed to move from memory unit high stimulated area to North Hall less stimulated area to decrease physical contact with objects when self-wheeling. Assist with repositioning. Identify potential causative factors and eliminate/resolve when possible. R3's Self Inflicted Injury Report, dated 4/13/2026, documents that R3 was wheeling herself in the dining area when she got a skin tear on top of her right hand from her wheelchair. Resident alert to person only and unable to give description of event. The wheelchair was observed and replaced. R3's Physical Contact with Object Report, dated 4/23/2026, documents called to resident room. Upon entering noted to have a skin tear to left outer arm. Above the elbow. Area cleansed, and dressing applied. Skin slight area of blood noted to shirt that just had been removed. Shirt very tight sleeved. Resident alert to person only and unable to give description of event. 4/24/26 resident and daughter agreed to move from memory unit high stimulated area to North Hall less stimulated area to decrease physical contact with objects when self-wheeling. R3's Injury Report, dated 5/31/2026, documents resident obtained skin tear to right shin during transfer, lower extremity hit on areas of wheelchair leading to tear. R3's Injury Report, dated 6/5/2026, documents Resident noted to have bruising during care, reported to nurse. DON and staffing director performed assessment. Bruising noted to left side of upper chest between arm, skin tear to left forearm noted. Upon review occurred during 2 person transfer with gait belt, resident dropped her weight during the transfer causing the belt to shift and cause bruising and skin tear. On 6/22/2026 at 1:45 PM R3 sitting in wheelchair. Foot pedals in place. No foot buddy in place. R3 moving feet on pedals, under pedals bumping legs with movement. Short sleeve shirt and no Geri sleeves in place. V11, Licensed Practical Nurse (LPN) and V18, LPN, applied R3's sling to the full body lift. V6, CNA, entered room and V11 and V18 exited. With R3 attached to the sling V6 then leaves the room. R3 noted to be rocking back and forth hitting forehead on mechanical lift. V6, and V22, CNA, assisted R3 into the bed. No dycem in wheelchair. On 6/23/2026 at 9:00 AM observed R3 sitting in wheelchair foot pedals in place with R3's legs behind. R3 moving legs freely behind pedals and bumping pedals. On 6/29/2026 at 9:36 AM observed R3 propel self in hallway bumping into arm rail. No foot pedals, pillows or foot buddy in place. On 6/22/2026 at 1:50 PM V6 stated that R3 has thin skin. V6 stated that R3 is to wear long sleeves to prevent skin tears. V6 stated that R3 does not have sleeves but should. V6 stated that R3 rolls her chair around and bumps into stuff causing skin tears. V6 stated that the foot pedals on the wheelchair have foot pedals that are in place but R3 bumps into them. V6 stated that this can cause a bruise or skin tear. V6 stated that R3 had a large bruise to her chest. R3 stated that she reported it to the nurse. V6 stated that she does not know how it got there. On 6/23/2026 at approximately 1:00 PM V18, LPN, stated that V6 reported to V18 that R3 had a bruise. V18 stated that she is not sure how the bruise was obtained. V18 stated that R3 has thin skin and bumps into things in her path. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/29/2026 at 10:30 AM V52, Physician, stated that any resident that has tears in the skin would experience pain from the injury. V52 stated that the facility should be pro active and not reactive. On 6/30/2026 at 10:30 AM V2, Director of Nursing, stated that with every incident they put interventions in place. V2 stated that R3 has had multiple skin tears, and the facility has tried multiple interventions after injury occurred. V2 stated that R3 is to have a foot buddy in place to wheelchair. V2 stated that R3 obtained 2 new skins from transfers on 6/23 and a bruise to leg from bumping padding on wheelchair. V2 stated that R3 picks at skins and does not like tight things on skin. V2 stated that Geri sleeves were applied and R3 attempted to remove them. V2 stated that she would expect the interventions to be in place. V2 stated that when R3 is in the hall and moving towards items she would expect the staff to redirect R3 away from objects. When asked about investigations related to bruises and skin tear. V2 stated that she did not provide the complete investigation and would provide. When asked about R3's falls V2 stated that she was aware of R3's falls in the past and would provide investigations. As of 1:00 PM on 6/30/2026 V2 had not provided fall investigations or complete investigations for skin tears and falls. The facility's Fall Evaluation and Prevention Policy, review date of 6/1/25, documents that Purpose: To ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review, the facility failed to provide complete incontinent care for 4 out of 5 residents (R8, R3, R19, R36); reviewed for incontinent care in a sample of 59.Findings include: 1.R8's Facesheet with a print date of 6/25/26 documented she was admitted on [DATE] with diagnosis of, in part, chronic obstructive respiratory disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and major depressive disorder. R8's Minimum Data Set (MDS) dated [DATE] documented R8 was cognitively intact, has upper extremity impairment on one side, lower extremity impairment on both sides, is dependent on staff for toileting hygiene, and always incontinent of urinary and bowel. R8's Care Plan dated 5/21/25 documented she has bowel incontinence with interventions of, in part, for staff to provide pericare after each incontinent episode. On 6/24/26 at 9:46 AM, V42 (licensed practical nurse/LPN) and V14 (certified nursing assistant/CNA) came to assist R8 with getting ready for therapy. V15 stated R8 had a bowel movement and will need to be cleaned up. V15 wiped R8's front vaginal region but did not wipe in between her thighs, then turned her on her left side and wiped her right buttock and anal region off. 2. R19's Care Plan, dated 4/22/26, documents that the resident has bladder incontinence. It also documents Clean peri-area with each incontinence episode. R19's [NAME] Data Set (MDS), documents that R19 is severely cognitively impaired, frequently incontinent of bowel and bladder and requires Substantial/maximal assistance with toileting. On 6/22/2026 at 8:41 AM R19 observed sitting on toilet with urine soiled incontinent brief. V23, Licensed Practical Nurse, assisted R19 with toileting. V23 removed urine soiled incontinent brief. V23 then assisted R19 into standing position and R19 had a bowel movement. V23 then cleansed R19's anal area and buttocks. V23 then applied a clean incontinent brief and pulled up R19's pants. V23 did not cleanse or rinse R19's groin, outer labia or inner labia, upper thighs or buttocks. V23 did not separate R19's labia and wipe each side separately. 3. R3's Care Plan, dated 5/21/25, documents that the resident has bladder incontinence. It also documents clean peri-area with each incontinence episode. R3's MDS, dated [DATE], documents that R3 is severely cognitively impaired, always incontinent of urine and bowel and dependent on staff for toileting. On 6/22/2026 at 1:50 PM observed R3 sitting in the doorway of room with pants visibly soiled. V6, Certified Nurse Assistant (CNA), performed incontinent care. R3 was incontinent of urine. V6 and V22, CNA, assisted R3 into bed using a full body mechanical lift. V6 then applied gloves, pulled tabs back and rolled the incontinent brief down in between R3's leg. Using a wet wipe V6 then wiped each side of R3's groin and inner labia. V6 then turned R3 onto her left side and cleansed R3's right buttock and partial left buttock. V6 then rolled R3 onto her right side, placed R3 on her back, pulled clean brief (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between R3's legs and fastened it. V6 did not cleanse R3's outer labia, upper thighs and entire left buttock. V6 did not separate R3's labia and wipe each side separately. V6 washed R3's groin before labia. 4. R36's Care Plan, dated 5/14/2025, documents that the resident has bladder incontinence. It also documents clean peri-area with each incontinence episode. R36's MDS, dated [DATE], documents that R36 is severely cognitively impaired, always incontinent of urine and bowel and dependent on staff for toileting. On 6/23/2026 at 10:09 AM V31, CNA, and V12, LPN, assisted R36 with incontinent care. V31 and V12 assisted R36 onto her right side revealing the incontinent brief had a green stripe and foul urine odor. V31 then rolled R36's soiled incontinent brief and lift pad beneath R36. V31 and V12 then rolled R36 onto R36's back. V31 then using a wet wipe cleansed R36's groin and inner labia. V31 then rolled R36 onto R36's left side and pulled clean brief under R36. V31 and V32 assisted R36 onto her back and pulled brief up and applied. V31 did not cleanse or rinse R2's outer labia, upper thighs or buttocks. V31 did not separate R36's labia and wipe each side separately. V31 wash R36's groin before labia. On 6/25/26 at 11:26 AM, V28 Licensed Practical Nurse (LPN) stated incontinent care on a female with a bowel movement would involve fully wiping from front to back, on both buttocks, in between thighs and then after cleaned to apply a new brief. On 6/25/26 at 11:54 AM, V41 (CNA) stated incontinent care on a female resident involves fully wiping in between the thighs and both buttocks. The facility's Incontinent Care policy, dated 12/28/25, documents Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. Procedure: 3. Assist the resident to lie on back and expose the perineal area. 4. Soap one cloth at a time to wash genitalia using clean part of the cloth for each swipe. In the female, separate labia was with strokes from top downward (with gloved hand), each side separately with a clean cloth or clean area of the cloth. Keep labia separated with one hand. A. Wash the labia first then groin area. C. Clean/rinse inner/upper thigh areas to remove urine moisture.