STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057109	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN VILLAGE HEALTHCARE	2202 NORTH KICKAPOO STREET , LINCOLN, Illinois, 62656

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S0000	Initial Comments Complaint Investigation 2523746/IL191170	S0000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1010h) 300.1210b) 300.1210c) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus	S9999		

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

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S9999	Continued from page 1 ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These regulations were not met as evidence by: Based on interview, observation and record review, the facility failed to provide supervision and implement fall prevention interventions to prevent resident falls for two of three residents (R1 and R4) reviewed for falls in the sample of 24. These failures resulted in R1 falling and sustaining an injury to right eyelid and R4 falling and experiencing left hip pain. Findings include: The facility's Fall Reduction Program (revised April 2019) documents the following: "It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The program's intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each resident's individual risks, and the implementation of appropriate interventions, supervision, and/or assistive devices deemed appropriate. Quality Assurance will monitor the program to assure ongoing effectiveness." This same policy documents, "Safety interventions will be determined and implemented based	S9999		

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S9999	Continued from page 2 on the assessed, individualized risks and in accordance with standards of care; interventions to be documented in the resident's care plan." This policy also documents, "Examples of Standard Fall/Safety Precautions that May be Applicable: Call lights answered in a timely manner; Supervision of residents who require staff assistance with bathing, showering, or toileting. If resident is not able to maintain proper sitting balance, staff shall remain with resident allowing as much privacy as is safe for the resident." 1. R1's Fall Risk Observation (dated 05/09/25) documents a score of 20, indicating R1 is at high risk for falls. R1's current Fall Prevention Care Plan documents the following: "(R1) is at risk for falling related to polyneuropathy, generalized muscle weakness and cognitive deficit related to progression of Parkinson's." R1's current Functional Status Care Plan documents the following focus: "(R1) requires extensive assistance with bed mobility due to weakness related to Parkinson's." R1's Functional Status Care Plan also documents the following intervention currently in place: "Never leave (R1) in a position that is unsafe or uncomfortable to him." R1's Minimum Data Set Assessments (dated 02/11/25 and 05/09/25) document in Section GG, R1 is dependent (helper does all of the effort, or the assistance of two or more helpers is required) in the following areas: Roll left and right, Sit to lying, and Lying to sitting on bed. R1's Fall Investigation (dated 04/15/25) documents, "IDT (Interdisciplinary Team) met to discuss alleged fall. (R1) was receiving cares in bed when CNA (Certified Nursing Assistant) turned away and (R1) rolled out of bed and onto the floor. (R1) has discoloration to right eyelid. Neurological checks initiated. (R1) not complaining of pain at this time. All notifications made, care plan updated. Root cause: Extensive assistance needed for all cares provided while in bed. Intervention: Two staff present during cares in bed at all times." On 05/14/25 at 11:15 AM, V2 (Director of Nursing) stated that V16 (former Certified Nursing Assistant),	S9999		

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S9999	Continued from page 3 "Was the only one in with (R1) at the time of his fall. (V16) walked away and left (R1) unattended in his bed to obtain supplies while she was providing cares to him, and he fell out of his bed while he was unattended. (R1) ended up with a black eye. (V16) should not have walked away from (R1) at any time. She knew better than that. She was terminated and no longer works at the facility." 2. R4's current Fall Prevention Care Plan documents the following: "(R4) is at risk for falling and repeat falls related to spinal stenosis, generalized edema, history of falls, generalized muscle weakness accompanied by poor safety awareness." This same care plan documents the following fall prevention interventions in place: CNAs (Certified Nursing Assistants) will assist (R4) to the bathroom and back using a wheelchair; Staff will frequently check on (R4) and anticipate her needs. R4's Fall Investigation (dated 03/14/25) documents the following: "(R4) stated she needed to use the bathroom and was in a hurry, so she attempted to get up alone. She lost balance and lowered herself to her knees. (R1) stayed on her knees until CNA (Certified Nursing Assistant) and Nurse entered room and were able to transfer resident back into the bed. No injury." This same investigation documents that R4's call light was on at the time of R4's fall. On 05/14/25 at 10:00 AM, R4 was sitting in a recliner in her room watching television. When asked about falling in the facility, R4 stated the following: "My legs are weak, so I do fall a lot. I'm supposed to ask for help and wait for them to come, but it usually takes too long. There're times I've had an accident in my pants waiting for help to go to the bathroom. I feel like this happens constantly. It takes a really long time for someone to answer the call light at nighttime. I've waited several hours. They try to get to you during the day, but at times you wait 30 to 45 minutes. They definitely need to schedule more nurses and CNAs." R4 was able to recall her 03/14/25 fall and stated the following: "I needed to use the bathroom, and I had my call light on. I waited and waited, and no one ever came, so I attempted to get up by myself. That was a mistake because I fell onto my knees. I stayed on my knees for several minutes until someone finally came to help."	S9999		

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S9999	Continued from page 4 On 05/14/25 at 11:25 AM, V2 (Director of Nursing) verified that R4's call light was on at the time of her 03/14/25 fall, and stated staff should be checking on R4 frequently, especially since she is a high risk for falls. R4's Fall Investigation (dated 04/10/25) documents the following: "Resident experienced an unwitnessed fall around 07:30 AM. After the fall, she stated she had left hip pain, and she stated she hit her head. Writer assessed resident after falling. No bleeding, resident alert, neuro (neurological) check done and normal, MD (Medical Doctor) and POA (Power of Attorney) notified. Resident is being sent to ED (emergency department) to be evaluated." This same investigation documents: "Resident statement of what happened: I was trying to use the bathroom." This investigation also documents the following conclusion: "Root cause: Staff did not follow plan intervention. Staff education and discipline." On 05/14/25 at 11:30 AM, V2 (Director of Nursing) stated, "After (R4's) fall on 04/10/25, (V18, Certified Nursing Assistant) received discipline because she did not check on (R4) frequently. I watched the camera that records the entrance to (R4's) room, and it was an extended period of time before (V18) checked on (R4) since she had last been checked. (R4) is supposed to be checked on frequently, at least every 15 minutes." (B)	S9999		