

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Clark-Lindsey Village		STREET ADDRESS, CITY, STATE, ZIP CODE 101 West Windsor Road Urbana, IL 61801	
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)		
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on interview and record review the facility failed to follow their Grievance policy by not following up on a resident (R1) complaint timely for one out of three residents reviewed for grievances in a sample list of three residents.</p> <p>Findings include:</p> <p>The facility policy titled Grievance Policy dated 10/19/22 documents each resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear or discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. The facility will ensure prompt resolution to grievances, keeping the resident and the resident representative informed throughout the investigation and resolution process. The Grievance Officer will be responsible for tracking grievances through their conclusion, lead necessary investigations, communicate with residents through the process to resolution. The Grievance Officer works with facility staff utilizing root cause analysis processes for resolution of the grievance or concern. The Grievance Officer will initiate the appropriate notification and investigation processes per individual circumstance and facility policies. The investigation will consist of at least the following: a review of the completed complaint report, interview with the person reporting the incident, interview with any witnesses to the incident, review of the resident medical record, interviews with staff having contact with the resident during the relevant periods of the alleged incident, interviews with the resident's family members and a root-cause analysis of the circumstances surrounding the incident.</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE] 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.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 is dependent on staff for toileting, dressing, bed mobility and maximum assistance for bathing.</p> <p>R1's Nurse Progress Note back dated 4/2/25 at 3:24 PM documents V8 (R1's spouse) reported to V9 (Licensed Practical Nurse/LPN) that someone bumped R1's head during her transfer this morning for a shower. This same note was dated as entered on 5/2/25.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145381
		If continuation sheet Page 1 of 9

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Electronic Medical Record (EMR) does not include any alleged accident nor any investigation.</p> <p>The facility grievance log dated 5/2/25 documents R1 stated she bumped her head during a transfer with a total body mechanical lift.</p> <p>On 5/14/25 at 11:20 AM R1 stated she doesn't remember exactly when her head was bumped on 4/2/25 but knows it was before actually taking a shower. R1 stated the staff pushed her in the shower chair around the corner of the bathroom too fast. R1 stated she felt like a knife was slicing through her head. R1 stated that hurt something awful. R1 stated she didn't know if the skin was broken or not on the top of her scalp where her incision was but it sure hurt like it did. R1 stated she didn't say anything to the staff at that time because she didn't want them to lie about it. R1 stated she told her husband so he could let the nurse (V9) LPN know.</p> <p>On 5/15/25 at 10:25 AM V19 (Director of Residential Services/Grievance Officer) stated R1 told V8 (R1's) husband on 4/2/25 that the staff bumped R1's head during a shower earlier that morning. V19 stated V8 reported this to V9 (LPN), who then reported this to V2 (DON) on 4/2/25. V19 stated V9 and V2 both looked at R1's head to find no injuries on 4/2/25. V19 stated there was nothing else done about this incident until 5/2/25. V19 stated R1's assessment of her head documented in her clinical record was actually entered on 5/2/25, not 4/2/25 as the grievance log documents. V19 stated the facility did not follow their Grievance policy by not immediately investigating this incident.</p> <p>On 5/15/25 at 11:25 AM V8 (R1's) husband stated R1 told him that the staff bumped her head that morning (4/2/25) and he let the nurse (V9) LPN know. V8 stated V9 (LPN) and V2 (Director of Nursing/DON) both looked at R1's head and there was no injury. V8 stated no one ever asked how R1's head was bumped or talked to R1 or the staff to try to prevent that from happening again.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>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 out of three residents reviewed for Quality Care/Treatment in a sample list of three residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE] 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.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 is dependent on staff for toileting, dressing, bed mobility, and maximum assistance for bathing.</p> <p>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.</p> <p>R1's Admission assessment dated [DATE] 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.</p> <p>R1's Skin Evaluation dated 3/27/25 documents R1 had no skin issues.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 cm wide.</p> <p>R1's Physician Order Sheet (POS) dated May 2025 documents a physician order starting:</p> <p>--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.</p> <p>--5/2/25-5/12/25 for Cephalexin (Keflex) 500 mg four times daily for ten days.</p> <p>--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.</p> <p>--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.</p> <p>--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.</p> <p>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.</p> <p>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.</p> <p>On 5/14/25 at 9:40 AM V3 (R1's family member) stated R1 admitted to the facility on [DATE] 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.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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, hospitalization s, 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 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.</p> <p>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.</p> <p>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.</p> <p>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 with bare hands during the transfers without wearing Personal Protective Equipment (PPE).</p> <p>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.</p> <p>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'.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 admitted to the facility on [DATE] 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 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.</p> <p>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.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on interview and record review the facility failed to timely investigate an accident and update the resident care plan for one (R1) resident out of three residents reviewed for Accidents in a sample list of three residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents R1 admitted to the facility on [DATE] 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.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 is dependent on staff for toileting, dressing, bed mobility and maximum assistance for bathing.</p> <p>R1's Nurse Progress Note back dated 4/2/25 at 3:24 PM documents V8 (R1's husband) reported to V9 (Licensed Practical Nurse/LPN) that someone bumped R1's head during her transfer this morning for a shower. This same note was dated as entered on 5/2/25.</p> <p>R1's Electronic Medical Record (EMR) does not include any investigation or updated care plan intervention for R1's reporting of the staff hitting her head during a shower on 4/2/25.</p> <p>On 5/14/25 at 11:20 AM R1 stated she was assisted up into her shower chair the morning of 4/2/25 by two Certified Nursing Assistants/CNAs (V5, V12). R1 stated after she was up, V12 left the room and V5 gave her a shower in the shower in her room. R1 stated she doesn't remember exactly when her head was bumped but knows it was after V12 left and before actually taking a shower. R1 stated the staff pushed her in the shower chair around the corner of the bathroom too fast. R1 stated she felt like a knife was slicing through her head. R1 stated that hurt something awful. R1 stated she didn't know if the skin was broken or not on the top of her scalp where her incision was but it sure hurt like it did. R1 stated no one ever asked her anything about that incident.</p> <p>On 5/14/25 at 11:25 AM V8 (R1's husband) stated V8 reported to V9 (Licensed Practical Nurse/LPN) on 4/2/25 that the staff had bumped R1's head in the shower. V8 stated no one ever asked him anything about the incident.</p> <p>On 5/15/25 at 9:05 AM V5 (CNA) stated R1 is cognitively intact and did not say anything to V5 about getting her head bumped. V5 stated no one ever asked her how it might have happened or who was in the shower assisting V5 with R1 until yesterday (5/14/25).</p> <p>On 5/15/25 at 9:10 AM V17 (CNA) stated R1 was not his client on 4/2/25 and did not help with her shower that morning. V17 stated no one asked V17 if he knew anything about R1's head being bumped on 4/2/25. V17 stated V17 heard about this incident on 5/14/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/15/25 at 9:15 AM V18 (CNA) stated he did not help transfer R1 to/from the shower on 4/2/25. V18 stated no one asked V18 if he knew anything about R1's head being bumped on 4/2/25. V18 stated V18 heard about this incident on 5/14/25.</p> <p>On 5/15/25 at 3:20 PM V2 (Director of Nurses/DON) stated R1's report of the staff bumping her head while in the shower on 4/2/25 was not investigated until 5/2/25. V2 stated V8 (R1's husband) did report this incident to V9 (LPN) that morning. V2 stated both V9 and V2 did look at R1's head but since there was no injury, there was no investigation as to the validity of R1's complaint. V2 stated the facility should have investigated to see if R1's head was bumped, how it may have been bumped and who all was involved with R1's shower that morning so that the facility could put measures in place to ensure R1's head was not bumped again the same way.</p> <p>The facility policy titled Incident and Accident Reporting dated July 18, 2013, documents an incident report in the resident's Electronic Medical Records (EMR) will be completed by the nurse as soon as possible after the incident/accident occurs. The nurse will start the incident investigation within 24 hours of the event or as soon as possible. After the incident investigation is complete, the Director of Nurses (DON) and other staff members as appropriate will review for further action/interventions that need to occur. Any interventions/actions will be documented on the investigative report. That information is then shared with the appropriate staff members and placed on the care plan.</p>		