STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview, and record review, the facility failed to ensure a resident (R4) was free from physical abuse and verbal abuse. These failures caused R4 to suffer humiliation and emotional distress due to derogatory language used by staff, and staff forcefully pulling multiple braided strands of hair from R4's scalp, resulting in removal of approximately six braids from the crown of R4's head causing pain and injury.R4 has a diagnosis which include but are not limited to: chronic obstructive pulmonary disease, bipolar disorder, suicidal ideations, hypertensive heart disease without heart failure, viral hepatitis c, schizoaffective disorder, alcohol abuse.R4's Brief Interview for Mental Status (BIMS) dated 2/3/26 shows a score of 15 which indicated that R4 is cognitively intact. The facility's initial reportable incident dated 2/13/26 documents in part: R4 reported to the charge nurse that a staff member was inappropriate towards her. Charge nurse asked R4 which staff member? R4 stated she does not know her name, but she is in the nursing department. Charge nurse asked R4 to describe the staff member. R4 describes the staff member in stated it happened over 2 weeks ago when she was going to the hospital. Charge nurse asked R4 to explain what happens. R4 stated that staff members used foul language. Charged nurse informed the medical doctor (MD) and psychiatrist and abuse officer of alleged incident. R4 will be wellness and behavior monitoring. S1 (who is now referred to as V6 (LPN for this investigation) is suspended pending investigation. The facility final reportable incident documents in part: R4 was discharged on 2/3/26 for aggressive behavior. Police officers were on site to escort her on the ambulance stretcher for her aggressive behavior with staff. Local hospital emergency room (ER) nurse called the facility for a report and stated that resident remains aggressive. A witness stated R4 was physically aggressive with V6 in front of police officers. Another witness stated that the police officers had to pull R4 off V6. Another witness stated they heard R4 and V6 arguing and using foul language. Witness states during the verbal confrontation R4 hit the nurse. Another witness stated that R4 was out of control, and the nurse was doing her job. R4 admitted that the nurse was trying to give her an intramuscular (IM) injection, and she resisted, and she hit the nurse and knocked her wig off her head. R4 states during the altercation the nurse grabbed her hair. V6 was interviewed and denied using foul language. V6 states R4 was very violent towards her and staff. Stated the police were called to the facility for assistance. V6 stated the police came and they were escorted to R4's room. V6 states R4 was very aggressive, and she does not remember R4 hit her. V6 denies grabbing R4 hair. V6 stated her and police officers had a hard time to get R4 back to baseline. V6 stated R4 was escorted by police officers on the stretcher to be discharged to the hospital. A police report was made out for this event. R4 will be on wellness and behavior monitoring. R4 care plan will be updated. R4 will receive a behavior event. V6 use of foul language was substantiated. V6 was terminated.On 3/5/26 at 9:33 a.m., V2 (Director of Nursing, DON) stated that V6 (Licensed Practical Nurse, LPN) was not R4's nurse on the 2/3/26 11:00 p.m. - 7:00 a.m. shift going into 2/4/26. V2 explained that on 2/3/26 at 5:03 a.m., V10 (LPN) informed her that R4 was acting physically and verbally aggressive and was attempting to elope several times and that V10 then had to call 911 to assist because staff could not get R4 to take a PRN (as needed) medication. V2 further explained that V10 stated that 911 came and transported R4 to the local (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	hospital emergency room. V2 then stated that upon R4's return to the facility on 2/13/26, V5 (Licensed Practical Nurse) reported to V1 (Administrator) that R4 reported to V5 (LPN) that V6 (LPN) was aggressive the morning of 2/4/26 prior to R4 being transported to the local hospital. V2 stated she was not given details of the abuse report and that the abuse was reported to V1 who conducted the investigation. V2 then explained that she was instructed by V1 (Administrator) to suspend V6 (LPN) during V1's investigation and then a few days after V2 suspended V6, V1 instructed V2 to terminate V6 (LPN) due to being verbally aggressive with R4 on the 2/3/26 11:00 p.m. - 7:00 a.m. shift prior to R4 being transported to the local hospital. V2 explained that she was informed that two residents witnessed the inappropriate language but denied any knowledge of reports of V6 pulling R4's hair. On 3/5/26 at 11:10 a.m., R5 stated that he recalls the incident with R4 a few weeks ago. R5 explained that it was around 4:00 a.m. when he heard R4 asking the nurse for her medication and started running up and down the hallway. R5 then stated that he saw the nursing staff grab R4 and administer R4 an injection. R5 stated that he then saw the police enter the facility after R4 set the back door alarm off. R5 then explained he heard R4 call one of the nurses a B* and the nurse (who was identified as V6 (LPN) responded back to R4 and stated, Calm your a** down. Your momma's a B*. R5 denied witnessing R4's hair being pulled by V6 or any other staff member. On 3/5/26 at 11:16 a.m., R6 stated he recalls the incident on the 11:00 p.m. - 7:00 a.m. shift with R4 and stated that R4 was walking around talking to herself saying she needed her medication and trying to leave out the A-wing door. R6 stated that a nurse and R4 began tussling, R4 knocked the nurse who was tussling with R4's wig off, and then staff instructed R6 to go into his room. R6 stated he could still hear the commotion with the nurse and R4 as well as hear R4 state, Let my hair go, B*, to the nurse V6. R6 further explained he heard V6 reply and state, Your momma B* back to R4. R6 then stated that he did not witness R4's hair being pulled and that he just heard R4 telling the nurse to let go of her hair. On 3/5/26 at 11:28 a.m., R4 stated that the day R4 was sent to the local hospital, it was around 2:00 a.m. and she was playing music in her room when staff asked her to turn her music down. R4 stated that she told the staff that her music was not loud. She explained the staff called the police and when the police arrived R4 and V6 (LPN) began tussling. R4 further explained during the tussle she knocked V6's wig off her hair and V6 then began pulling R4's hair (which was braided) until R4's braided hair detached from the center of her scalp. During the interview, R4 showed the surveyor a bald area at the crown of her head and stated that the hair had been pulled out by V6 during the incident. R4 also showed the surveyor a plastic bag with six individual braided strands of hair with hair attached to the ends and stated that the braids had been pulled from her scalp by V6 during the incident. R4 also explained that there was an exchange of words from R4 and V6. R4 stated she called V6 a B* and V6 called R4 a B* back. R4 stated that she felt head pain, disrespected, humiliated, and embarrassed from the situation.On 3/5/26 at 11:50 a.m., V5 (Licensed Practical Nurse, LPN) stated that on 2/13/26 V5 informed V1 (Administrator) that R4 reported an allegation of abuse against V6 (LPN). V5 stated that when she was in R4's room R4 began to state that her head was hurting and she asked R4 how often she got headaches and R4 replied and stated, No I don't have a headache. My head hurts because I got into a fight with the nurse (whom she described to V5 as V6) before I went to the hospital. She pulled my hair out the top of my head, and my head is still sore. V5 then stated that R4 showed V5 a plastic bag with several strands of braids that R4 stated V6 pulled out of her head. V5 denied R4 informed her of any verbal abuse or derogatory exchange from V6. V5 stated that she immediately informed the abuse coordinator V1 of R4's allegation. On 3/9/26 at 12:00 p.m., V12 (R4's Physician) stated he is the medical director of the facility and recalls R4 having an unusual delusion with combativeness. V12 stated that staff informed him regarding the verbal and physical exchange between R4 and V6. V12 further stated that if derogatory language is used towards a resident it can result in the resident having emotional distress and humiliation. V12 also stated that he agreed 100% with V6's termination of employment when he was informed of R4's hair being pulled out. V12 also explained that he did not see R4's head and that if a resident has their hair pulled out it can cause (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	momentary pain and injury. On 3/9/26 at 1:11 p.m., V10 (Licensed Practical Nurse, LPN) stated that on 2/3/26 R4 was having behaviors and called the local police and stated that there were people on the roof with guns. V10 stated that police verified no one was on the roof and left the facility. V10 further explained that R4 remained agitated and V10 administered her a PRN injection to calm R4 down. V10 further explained that R4 did not calm down and came out of her room speaking very loudly and agitated. V10 then stated that after several attempts to call R4's physicians (psychiatric physician and primary physician) and not reaching them, V10 called the police back to request the police transfer R4 to the local hospital for an evaluation. V10 stated that the police arrived and informed V10 that he would have to call the fire department to transport R4 to the local hospital. V10 then explained that she called the fire department and the police stayed with R4. V10 then explained when the fire department arrived the police brought R4 to the front door in a wheelchair wrapped in a blanket and the fire department transported R4 to the local hospital. V10 denied ever witnessing R4 and V6 or any other staff member in a verbal or physical altercation. V10 stated she learned about the altercation with V6 and R4 when V1 (Administrator) questioned her regarding the incident. On 3/10/26 at 9:56 am, V6 (Licensed Practical Nurse, LPN) stated that she recalls the incident with R4 on 2/3/26. V6 explained that R4 was erratic, pushing all the alarm doors and the Certified Nursing Assistants (CNA'S) out the exit doors at the facility. V6 then explained that R4 was not V6 assigned resident on 2/3/26 at the time of the event. V6 further explained that she was trying to calm R4 down due to R4's behaviors which also included R4 picking up a bottle of pop and throwing the bottle of pop in attempts to hit V6 in the face. V6 then explained that she (V6) pushed the bottle out of R4's hands to prevent R4 from hitting V6 in the face. V6 stated that R4's nurse V10 (LPN) was afraid to come to where R4 was at the A- wing unit and therefore V10 remained down the hall out of view of V6 and R4. V6 further stated that she instructed a CNA to tell V10 (LPN) to call the police while V6 remained trying to prevent R4 from pushing the door. V6 then explained that she grabbed R4's arms in attempts to remove her (R4's) arms off the exit door and R4 then knocked V6's wig off of her (V6's) head. Next, V6 explained that the police arrived and R4 tried to calm down after V6 stated to R4 This was not necessary. V6 then explained that the police then called for ambulance to transport R4 to the local hospital because R4 was still having a psychotic breakdown. V6 further explained once the ambulance arrived V6 walked away from R4 to open the door for the ambulance paramedics. V6 then stated that she took the paramedics to R4's room and R4 then attempted to spit on the ambulance paramedics therefore the police covered R4's face with a sheet to prevent her from spitting. V6 explained that R4 was placed on a stretcher and transported to the local hospital. V6 then stated that after R4 left the facility she informed V10 (LPN) regarding everything that occurred with R4, informed V10 that she was not charting the event with R4 because she was not R4's nurse and instructed V10 (LPN) to chart the occurrence. V6 denied the use of and derogatory language from R4 or V6 during the event. Surveyor then asked V6 if R4 called V6 a B* and V6 stated, Yes. However, V6 denied stating any derogatory language back to R4. V6 also denied grabbing R4's hair and stated that she only picked her (V6's) wig off the floor and placed it back on her (V6) head. V6 stated If staff uses derogatory language to a resident, it is verbal abuse and if staff pulls a resident's hair that is physical abuse. V6 then stated, I don't remember grabbing her hair. Abuse is reported immediately to V1 (Administrator).On 3/10/26 at 1:19 pm, V1 (Administrator) stated she is the facility's abuse coordinator and that abuse is reported immediately to V1 investigate. V1 stated that V5 (Licensed Practical Nurse, LPN) informed V1 that R4 complained of having a headache and that she had a fight with a staff member. V1 then stated that she began investigating R4's allegations and interviewed R4. V1 explained that R4 initially stated that R4 and the nurse got into an altercation and R4 hit the nurse and the nurses wig fell off her head onto the floor. V1 further explained that R4 stated that the nurse was walking behind her like a gangster while the police was present and was laughing at R4. V1 also stated that R4 stated the incident happened about two weeks ago and then further explained that she recalled a few weeks ago when she (V1) was informed by the nurse V10 (LPN) that R4 called the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	police and stated there was active shorter on the roof of the facility. V1 further explained that V10 sent R4 to the local hospital for hallucinations and delusions due to R4's hallucination episode. V1 then stated that she asked R4 who the staff member was and R4 stated that she did not know and directed V1 to ask R6. V1 then stated that she asked R6 and R6 stated that staff member was V6 (LPN) and that he heard R4 call V6 a B* and V6 replied back to R4 stating, Your momma is a B*. V1 further explained that R4 stated her hair was pulled by V6. V1 denied any other residents stated or reported hearing or seeing verbal or physical abuse transpire with V6 and R4. V1 then stated that if a resident's hair is being pulled by staff that is considered physical abuse. V1 further explained that R4 showed V1 the top of her head and informed V1 that V6 pulled her hair out. V1 stated that R4 showed V1 one braid that was removed from R4's head. R4's progress note dated 2/13/26 at 4:14 pm, authored by V5 (LPN) documents, in part: Resident informed the writer that a staff member was inappropriate to her. Writer notified abuse officer MD (Medical Doctor) and the psychiatric doctor of the allegations. Writer received no new orders. Resident will be on wellness and behavior monitoring. V6's Employee Report dated 2/12/26 authored by V2 (Director of Nursing, DON) documents in part: Staff member failed to report incident involving resident to immediate supervisor. Staff member was verbally aggressive to resident displaying inappropriate verbal interaction with resident. Staff member discharged due to discourteous verbal aggression towards resident.The facility's policy dated 10/2022 and titled Abuse documents in part: The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive in residence secure environment. Purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents . Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment . Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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 - 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 interview and record review, the facility failed to ensure staff followed a resident's assessed transfer status, which required the use of a mechanical lift for transfers. This failure affected one out of three residents reviewed for falls and caused R3 to be sent to the local hospital due to R3 sustaining a fracture of the distal femoral shaft, which requires R3 to use a left leg brace.Findings include: R3's diagnosis include but are not limited to: fracture of unspecified part of neck of right femur subsequent encounter for closed fracture with routine healing.R3's Brief Interview for Mental Status (BIMS) dated 2/24/26 shows a score of 5 which indicated that R3 has moderate cognitive deficits. R3's Minimum Data Set (MDS) dated [DATE] and 2/10/26 documents, in part: R3 requires maximum to dependent assistance with ADLs (Activities of Daily Living), transfer and bed mobility. The facility initial reportable incident dated 2/11/26 documents in part: R1 was being transferred to her wheelchair from the shower chair by staff and lost her footing. R1 was lowered to the floor by staff. R1 was immediately assessed by nurse on duty. R1 complained of discomfort to right lower extremity. R1 MD (Medical Doctor) made aware with orders to transfer to local hospital for evaluation. R1 family made aware via telephone. Local hospital called hospital in stated R1 sustained a right femur fracture. The facility final reportable incident 2/11/26 documents in part: Spoke with R1's primary MD who stated that R1 will be placed in an immobilizer and will not have surgical intervention she will be referred to therapy and monitored for pain and abnormal occurrences. R1's Hospital Record dated 2/10/26 .documents, in part: [AGE] year-old female presents from the nursing home for evaluation of right knee pain after a witnessed fall in the shower. Paiten said she fell down onto her right side . Imaging: x-ray femur RT (right) 2V (two view). Impressions: angulated foreshortened fracture of the distal femoral shaft, distal to the right femoral hardware. On 3/5/26 at 11:51 a.m., R3 stated she does not recall the full details of the fall but remembers losing her balance and breaking her leg during the incident on 2/10/26. R3 stated, I lost my balance, and she (referring to the CNA) could not catch me.On 3/5/26 at 11:57 a.m., V15 (Certified Nursing Assistant, CNA) stated that she was R3's CNA. V15 stated that prior to R3's fall on 2/10/26, R3 required assistance from two staff with a gait belt for transfers, and upon R3's return from the local hospital, staff now use a mechanical lift to transfer R3. V15 explained that R3 previously was able to assist with transfers; however, staff have now been instructed to use a mechanical lift when transferring R3.On 3/5/26 at 1:32 p.m., V4 (Licensed Practical Nurse, LPN) stated that approximately 2-3 weeks ago she was sitting at the nursing station when V9 (CNA) notified her that she had to lower R3 to the floor while transferring R3 from the shower chair to the wheelchair after R3's shower. V4 stated that she went into the shower room and observed R3 wet, in a gown, lying on the shower floor. V4 explained that R3's right leg was contracted and appeared pulled back further than normal. V4 stated that R3 uses a wheelchair for ambulation and that she did not know R3's transfer status at that time. V4 stated that she instructed the CNAs to transfer R3 to the wheelchair using a mechanical lift. V4 stated that she asked R3 if she was in pain, and R3 responded, Yes, and verbalized pain in the right leg. V4 further stated that she called R3's physician, who gave orders to send R3 to the local hospital, and R3 was sent for further evaluation.On 3/5/26 at 2:15 p.m., V9 (Certified Nursing Assistant, CNA) stated that in February 2026 she was assigned as R3's CNA on the evening shift. V9 explained that it was R3's shower day, and she wheeled R3 into the shower room in the wheelchair with a gown on and transferred R3 to the shower chair without the use of a gait belt, assistive device, or staff assistance. V9 stated that she had previously showered R3 by herself and did not think to ask for help. V9 stated that after finishing the shower, she dressed R3 in a gown and asked R3 to stand and hold the rail so she could transfer her back to the wheelchair. V9 stated that she placed a towel on the floor of the shower stall for R3 to stand on due to a bandage on one of R3's feet, which she could not recall, to prevent it from getting (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

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 - Actual harm Residents Affected - Few	wet. V9 explained that when R3 stood up, her foot slipped, and she tripped on the footrest of the shower chair. V9 stated that she caught R3, and R3 began yelling, My leg, and V9 lowered R3 to the floor. V9 stated that during shift report, staff inform each other of the assistance each resident requires and how each resident transfers.On 3/9/26 at 11:45 a.m., V13 (R3's physician) stated that he recalls R3 at the facility. V13 explained that R3 suffered a right femur fracture after a recent fall in the shower room. V13 stated that when he received the call regarding the fall, the nurse reported that R3 was complaining of knee pain, and he directed the nurse to send R3 to the local emergency room to rule out fracture. V13 explained that staff should use a gait belt when transferring a resident for safety. V13 further explained that residents should be transferred according to their assessed ability documented in the medical record to prevent injury. V13 also stated that he initially thought R3 had a hip fracture and was glad R3 did not sustain a head injury.On 3/10/26 at 11:35 a.m., V2 (Director of Nursing, DON) stated that V4 called her on the evening of 2/10/26 and reported that R3 had a fall in the shower, then clarified that V9 (CNA) lowered R3 to the floor. V2 stated that V4 reported that R3 had no visible injuries and did not hit her head. V2 further stated that V4 called V13 (physician), who ordered that R3 be sent to the local hospital. V2 then stated that V4 had already called the ambulance and notified the family. V2 also stated that the following day she was informed that R3 sustained a fracture of the left femur related to the incident on 2/10/26. V2 explained that when she spoke with V9, V9 reported that she was transferring R3 from the shower chair to the wheelchair, both chairs were locked, and a bath blanket was placed on the floor to keep R3's dressings dry; however, she believed the blanket may have contributed to R3 sliding. V2 stated that when V9 noticed R3 sliding, she lowered her to the floor. V2 stated that R3's transfer status at the time required one-person assistance with pivot transfer. V2 explained that CNAs are instructed to review the resident care card to determine transfer status. V2 then stated that residents requiring one-person assistance should be transferred using a gait belt, and failure to use a gait belt can result in injury. V2 stated that residents requiring two-person assistance should also be transferred using a gait belt and mechanical lift. V2 also stated that on 2/19/26 she conducted an in-service with nursing staff regarding safe transfers, competency, return demonstration, and testing.R3's progress note dated 2/10/26 at 10:43 pm, authored by V4 (Licensed Practical Nurse, LPN) documents, in part: The writer made aware by CNA (Certified Nursing Assistant, CNA) that patient was lowered to the floor in shower room. CNA stated patient didn't hit her head. Writer assessed patient, patient c/o (complained of) pain to right knee/leg upon ROM (range of motion). Patient skin intact with no abnormalities noted. Writer administer pain medication as order pain 5/10. MD (Medical Doctor) notified gave orders to send resident to local hospital for post fall work up.R3's progress note dated 2/10/26 at 10:06 pm, authored by V4 (Licensed Practical Nurse, LPN) documents, in part: The writer made aware by CNA (Certified Nursing Assistant, CNA) that patient was lowered to the floor in shower room. CNA stated patient didn't hit her head. Writer assessed patient, patient c/o (complained of) pain to right knee/leg upon ROM (range of motion). Patient skin intact with no abnormalities noted. Writer administer pain medication as order pain 5/10. MD (Medical Doctor) notified gave orders to send resident to local hospital for post fall work up.R3's Care Plan documents in part that R3 has limited ability to transfer and requires mechanical lift and is dependent on staff assistance with transfers.R3's Minimum Data Set (MDS) dated [DATE] and 2/10/26 documents, in part: R3 requires maximum to dependent assistance with ADLs (Activities of Daily Living), transfer and bed mobility.The facility undated policy titled Safe Lifting and Movement of Residents documents, in part: Policy Statement: In order to protect the safety and wellbeing of staff and residents, and to promote quality care, this facility uses mechanical lifting devices for the lifting and movement of residents. Policy Interpretation and Implementation: 1. Mechanical lifting devices shall be used for any resident needing two-person assistance. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted.The facility's job description titled C.N.A. documents, in part: Duties/Responsibilities/Function: 10. Ensure that al transfers and lifts are performed with concern for safety of the resident according to the policies of the facility.