STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review facility failed to initially report a severe injury of unknown origin to the Illinois Department of Public Health (IDPH) no later than two hours after the incident for one resident (R2) of eight residents in the sample. This injury resulted in R2 being hospitalized for scalp laceration requiring sutures, and a subdural hemorrhage. Findings include: On 4/19/2026 at 5:00 AM V13 (Registered Nurse) documented in the risk management/incident report V13 (Nurse) was informed by Certified Nursing Assistant (CNA) R2 had blood on R2's bed. Upon assessment a small laceration was noted to the right top of R2's head. R2 was unable to recall what happened. Incident was unwitnessed. R2 was transferred to the hospital for head injury. On 4/19/2026 at 6:24 AM V13 (Nurse) documented in the electronic health record (EHR) V13 was informed by CNA that R2 was noted with dried blood on linens and floor near bed. Upon assessment, R2 was observed with a 1-inch laceration to right top of head. R2 complained of pain to right hip and sacral area. Physician notified with order to send R2 to the emergency room for evaluation. V2 (Director of Nursing) was made aware.On 4/19/2026 at 11:05 AM V13 (Nurse) documented in the EHR R2 is admitted to the hospital with a diagnosis of subdural hemorrhage and laceration to right top of head requiring five staples.On 4/20/2026 at 8:50 AM V2 (Director of Nursing) emailed the initial report of severe injury of unknown origin to Illinois Department of Public Health (IDPH). Incident category was severe injury of unknown origin. R2 was not interviewable.On 4/24/2026 at 12:35 PM V2 (Director of Nursing) emailed the final incident reporting for R2's injury of unknown origin on 4/19/2026.On 5/20/2026 at 11:25 AM V1 (Administrator) stated the initial report of a fall with severe injury needs to be submitted to IDPH within 24 hours.On 5/20/2026 at 11:40 AM V2 (DON) stated we have 24 hours to send the initial report of injury of unknown origin to the state.Fall Prevention, Post Fall and Communication Policy stated 1/21/2026 stated the purpose is to promote resident safety by identifying fall risk, implementing individualized fall prevention interventions, ensuring timely post-fall evaluation and reviewing outcomes to prevent recurrence.

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
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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 observation, interview, and record review, the facility failed to provide adequate supervision and safe transport technique and failed to implement care plan interventions to prevent an accident for a resident (R1). The facility failed to follow facility fall prevention policy, failed to develop and implement care plan interventions to prevent recurrent falls, and failed to complete post fall assessment for one of three residents (R2), reviewed for falls. These failures resulted in R1 falling and sustaining a closed head injury, abrasion of the forehead, avulsion of right elbow skin, and a closed nasal bone fracture, and R2 sustaining seven falls within sixteen days, hospitalization, scalp laceration requiring sutures, and a subdural hemorrhage. Findings include:R1 is an [AGE] year old resident with latest admission to the facility on 3/24/26. R1 has diagnoses which include but are not limited to Polyneuropathy and Generalized Anxiety disorder.R1's Records show the following:Fall Risk assessment dated [DATE] shows that R1 is at high risk for falls.Care Plan dated 3/24/26 states that R1 has mobility issues and uses a wheelchair, R1 requires total assistance with personal hygiene and ADL(Activities of Daily Living) care, and R1 requires safety checks at frequent intervals. Care plan dated 4/27/26 states Ensure the use of wheelchair leg rests when the resident is not propelling self. Additionally, a bag will be placed on the back of the wheelchair to store the leg rests when the resident is propelling self.MDS (minimum Data Set) section GG dated 2/26/26, under functional ability, states that R1 requires partial/moderate assistance for transport and requires a wheelchair for mobility, and that R1 is dependent on staff for some of the other functional abilities.Transfer and Mobility Evaluation dated 4/14/26 shows that R1 requires assistance for transfer.Mental Status assessment dated [DATE] indicates the resident has moderately advanced cognitive impairment.R1's Hospital Records dated 4/27/26 show R1 fell and R1's Diagnoses at the hospital emergency room are: Closed Fracture of Nasal Bone, Avulsion of Skin of Right Elbow, Abrasion of Forehead, and Closed Head Injury, from R1's fall.On 5/18/26, at 10:45 AM on the second floor, V1(Administrator) was observed pushing R1 from the Activity room, down the hallway, to the room in the wheelchair without a leg/footrest. R1's feet were dangling and dragging on the floor; the wheelchair footrests were not available for use. V1 told R1 twice during the transport to raise up R1's legs, but R1 was barely able to raise up her legs.On 5/19/26 between 10am and 11am during observation with V4(ADON/Assistant Director of Nursing), R1, R4 and R5 were observed in the activity room sitting in the wheelchair without leg/footrests, and V4 stated that the care plans were updated for the residents to have their legs on the leg rest while staff move them in the wheelchair, to prevent residents from falling forward like in the case of R1. However, only one pair of leg rest was available in the activity room where several residents were sitting in the wheelchair. Inquired from V4 why the residents did not have leg rests available; V4 made a phone call and later informed the surveyor that the leg rests were kept in the storage room of the medication room. Inquired from V4 if the CNAs have free access to the medication room to get leg rests for the residents before pushing the residents in the wheelchair from one place to the other, as it happened in the case of R1. V4 stated that the medication room is locked, but the CNA can find the nurse to open the medication room when they need the leg rest. R1's care plan states the leg rest should be placed on the back of the wheelchair.On 5/18/26, at 11:15 AM, V3 (Certified Nursing Assistant (CNA), was interviewed. V3 stated On that day, earlier in the morning, I noticed that her (R1)'s balance was a little off in the wheelchair, maybe she (R1) was not feeling well. After breakfast, maybe around 9:30am, I was pushing her in the wheelchair from the dining room to the activity room. Both of her feet were on only one leg rest, and she was not steady, her shoulder went close to her knees as I was moving her, and the next thing, she was on the floor. I immediately called the nurse for help, and the nurse sent her to the hospital. The surveyor inquired from V3 what V3 could have done differently to prevent the fall. V3 stated I probably could have monitored her more (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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	closely while pushing the wheelchair. The surveyor asked V3 if V3 had any training about transporting a resident in the wheelchair from one place to the other, V3 stated that she had training about mechanical lift transfer, but that she (V3) did not have any training about moving a resident in the wheelchair. V3 added that she(V3) started working at the facility about a year ago.Facility's incident report sent to the State Agency on 4/27/2026 at Approximately 9:30 AM states in part: R1 was being escorted by staff to activity. During transport, R1 placed her foot on the floor resulting in a fall from her wheelchair. R1 was sent to the hospital. R1 returned from the Hospital with Diagnoses of Closed Fracture of Nasal Bone, Avulsion of Skin of Right Elbow, Abrasion of Forehead, and Closed Head Injury.Final Incident Report dated 5/1/26 states in part: On 04/27/2026 at approximately 1:30 PM, R1 returned from hospital with Diagnoses: Closed Fracture of Nasal Bone, Avulsion of Skin of Right Elbow, Abrasion of Forehead, and Closed Head Injury.The report further states: In conclusion, following a thorough investigation, it was determined that during transport R1 placed her foot on the floor, resulting in a fall from her wheelchair. Staff responded immediately. MD (Medical Doctor) notified and issued orders for R1 to be sent to the hospital for further evaluation. The POC (plan of care) was reviewed and revised to ensure the use of wheelchair leg rests when R1 is not propelling herself. Additionally, a bag will be placed on the back of the wheelchair to store the leg rests when R1 is propelling herself.On 5/19/26 at 1:13pm, V8 (Physician) was interviewed regarding falls and residents' care plans. V8 stated, Of course, the staff should follow the fall prevention care plan. V8 added that fall care plan is individualized and different for each resident, and he (V8) could not speak to the care plan for any resident.On 5/18/26, at 11:30 AM, the Director of Nursing (DON) stated that staff have being retrained regarding safety when moving residents. At this time, V2 presented the Training In-service records that state: Chair safety inspection: Confirm leg rest are present and functional. Leg rest application and removal - Ensure leg rests are locked into place, Place both legs properly on footplates; Prevent residents' feet from dragging or slipping. Transfer technique: ensure residents stability before moving wheelchair. Demonstrate safe wheelchair transport. Wheelchair safety inspection: Ensure footrests are secure and properly positioned.V2 also presented the facility's policy on Fall Prevention, Post-Fall, and Communication. This policy dated 1/21/26 states in part: To promote safety by identifying fall risk, implementing individualized fall prevention interventions, ensuring timely post fall evaluation, and reviewing outcomes to prevent recurrence. Interventions will be individualized by the IDT (Interdisciplinary team) and may include supervision level, transfer status, mobility assistance, and therapy involvement and assistive device use, etc. Interventions must be implemented consistently and revised when not effective. V3 failed to ensure that R1 was safely positioned and failed to ensure that the wheelchair footrests were properly utilized during transport, resulting in R1 falling forward out of the wheelchair.R2 is a [AGE] year-old female admitted to facility on 4/3/2026 for rehabilitation following a fall with injury at home and subsequent hospitalization. R2's admission diagnoses included fracture of the superior rim of the right pubis, aftercare following total join replacement, urinary tract infection, dementia and history of transient ischemia attack and cerebral infarction without residual deficits. The Minimum Data Set (MDS) dated [DATE] noted a Brief Interview of Mental Status (BIMS) of 8 indicating moderate cognitive impairment. The Resident Mood Interview had a severity score of 14 indicating moderate depression. R2 was dependent for indoor mobility (ambulation) meaning R1 needed a helper to complete all activities for the resident. R2 was also dependent for functional cognition meaning R2 needed assistance with planning regular tasks prior to the current illness, exacerbation or injury. For toileting, R2 needed partial/moderate assistance meaning the helper did less than half the effort. For lower body dressing, R2 needed substantial/maximal assistance meaning the helper did more than half of the effort. For sit to stand or chair/bed to chair transfer or toilet transfer, R2 needed substantial/maximal assistance. R2 was assessed as being at high risk for falling upon admission to the facility on 4/3/2026.On 5/19/2006 at 10:53 AM V16 (Certified Nursing Assistant) stated we generally check on residents every 2 hours. If a resident is at risk of falling, we keep the bed in 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
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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	low position. We make sure call light is close, but if a resident is confused, that doesn't help because they don't call for help. V16 could not think of anything else the facility does to prevent falls.On 5/19/2026 at 11:01 AM V17 (Lead Certified Nursing Assistant/CNA) stated some residents are confused. A urinary tract infection can cause confusion. V17 stated, I am expert in memory care, some CNAs have not dealt with it, so they don't know how to manage the residents. Some residents are at risk of falling. It is often because the resident has to go to the bathroom. R2 was nervous and anxious. R2 would try to use the bathroom without assistance, but R2 needed assistance to the bathroom. R2 was nervous to stand without assistance. R2 had a bladder infection, so R2 had to use the bathroom quite often. R2 could get up and stand and walk to the bathroom, but R2 wasn't safe. When walking, R2 would try to hold on to anything R2 could to prevent R2 from falling. R2 had a couple of falls. R2 had floor mats on both sides of R2's bed. R2 had blow up siderails or bolsters on the bed, but those were not good for R2 because R2 could put R2's legs over the bolster or between the bolsters so staff would find R2 sitting on the side of the bed when the bolsters were supposed to keep R2 in bed. R2 was confused about the call light and did not use the call light. We did not put R2 with a roommate who could have called for help. V17 found R2 after one of R2's falls. R2 was trying to get out of bed. R2 was found on the floor. R2 was getting up and fell because R2 had to go to the bathroom.On 5/19/2026 at 12:50 PM V3 (Assistant Director of Nursing/ADON) stated the facility does not have a fall prevention coordinator. We have an Interdisciplinary Team (IDT). No one is in charge of fall prevention. V2 oversees assisted living, and V2 (Director of Nursing/DON) oversees skilled nursing if there is a fall, but no one is the fall prevention coordinator.On 5/19/2026 at 1:01 PM V2 (DON) stated the facility does not have a fall prevention coordinator. If there is a fall, we talk about it at the morning meeting and then V2 closes the fall out in the risk management system if it is on the skilled side. ADON closes out the fall in the risk management system if the fall is on the assisted living side. If a resident falls, the nurse will call the DON or ADON and notify the family and the doctor. If the DON or ADON is not in the building at the time of the fall, the fall is discussed the next day. At the morning meeting, interventions and best practices are discussed, but that discussion is not documented anywhere. R2 was at the facility for two or three weeks. For each fall, there should be a progress note, risk management/incident reporting system documentation, and a care plan update. For each fall, at a minimum, the nurses document a post fall assessment each shift for at least 72 hours after the fall. Seventy-two hours of assessment would be 3 assessments per day/once per shift and nine post fall assessments for each resident fall.On 5/20/2026 at 9:58 AM V2 (Director of Nursing) stated all post fall assessments were provided to surveyor. V2 stated, That is all we have. We didn't do an assessment every eight hours for seventy-two hours after each fall.On 5/20/2026 at 11:10 AM V1 (Administrator) stated the facility does not have a fall prevention coordinator. DON and ADON have responsibility for fall prevention. When a resident falls, we have a post-fall huddle led by the charge nurse, ADON, DON or staff nurse. We conduct an investigation which is documented in electronic health record.On 5/20/2026 at 11:25 AM V2 (Director of Nursing) stated I don't see a progress note about R2's fall on 4/12/2026. I see documentation R2 returned to the facility after being at the emergency department, but there is no progress note about the fall on 4/12/2026. The nurse should have documented the fall and R2's assessment after the fall. None of that documentation is in the electronic health record (EHR). After a resident falls, V2 expects nurses to document in the progress notes of the EHR the resident's neurological assessment, any pain, any decrease in range of motion and any impairment of gait. Regardless of whether the assessment is normal or not, it should be documented which will allow staff to identify if there is any change in the resident over the 72 hours they are assessing and reassessing the resident. During the morning meeting, we try to determine the root cause of the fall. That discussion is not documented, We just talk about what the root cause could be and what interventions might be needed. Interventions to prevent further falling are put in the care plan. On 5/21/2026 at 9:16 AM V2 (Director of Nursing) stated for any resident at high risk of falls, the fall prevention interventions upon admission include low bed position and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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	frequent rounding. We would implement floor mats upon admission if the resident had multiple falls, confusion, or a fall with injury prior to admission. R2 was at high risk of falling upon admission. Upon admission, R2's bed was placed in low position and we kept her in a supervised area during the day. At night, the CNAs and nurses would round hourly on R2. Sometimes the nurses would keep R2 at the nurses station at night if R2 was awake. V2 could not recall any other fall prevention interventions upon admission. After the 4/4/2026 fall, the care plan intervention was frequent rounding to anticipate needs. R2 had a UTI so that intervention meant staff should round on R2 to see if R2 had to go to the bathroom or needed water, but the staff were already rounding on R2 hourly before that care plan intervention on 4/4/2026, so no new fall prevention interventions were implemented after R2's 4/4/2026 fall. After the 4/7/2026 fall, the care plan intervention was keep bed in the lowest position, but the bed was placed in the low position upon admission, so no new fall prevention interventions were implemented after R2's 4/7/2026 fall. The bed was in low position upon admission because R2 had a history of falling and confusion upon admission. After the 4/8/2026 fall, the intervention was floor mats, however R2 had floor mats in place before the 4/8/2026 fall, so no new fall prevention interventions were implemented after R2's 4/8/2026 fall. After the 4/11/2026 fall, the intervention was frequent toileting every 2 hours, however V2 stated R2 was actually being rounded on hourly prior to the 4/11/2026 fall, so no new fall prevention interventions were implemented after R2's 4/11/2026 fall. After the 4/12/2026 fall, bed bolsters were implemented. Staff did not tell V2 that R2 was climbing over the bolters. After the 4/13/2026 fall, the intervention was medication review of all medications. V2 stated V2 looked at R2's medications to see if R2 had anything ordered for sleeping, anxiety or pain or if R2 needed something for pain. V2 spoke to V18 (Physician) who ordered a psychiatry evaluation V2 stated psychiatry should have seen R2 before the 4/19/2026 fall, but V2 could not find a psychiatry consult note in the EHR. V2 stated I don't know if R2 fell on 4/19/2026, because R2 was found in bed. There was a nightstand next to R2's bed. R2 could have hit R2's head on the nightstand. V2 could not say how R2 got injured on 4/19/2026. The IDT root cause analysis is completed the day after a resident fall unless it is the weekend. V2 stated the facility has up to four days to complete the IDT root cause analysis. A sitter could have helped prevent R2 from falling because someone would have been right next to R2 especially during the night hours. The facility does not provide sitters.On 5/21/2026 at 1:33 PM V2 (Director of Nursing) provided psychiatry consultation note by V21 (Psychiatry/Mental Heath Nurse Practitioner). Visit date was 4/17/2026 at 3:30 PM and consultation note was signed by provider on 5/21/2026 at 9:44 AM. V21 documented that R2 was approached for medication management. R2 declined to engage and appeared sedated and asleep. No concerns could be assessed due to limited participation by R2. Review of R2's fall incident reports document: On 4/4/2026 at 3:45 PM V10 (Nurse) documented in the risk management/incident report R2 was observed sitting on the floor in her room during rounds. Incident was unwitnessed. The fall prevention care plan intervention after the 4/4/2026 fall was frequent rounding to anticipate needs. On 4/7/2026 at 6:05 PM V9 (Nurse) documented in the risk management/incident report R2 was observed on the floor next to her bedside during rounding. Incident was unwitnessed. The fall prevention care plan intervention after the 4/7/2026 fall was keep bed in the lowest position. On 4/8/2026 at 8:30 AM V11 (Nurse) documented in the risk management/incident report R2 was on the floor with R2's wheelchair cushion underneath R2. R2's wheelchair was also facing R2. Incident was unwitnessed. Pain medication administered for back pain. The fall prevention care plan intervention after the 4/8/2026 fall was floor mats on both sides of the bed. On 4/11/2026 at 8:30 PM V12 (Nurse) documented in the risk management/incident report R2 was found on the floor next to the bathroom door by nursing staff. R2 stated R2 was trying to walk to the bathroom. Incident was unwitnessed. R2 was transferred to the hospital with pain score of 7. The fall prevention care plan intervention after the 4/11/2026 fall was frequent toileting (every two hours). On 4/12/2026 at 12:23 PM V19 (Nurse) documented in the risk management/incident report R2 was found sitting Indian style on the left side of R2's bed. R2's wheelchair was right next to R2. The bed was in the lowest position. R2 was trying (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60527

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	to go to the bathroom. Incident was unwitnessed. The fall prevention care plan intervention after the 4/12/2026 fall was bed bolsters. On 4/13/2026 at 11:30 AM V9 (Nurse) documented in the risk management/incident report R2 was noted scooting on the floor to the door. R2 was trying to go to the bathroom. Incident was unwitnessed. Radiographs were ordered. The fall prevention care plan intervention after the 4/13/2026 fall was medication review of all medications. On 4/19/2026 at 5 AM V13 (Registered Nurse) documented in the risk management/incident report V13 was informed by Certified Nursing Assistant (CNA) R2 had blood on R2's bed. Upon assessment a small laceration was noted to the right top of R2's head. R2 was unable to recall what happened. Incident was unwitnessed. R2 was transferred to the hospital for head injury.Facility document titled Incidents by Incident Type was presented by V2 (Director of Nursing) as the list of all falls in skilled nursing and assisted living at the facility. Date range of the report 1/21/2026 - 5/19/2026. According to the Incident-by-Incident report, R2 sustained a fall on 4/4/2026, 4/7/2026, 4/11/2026, 4/12/2026 and 4/13/2026. The 4/8/2026 fall and 4/19/2026 falls were not listed on the fall summary report.Review of post fall assessments: R2 fell 4/8/2025 at 8:30 AM. No post fall assessment was completed 4/9/2026 day shift, afternoon shift or night shift (11PM-7AM). No post fall assessment was completed 4/10/2026 day shift or night shift (11 PM - 7 AM). R2 fell 4/11/2026 at 8:30 PM. No post fall assessment was completed on 4/11/2026 day shift or night shift (11 PM-7AM). R2 fell on 4/12/2026 at 12;23 PM. No post fall assessment was completed on 4/13/2026 night shift (11PM-7AM). R2 fell on 4/13/2026 at 11:30 AM. No post fall assessment competed 4/14/2026 day shift. No post fall assessment was completed on 4/16/2026 day shift. R2 fell on 4/19/2025 at 5 AM.Review of the Interdisciplinary Team (IDT) Post Fall Review/Summary: 4/4/2026 IDT post fall review was signed 4/6/2026. IDT post fall reviews dated 4/7/2026, 4/8/2026, 4/11/2026 and 4/12/2026, were signed 4/13/2026. The 4/13/2026 post fall review was signed 4/14/2026. No post fall analysis was provided by facility for the 4/19/2026 fall. For the 4/4/2026 fall, the root cause of fall was Resident is a poor historian and unable to recall. For the 4/7/2026 fall, the root cause of fall was Resident slid from bed to floor. For the 4/8/2026 fall, the root cause of fall was Resident was observed sitting near wheelchair with cushion underneath her. For the 4/11/2026 fall, the root cause of fall was I was trying to walk to the bathroom. For the 4/12/2026 fall, the root cause of fall was I was going to the bathroom. For the 4/13/2026 fall, the root cause of fall was I was trying to use the bathroom. To the question What is the effectiveness of those interventions put into place after the incident?, the response was reduction in fall and injury on 4/4/2026, 4/7/2026, 4/8/2026, 4/11/2026, 4/12/2026 and 4/13/2026.Fall prevention, Post Fall and Communication Policy dated 1/21/2026 stated the purpose is to promote resident safety by identifying fall risk, implementing individualized fall prevention interventions, ensuring timely post-fall evaluation, and reviewing outcomes to prevent recurrence. A fall is defined as an unintentional coming to rest on the ground, floor or a lower level, not as a result of an overwhelming external force. Risk is any condition, environment or process that increases the likelihood of a fall. The Interdisciplinary Team (IDT) participates in fall risk assessment, intervention planning post-fall review, plan of care revision and program evaluation. Fall risk factors include prior falls, gait instability, cognitive impairment, medication side effects, continence needs nutrition/hydration deficits, vision changes, illness and environmental hazards. Fall prevention interventions may include supervision level, transfer status, mobility assistance, therapy involvement, medication review, toileting plans, environmental safety measures, assistive device use, and resident preference considerations. Interventions must be implemented consistently and revised when not effective. The IDT will complete a root-cause analysis after each fall. This includes review of environmental, physiological, behavioral, medication -related and process factors. Care plans will be updated to include new or revised interventions.