STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Village Healthcare	2202 North Kickapoo Street Lincoln, IL 62656

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to assess, document, and communicate the residents' Activities of Daily Living (ADL) needs, and ensure a comprehensive, person-centered care plan was timely reviewed and revised for one (R1) of four residents reviewed for care plan revision in the sample list of four.Findings include:The facility's Care Plan policy revised 1/2025 documents that care plans are revised as changes in the resident's condition dictate. The policy further states that the facility's interdisciplinary team, in coordination with the resident and family, develops and maintains a comprehensive care plan for each resident that identifies the highest level of function the resident may be expected to attain.The facility's Falls and Fall Risk Management policy (revised 8/2008) documents staff are to identify and implement relevant interventions to minimize the risk and consequences of falls.The facilities Resident Roster dated 3/23/26 documents R1 is hospitalized and was transferred to the hospital on 3/17/26.A facility incident note dated 3/10/26 documented R1 sustained a fall from bed during care and was found on the floor between the bed and the window after being left unattended during cares.R1's care plan revealed a revision dated 3/11/26 added an intervention to suction R1 prior to care due to coughing. However, the care plan did not include interventions to prevent rolling from bed during care, direction for staff to remain with the resident during care, reinforcement of two-person assistance for bed mobility and accurate documentation of R1's Activities of Daily Living (ADL) status and required level of assistance.On 3/23/26 at 12:00 PM, V9 (Certified Nursing Assistant/CNA) stated she was providing care to R1 on 3/10/26 when R1 rolled off the bed. V9 stated that R1 was turned on his side and V9 stepped away to retrieve supplies, and upon return observed R1 coughing and rolling off the bed. V9 stated she attempted to stop the fall by grabbing R1's upper body, but R1 was too heavy for V9 to hold onto. V9 confirmed R1 fell completely to the floor laying on his stomach. V9 further stated R1 was lifted from the floor by staff without use of a mechanical lift because they were unable to get the lift in the area R1 was lying.On 3/23/26 at 2:04 PM, V13 (Certified Nursing Assistant Supervisor) stated staff rely on a binder and verbal communication for care updates. Upon reviewing R1's care plan, V13 stated it did not include documentation regarding R1's ADL status and that staff unfamiliar with the residents would not know how to safely provide care. V13 stated, it looks like we dropped the ball. V13 further confirmed that CNA (V9), who was involved in the incident, did not routinely work on the unit and would not have been familiar with R1's care needs.On 3/23/26 at 1:40 PM, the Director of Nursing (V2) and Assistant Director of Nursing (V3) stated they did not directly communicate care plan updates to Certified Nursing Assistants (CNAs) and relied on shift report and supervisory staff for communication. Both stated they were unaware that R1's care plan lacked ADL care instructions.On 3/24/26 at 1:00 PM, V1 (Administrator) stated it was the responsibility of nursing leadership to ensure care plans were updated and that staff had the information necessary to provide care.

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: 145719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Lincoln Village Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2202 North Kickapoo Street Lincoln, IL 62656	

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 interview, and record review, the facility failed to ensure adequate supervision, safe transfer practices, post-fall assessment, and timely medical evaluation for one (R1) of four residents reviewed for accidents in the sample list of four. This failure resulted in R1 sustaining multiple rib fractures and a spinal compression fracture following a fall from R1's bed on 3/10/26, with no physician evaluation or diagnostic testing completed until seven days later. Findings include:The facility's undated Assisting a Client with Bed Mobility policy documents do not leave the resident lying on the edge of the bed. Stand next to the side of the bed the person is closest to, assist them to roll to their side and face you. This policy also documents under safety to make sure the person is in the middle of the bed. Lower the bed into a standard position and adjust the head of the bed to reduce injury. The facility's Falls and Fall Risk, managing policy revised 8/2008 documents staff will identify and implement relevant interventions to try and minimize serious consequences of falling.The facilities Resident Roster dated 3/23/26 documents R1 is hospitalized and was transferred to the hospital from the facility on 3/17/26. R1's electronic therapy records document R1 required extensive assistance with activities of daily living and was dependent on staff for transfers, requiring a mechanical lift. R1's Therapy documentation indicated R1 had poor trunk control, required two-person assistance for sitting, and was non-ambulatory.R1's care plan did not contain documented interventions addressing safe positioning during care, staff positioning, or to remain with the resident during care. This care plan did not include R1's Activities of Daily Living abilities or how many staff were needed to provide R1's cares.R1's Facility Incident note dated 3/10/26 documents R1 was found on the floor between the bed and the window after being left unattended during care. The note documents only minor scratches and indicated no complaints of pain at that time. R1's Nurse Progress Note dated 3/10/26 and 3/13/26 documented administration of as needed (PRN) Tylenol and Tramadol for general discomfort and back pain.R1's Facility Incident Report dated 3/17/26 documents R1 complained of rib pain and was sent to the emergency room for evaluation.R1's Hospital Skin assessment dated [DATE] included documentation that Skin is warm and dry (scattered bruises to body, worse on left side).R1's Radiology Report dated 3/17/26 revealed a Computed Tomography (CT) scan of the chest, abdomen, and pelvis were performed and compared to prior imaging dated 1/6/26 and 12/25/25. The CT scan identified new rib fractures of fifth through eighth rib an and a spinal compression fracture of the L2 Vertebral Body that were not present on prior imaging studies.R1's Hospital documentation dated 3/17/26 included the following note: dated 3/17/26 documents Called and spoke with V8 (Licensed Practical Nurse/LPN) from nursing home. Per V8, R1 fell at their facility on March 10th, V8 confirmed R1 was not sent to a hospital for evaluation or for any imaging. Per V8, a CNA was cleaning the patient up by herself and when patient was on their side, patient slid out of bed since their mattresses are so slick and fell onto the floor.R1's emergency room Physician Note dated 3/17/26 documents We were initially given history that R1 had just been acting oddly but then we did get history of a fall that occurred. I would be concerned for a chest wall injury as this is area of pain. V17 (emergency room Physician) further documented: Patient has findings of new rib fractures and post obstructive pneumonia as well as typical pneumonia. V17 documented concern that the injuries and resulting condition required advanced care, including potential transfer for specialized treatment. Additional hospital documentation noted scattered bruising, worse on the left side, and confirmed that no prior imaging or physician evaluation had been completed by the facility following the fall on 3/10/26.On 3/23/26 at 12:00 PM, V9 (Certified Nursing Assistant/CNA) stated she was providing care to R1 on 3/10/26 when R1 rolled off the bed. V9 stated that R1 was turned on his side and V9 stepped away to retrieve supplies, and upon return observed R1 coughing and rolling off the bed. V9 stated she attempted to stop the fall by grabbing R1's upper body, but R1 was too heavy for V9 to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hold onto. V9 confirmed R1 fell completely to the floor laying on his stomach. V9 further stated R1 was lifted from the floor by staff without use of a mechanical lift because they were unable to get the lift in the area R1 was lying.On 3/23/26 at 1:19 PM, V11 (Physical Therapy Assistant) stated R1 required a mechanical lift for transfers and would not be safe to stand or transfer without it.On 3/23/26 at 1:31 PM, V12 (Occupational Therapy Assistant) confirmed R1 had poor trunk control, required assistance from two staff, and was not safe for transfers without a mechanical lift.On 3/23/26 at 1:40 PM, V2 (Director of Nursing (DON) and V3 (Assistant Director of Nursing (ADON) stated they did not oversee CNA care plan communication and were unaware of CNA access to care plans. They stated changes in care were communicated through shift report rather than direct care plan review. V2 and V3 both stated they were not aware of what an Activity of Daily Living (ADL) Care plan was or that there was no documentation as to how R1's ADL cares should be provided. V3 further stated that she believed the reason R1 fell was because he was coughing and rolled off the bed. V2 and V3 further stated that V9 should not have walked away from R1's bed to gather items while R1 was lying on the side of the bed.On 3/23/26 at 10:34 AM, V14 (Hospital Registered Nurse) stated R1 was admitted to the hospital on [DATE] after being sent from the facility in an ambulance to the local emergency room. V14 stated V8 (Licensed Practical Nurse/LPN) the facility informed V14 that R1 had fallen out of bed on 3/10/26. V14 confirmed diagnostic imaging revealed multiple rib fractures and a spinal compression fracture. The nurse further stated that facility staff reported no physician evaluation or imaging was completed following the fall.On 3/23/26 at 1:06 PM, V10 (R1's Family Member) stated the facility informed her that R1 fell out of his bed and sustained only minor scratches after the fall. V10 stated she was not given all the information as to what happened and was under the impression R1 had been evaluated by V16 (Physician) V10 expressed concern that no further medical evaluation was completed despite the severity of injuries later identified. V16 was contacted and a message was left for V16 with no return call.On 3/24/26 at 12:00 PM, V4 (Respiratory Therapist) stated R1 exhibited a change in condition on 3/17/26 when V4 went in to provide respiratory care, including confusion, elevated heart rate, and complaints of chest and rib pain. V4 stated she immediately told V3 that R1 needed evaluation at the hospital. V4 further stated that V3 evaluated R1 and sent R1 by ambulance to the hospital.On 3/23/26 at 2:04 PM, V13 (Certified Nursing Assistant Supervisor) stated when changes occur, staff place a notification in a care needs binder at the nurses' station and verbally inform other staff. V13 provided the surveyor with access to the binder and reviewed R1's care plan. Upon review, V13 stated the care plan did not include documentation regarding R1's activities of daily living (ADL) status and further stated that if staff were unfamiliar with R1, they would not know how to safely provide care. V13 stated, it looks like we dropped the ball. V13 further confirmed that V9 does not normally work on the respiratory unit and would not have been as familiar with R1.On 3/24/26 at 1:00 PM, V1 (Administrator) stated it is the responsibility of V2 and V3 to ensure care plan updates are done and that staff have the information to provide care to the residents. V1 further stated that V9 should have never walked away from R1's bed while providing cares.