STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145720	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Clara's Rehab & Senior Care	1450 Castle Manor Drive 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. (continued on next page)

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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its procedure for transportation and failed to adequately supervise and safely secure resident during transport to prevent a fall for one (R1) resident of three residents reviewed for accidents/incidents in a sample of three. These failures resulted in R1 sustaining a subdural hematoma and left scapula fracture. Findings include: The facility's (State) Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, dated 11/28/18 documents: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life; and, Your rights to safety: The facility must provide services to keep your physical and mental health, at their highest practical levels.The facility's Passenger Carrier Safety Orientation-Return Demonstration Procedure dated 5/21/2015 (Signed and Dated 9/10/25 by V5 licensed Practical Nurse/LPN) documents: Any employee who will be a designated driver of a passenger carrier must complete the assigned online training as well as behind the wheel training by the facility's designated driving coach. 9. Employee backs the resident into the van. 10. Employee securely fastens and secures the resident into the van. R1's Hospital Notes dated 9/27/25 document: Radiology Report: Impression: Left subdural hematoma along the posterior falx. Minimally displaced left scapular fracture medially. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a BIMS (Brief Interview of Mental Status) score of 15. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.) R1's diagnoses include: History of Transient Ischemic Attack (TIA), Cerebral Infarction, Hemiplegia and Hemiparesis affecting left non-dominant side, Type 2 Diabetes, Depression, Obstructive Sleep Apnea; Dementia with other behavior disturbance, psychotic disturbance, mood disturbance; Chronic obstructive pulmonary disease (COPD), Acquired absence of left leg above knee, Traumatic subdural hemorrhage without loss of consciousness, Displaced fracture of body of scapula, left shoulder. R1's recent Care Plan documents: (R1) is at risk for falls related to needing assist with mobility and transfers, history of fall; use of psychotropic medication, left above the knee amputation. (R1) has been noted to be non-compliant with non-weight bearing and not to wear shoes. Facility's Initial and Final Reports to (State Department of Public Health) for R1 dated 9/27/25 and 10/3/25 document: On 9/27/25 at (1:50am), (R1) was being transported via facility van from an (Emergency Room) evaluation, fell over backwards, hitting his head on the rear door of the van. (R1) was diagnosed with an intracranial bleed and was transferred to (City) Medical Center for admission. Conclusion: (R1) was transported to the (Emergency Room), was diagnosed with a superficial abrasion to the scalp, a left subdural hematoma along the posterior falx measuring 0.8 centimeters, and a minimally displaced left scapular fracture. (R1) returned to facility on 10/2/25. (Documentation and Interviews indicated that V5 Licensed Practical Nurse/LPN was the driver of the facility van on 9/27/25.) On 10/14/25 at 1255pm, V8 Transport/Certified Nursing Assistant/CNA, stated that she did train (V5 Licensed Practical Nurse/LPN) on how to secure residents in the van during (V5's) transportation training and orientation. On 10/15/25 at 9:01am, V5 LPN stated that on the day of R1's accident, that V5 used the van for the first time; had just gotten his license to drive it to transport residents. V5 stated that he had been trained on how to secure wheelchairs in the van but that he only locked R1's wheelchair wheels and that was it, stated that the facility was only a block away (from hospital). V5 stated, It was around 1:30am in the morning; figured it was just a block away to the facility. I stopped at the stop sign out of the hospital parking lot; stepped on gas and (R1) rolled backwards. At this same time, V5 stated that he was no longer at the facility; stated I felt so bad about this; I resigned the next day. On 10/15/25 at 10:50am, V1 Administrator stated: (V3 Power of Attorney/POA to R1) was called after the accident. Both myself and (V3) agreed that the accident could have been avoided. When I called (V5 LPN) about the accident, he said he is getting too old for all the new technology; and said he was putting in his resignation immediately. (V5) was responsible for securing residents in the van.