STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2564019/IL191801	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.696a) 300.696d)4) 300.1210a) 300.1210b)4) 300.1210d)2)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.696 Infection Prevention and Control a) A facility shall have an infection prevention and control program for the surveillance, investigation, prevention, and control of healthcare-associated infections and other infectious diseases. The program shall be under the management of the facility's infection preventionist who is qualified through education, training, experience, or certification in infection prevention and control. d) Each facility shall adhere to the following	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S9999	Continued From page 1	S9999		

guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340):
4) Guideline for Prevention of Surgical Site Infection

Section 300.1210 General Requirements for Nursing and Personal Care
a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
4) All nursing personnel shall assist and encourage residents so that a resident's abilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow physician admission orders to assess and monitor a surgical site, failed to provide a physician ordered shampoo to use over a surgical site, failed to initiate Enhanced Barrier Precautions (EBP), and failed to update the care plan. These failures resulted in a surgical infection which required additional appointments, antibiotics, a second hospitalization, and surgery for one (R1) resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S9999	Continued From page 3	S9999		

out of three residents reviewed for Quality Care/Treatment in a sample list of three residents.

Findings include:

R1's undated Face Sheet documents R1 admitted to the facility on 3/24/25 with medical diagnoses as Cerebral Infarction, Nontraumatic Intracerebral Hemorrhage, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side, Dysphagia, Lack of Coordination, and Difficulty in Walking.

R1's Minimum Data Set (MDS) dated 3/30/25 documents R1 is dependent on staff for toileting, dressing, bed mobility, and maximum assistance for bathing.

R1's Hospital Summary and Discharge Record dated 3/24/25 documents R1's medical diagnoses as Left Hemiplegia, Midline shift of brain, Oropharyngeal Dysphagia, PEG (Percutaneous Endoscopic Gastrostomy) status, Status post Craniectomy, Left Homonymous Hemianopsia, Neurologic neglect, and Intercranial bleed. This same record documents physician orders for staff to complete daily skin checks, bathe R1 with a disinfectant/antiseptic soap, R1 is to wear a cranium helmet when out of bed, and R1 should be on Craniectomy precautions.

R1's Admission Assessment dated 3/24/25 documents R1 as cognitively intact. This same assessment does not document R1's surgical site on her scalp, use of helmet, or isolation precautions to be used for R1's surgical site.

R1's Skin Evaluation dated 3/27/25 documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S9999	Continued From page 4	S9999		

R1 had no skin issues.

R1's Nurse Progress Note dated 4/28/25 at 8:03 PM documents R1 returned from V7 (Neurologist) appointment. An infection on R1's Hemicraniectomy wound. R1 was started on an antibiotic for the infection and referred to V29 (Infectious Disease Physician) and to the wound clinic. A dressing was applied to R1's scalp at the follow up appointment which was rewrapped upon return from facility.

R1's Neurology Progress Note dated 4/28/25 documents V7 (Neurologist) saw R1 for a post operative visit. V7 found two areas of dry material that once uncovered shows purulent material for R1's two areas on her Cranial surgical site that were not healed. Wound cultures were obtained and sent out for evaluation. R1's infection did not spread and has no fluid collection. R1 will be referred to an Infectious Disease Physician and a wound clinic.

R1's Neurology Progress Note dated 5/12/25 documents R1 recently developed two spots of infection on the upper and anterior portion of the Cranial flap that are not improving. V7 (Neurologist) recommends re-exploration of the area of the Craniectomy with scalp excision and debridement.

R1's Procedure Note dated 5/15/25 documents R1 underwent a Right re-exploration of Right Frontal/Parietal Craniectomy for scalp excision with debridement. R1 was placed under general anesthesia with an endotracheal tube placed. R1's head was shaved. R1's scalp was dissected, lifted over the infected area and then the piece of scalp was sharply removed for the approximate length of six centimeters (cm) by two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S9999	Continued From page 5	S9999		

cm wide.

R1's Physician Order Sheet (POS) dated May 2025 documents a physician order starting:
--4/28/25-5/12/25 for Sulfamethoxazole-Trimethoprim (Bactrim) 800-160 milligrams (mg) twice daily for fourteen days for (surgical site) wound infection. This order was discontinued 5/2/25 per (V29) Infectious Disease doctor recommendation.
--5/2/25-5/12/25 for Cephalexin (Keflex) 500 mg four times daily for ten days.
--5/2/25 with no ending date for Enhanced Barrier Precautions (EBP) per facility guidelines. R1's POS does not include an EBP order prior to 5/2/25.
--5/3/25 to cleanse R1's scalp incisional wounds/scabs if there is any drainage with wound cleanser, pat dry, apply absorbent gauze, wrap with gauze, and secure with tape over gauze as needed.
--5/6/26 with no end date for R1 to wear a helmet to be worn at all times, including while sleeping, except for personal hygiene. There were no physician orders in R1's POS prior to 5/6/25 for R1 to wear a helmet.

R1's Medication Administration Record (MAR) dated March, April and May 2025 do not include physician orders to check R1's skin daily, ensure R1 was wearing her helmet when out of bed or provide antiseptic/disinfectant shampoo to R1's surgical site during showers.

R1's Treatment Administration Record (TAR) dated March, April, and May 2025 do not include physician orders to check R1's skin daily, ensure R1 was wearing her helmet when out of bed, or provide antiseptic/disinfectant shampoo to R1's surgical site during showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

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S9999	Continued From page 6	S9999		

On 5/14/25 at 9:40 AM V3 (R1's family member) stated R1 admitted to the facility on 3/24/25 after having a Cerebral Vascular Accident (CVA) followed by a Right sided Craniectomy in February 2025. V3 stated R1 was admitted to a hospital and then went to an acute Rehabilitation facility prior to admitting to this facility. V3 stated R1 has not been receiving the care that V7 (Neurosurgeon) ordered for R1. V3 stated R1 admitted to the facility with an open wound on her head and was supposed to wear a helmet at all times. V3 stated R1's incision had two separate areas that were not completely healed upon admission to the facility. V3 stated the facility has not monitored R1's incision site since admission and now R1 has an infection that will require surgery to remove the infection. V3 stated the facility is at fault for R1 obtaining an infection and R1 having to stay in the hospital again and losing 'precious' time in therapy. V3 stated R1 will have to start from scratch again if she makes it out of surgery.

On 5/14/25 at 11:25 AM V8 (R1's husband) stated R1 was living at home with V8 when she had a CVA. V8 stated R1 had to have almost half of her skull removed due to the pressure from a bleed inside her head. V8 stated they (R1, V8) have had a long road due to her Craniectomy, hospitalizations, therapies, and ongoing struggles with trying to keep up with everything. V8 stated R1 entered this facility with the intention to get therapy and then go back home. V8 stated because the staff didn't look at R1's incision site and didn't clean it or report any changes, R1 got an infection and now must have another surgery on 5/15/25. V8 stated V7 (Neurosurgeon) is going to remove the infection by removing approximately one to two inches wide and four to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

six inches long of her scalp and then sew the remaining sides back together again. V8 stated R1 was progressing in her therapy and now will have to start all over. V8 stated "I just hope she (R1) makes it out of surgery. There is a risk of her not making it through this surgery and I just can't stand the thought of any life without her. (R1) should not have to be going through this at all. This wasn't in the plan."

On 5/14/25 at 11:35 AM R1's room did not have any signage designating R1 was on Enhanced Barrier Precautions (EBP), no Personal Protective Equipment (PPE) available and no designated bins in her room for PPE disposal. V9 (LPN) removed R1's helmet to show two dime sized dark scabbed areas with unattached edges and yellow drainage around both areas. V9 did not wear a gown when removing bandage on R1's Scalp surgical site. V9 stated during the observation that the drainage had been present 'for a couple of days'. V9 confirmed there was no dressing covering R1's two open draining areas from her surgical incision.

On 5/14/25 at 1:45 PM V14 (LPN) did not wear a gown when obtaining a blood sample from R1. V14 LPN stated she did not know R1 was on any type of precautions.

On 5/14/25 at 1:50 PM V11 and V12 (Certified Nursing Assistants/CNAs) transferred R1 from her high back padded wheelchair to her bed and then back from her bed to her wheelchair using a total body mechanical lift. V11 and V12 did not wear gloves or gowns when transferring R1. R1's helmet has several long oval shaped openings in the top which shows R1's scalp. Both V11 and V12 CNAs adjusted R1's helmet from the top end

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

with bare hands during the transfers without wearing Personal Protective Equipment (PPE).

On 5/14/25 at various times during first and second shifts R1 did not have a sign posted outside her room indicating R1 was on Enhanced Barrier Precautions (EBP). R1 did not have any supply of Personal Protective Equipment (PPE) outside her door or easily accessible.

On 5/15/25 at 9:00 AM V5 (CNA/Shower Aide) stated she has given R1 showers multiple times. V5 stated she does not know of any kind of antiseptic/disinfectant soap to use on R1. V5 stated she has only used the facility soap to wash R1's hair. V5 stated R1's incision site has been red for a long time and that she did not need to report this 'because the nurses already know'.

On 5/15/25 at 3:45 PM V28 (Advanced Nurse Practitioner) stated she would expect that the facility follows the physician and discharge summary/orders for R1. V28 stated R1 obtained the infection Methicillin Susceptible Staphylococcus Aureus (MSSA) under the care of the facility and R1's infection was not sourced internally. V28 stated R1's infection was 'an external infection' which could have been caused by the staff not properly caring for R1's surgical incision. V28 stated the staff should have been assessing R1's surgical incision site daily, R1 should have been wearing her helmet when out of bed, and any changes such as redness to the surgical site or a change in R1's neurological status should have been reported to V7 (Neurologist) immediately. V28 stated R1 required surgery to debride the surgical site due to the infection. V28 stated R1 would not have to have a second surgery if the facility followed V7's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

physician orders upon admission. V28 stated R1 would require a hospital stay in the Intensive Care Unit (ICU) following her second surgery and that this would be a setback for R1 reaching her therapy goals and eventual return to her home.

On 5/16/25 at 9:50 AM V1 (Administrator) stated R1 admitted to the facility with physician orders to assess her surgical site on her Superior scalp daily, R1's helmet was to be on when out of bed and antiseptic/disinfectant was to be provided for cleansing R1's surgical site during showers. V1 stated the facility did not put those orders in place and did not clarify any orders with V7 (Neurologist). V1 stated R1 should have been placed on Enhanced Barrier Precautions (EBP) upon admission. V1 stated R1 should have had her surgical site assessed upon admission and monitored at least weekly thereafter. V1 stated R1's helmet should have been on when R1 was out of bed only. V1 stated the facility cannot provide documentation of any of these things being done for R1 because the staff did not follow the discharge summary/instructions. V1 stated if the staff had been assessing R1's wound she might not have had an infection. V1 stated R1's second surgery on 5/15/25 was not a part of her rehabilitation plan. V1 stated R1 had to have this second surgery due to an MSSA infection that 'was most likely caused by us (facility)'. V1 stated V1 and V2 (DON) will be doing a lot of training to help the staff understand a higher level of care and to help educate the staff to let them know that reporting questions and/or changes in a resident's care is very important.

On 5/16/25 at 11:00 AM V2 (DON) stated R1 had a massive Cerebral Vascular Accident (CVA) followed by a Craniectomy in February 2025 prior to her admission to the facility. V2 stated R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001804	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

admitted to the facility on 3/24/25 with two areas on her surgical scalp incision that were not completely healed. V2 stated there is no documentation of R1 admitting with a surgical site, no documentation of R1's surgical site being assessed or monitored and no documentation of R1's helmet that she was supposed to be wearing when out of bed. V2 stated the facility should have entered in the physician discharge summary/instructions. V2 stated R1 was supposed to have an initial assessment and then daily skin assessments of her surgical site from her Craniectomy but the facility did not initiate those orders and therefore the staff did not know to check R1's surgical site daily. V2 stated the facility does not have a wound program for skin tears, surgical sites, abrasions, bruises, etc. V2 stated "We (facility) have a skin program for pressure ulcers but not for any other type of wound. I am fixing that problem today. We (facility) could have done a much better job at managing (R1's) surgical wound. R1 should have been placed on Enhanced Barrier Precautions (EBP) from her admission, we should have called to clarify her orders when she admitted and not waited until she had been a resident here for over a month. Unfortunately (R1) did obtain her infection to her surgical site under our care from not implementing isolation precautions and not following physician orders for the care of her surgical site." V2 stated the facility provides a standard shampoo and body wash but did not provide R1's antiseptic/disinfectant shampoo for her showers. V2 stated R1's care plan did include 'helmet for protection' but that should have been clarified as to when R1's helmet should have been on and off. V2 stated she understood why the staff were confused about the placement of R1's helmet because the intervention was unclear. V2 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 11	S9999		

combination of the staff not assessing R1's surgical site, not using the correct shampoo that was ordered by V7 (Neurologist) and not following up timely after her admission most likely caused her infection which led to her second surgical procedure.

The facility policy titled Skin Impairment Prevention and Wound Management effective December 12, 2024, documents the facility will provide an aggressive skin care program using current standards of clinical practice. The presence of wounds will be indicated on the admission nursing assessment. Wound status will be monitored as ordered by the Physician. A complete wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairments in the skin integrity. Staff will document the wound using the weekly observation assessment.

"A"