

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Twin Lakes Extended Care		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Eads Avenue Paris, IL 61944	
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	<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** Based on observation, interview, and record review the facility failed to ensure a resident was properly supervised during a transfer with a mechanical lift. This failure resulted in a fall for one resident (R1) of three reviewed for accidents, causing an acute break to both sides of the nasal bones as well as a break in the nasal septum and a laceration to the nose. Findings Include: The facility's Policy and Procedure for Use of a Mechanical Lift, dated November 1, 2025, and revised September 2, 2025, states the purpose of using a mechanical lift is to assist in lifting residents who are too heavy to lift manually, to promote comfort, and to maintain proper body alignment while residents are being moved. The procedure includes ensuring the resident is placed comfortably in the chair by grasping the top of the sling with one hand and pulling back on the sling while lowering the resident into the chair. Staff may also gently push on the resident's knees while lowering the resident into the chair to ensure comfort. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has an anxiety disorder, a cognitive communication deficit, and severe cognitive impairment. R1's Care Plan dated 9/21/25 documents interventions for communication deficits related to developmental delays, including allowing R1 adequate time to respond, repeating information as necessary, not rushing R1, requesting clarification to ensure understanding, making eye contact, using task segmentation by breaking tasks into one step at a time to support short-term memory deficits, and using alternative communication tools as needed. In addition, R1's Care Plan dated 12/15/25 documents R1 experienced an actual fall while staff were attempting a transfer with a mechanical lift to a wheelchair, during which R1 rolled out of the sling onto the floor. R1 was noted to have excessive bleeding and was sent to the emergency room, where R1 was diagnosed with a broken nose. On 2/6/26 at 10:51 a.m., V9, Certified Nursing Assistant (CNA), stated R1's fall was very traumatic. V9 reported that V7 (CNA) was operating the mechanical lift controls while V9 was positioned behind R1, guiding her into the wheelchair. V9 stated they were using a sling R1 does not like because the material is fuzzy, making it easier for a resident to slide. V9 stated R1 repeatedly leaned forward during the transfer. V9 attempted to guide R1 by holding the straps on the back of the sling; however, R1 leaned forward again, as she often does, and fell forward, landing face-first on the foot of the mechanical lift. On 2/6/26 at 11:16 a.m., V7, Certified Nursing Assistant (CNA), stated she assisted with transferring R1 on the day of the fall and was operating the mechanical lift using a regular sling. V7 stated R1 frequently leans forward in the sling and staff must remind her to lean back to complete the transfer. V7 stated she repeatedly instructed R1 to sit back; however, R1 continued to lean forward. V7 stated they proceeded with the transfer, and while lowering R1, she fell from the sling like she was doing a somersault. On 2/6/26 at 10:25 a.m., V6, Licensed Practical Nurse (LPN), confirmed that on the day of R1's fall from the mechanical lift, a CNA summoned her for assistance. V6 stated she found R1 lying face down with her face resting on the leg of the mechanical lift and noted R1 was bleeding. V6 instructed the CNAs to</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: 145466	Facility ID: 145466 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>leave R1 in that position while she called for emergency assistance. On 2/6/26 at 11:38 a.m., V8, Certified Nursing Assistant (CNA), stated she has transferred R1 several times and that staff often must instruct R1 to sit back because she is known to lean forward. V8 stated R1 usually follows instructions. V8 stated that when R1 leans forward, staff stop the transfer until R1 is in a safe position before proceeding. On 2/6/26 at 12:46 p.m., V10, Certified Nursing Assistant (CNA), stated staff are trained not to rush transfers and should not proceed if the resident is moving in the sling or leaning forward. V10 stated she would not feel comfortable continuing a transfer if a resident was leaning forward and that she always ensures the resident is properly positioned before proceeding. On 2/6/26 at 1:19 p.m., V11, Certified Nursing Assistant (CNA), stated she is new but has been taught that during mechanical lift transfers, the CNA is responsible for ensuring proper positioning and confirming the resident is not leaning forward during the transfer. On 2/6/26 at 12:37 p.m., V3, Social Services Director and CNA Supervisor, stated R1 frequently leans forward and staff often must remind her to sit back. V3 stated R1 follows instructions approximately 80% of the time but sometimes requires additional prompting. V3 stated the CNAs should not have continued the transfer on the day R1 fell until R1 was in a safe position. On 2/6/26 at 3:15 p.m., V2, Director of Nursing (DON), stated the facility removed the sling and provided staff training on the same day as R1's incident, primarily because she anticipated questions regarding staff training if the incident was investigated. V1, Administrator, and V2 were unable to provide training materials documenting the content of the in-service, and were only able to provide the in-service sign-in sheet. R1's X-ray results dated 12/15/25 document R1 sustained acute fractures of the bilateral nasal bones and nasal septum, as well as a laceration to the nose.</p>		