

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/10/2026
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 - Minimal harm or potential for 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 prevent a fall for one resident (R1) of three residents reviewed for falls in the sample of five. Findings include: The Fall Evaluation and Safety Guideline policy dated 1/14/26 documents Purpose- To consistently identify and evaluate residents at risk for falls and those who have fallen, to treat or refer for treatment appropriately, and to build organization-wide ownership of fall prevention in order to: Prevent or reduce injuries related to falls. Intent of This Guideline- To ensure the facility provides an environment free from controllable hazards and delivers appropriate supervision to each resident through the following process: 3. Implementation of interventions. The Activities of Daily Living policy dated 2/2023 documents Purpose: Based on a comprehensive assessment of the resident and consistent with the resident's needs and choices, our facility provides necessary care and services to ensure that resident's abilities in activities of daily living (ADL) do not diminish unless the circumstances of the individual's clinical condition demonstrates that such decline was unavoidable. Guideline: In accordance with the comprehensive assessment, together with respect for individual resident needs and choices, our facility provides care and services for the following activities: Elimination: Toileting. R1's computerized Medical Record documents that R1 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Unspecified sequelae of cerebral infarction, Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus, Dysphagia, following Cerebral Infarction, Tracheostomy Status, Contracture of Right and Left hand, and Aphasia Following Cerebral Infarction. R1's MDS (Minimum Data Set) assessment dated [DATE] documents a BIMS (Brief Interview for Mental Status) of 9, indicating (moderate cognitive impairment). R1 has lower extremity impairment, is dependent on two staff for all activities of daily living, bed mobility, and transfers. R1's Care Plan documents that R1 is at risk of falling related to impaired physical mobility related to Sequelae of Cerebrovascular Accident. The Care Plan also documents that R1's bed mobility has deteriorated and R1 requires two assists for bed mobility. (R1) will roll side to side and maintain a side lying position with 2 (two) staff assistance while cares are provided. R1's Fall Report documents on 4/14/26 at around 9:45 PM. R1 fell from bed and was lying face down with his head against the nightstand. There was no injury noted but R1 was sent to the emergency room for evaluation since R1 hit his head. The fall was witnessed by V3/Certified Nursing Assistant. On 6/8/26 at 2:25 PM, V3/Certified Nursing Assistant/CNA stated that R1 was in bed and V3 and V12/CNA Manager were doing incontinent care on R1. R1 was on his side with V3 on one side of the bed and V12 on the other side. V12 left the bedside to get the washcloths wet. While V12 was in the bathroom R1 rolled out of bed and fell to the floor. On 6/8/26 at 2:32 PM, V12/CNA Manager stated she was helping V3 with incontinent care for R1. R1 was lying on his side and when V12 went to the bathroom to wet the washcloths R1 rolled out of bed landing on the floor. V3 also stated that R1 is care planned for two staff when providing care for R1. On 6/10/26 at 12:00 PM, V1/Administrator stated that per the care plan R1 should have had two people at the bedside during incontinent 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