

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000440		(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, Illinois, 61944			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			02/13/2026	
	Facility Reported Incident of 12/15/25/2698829						
S9999	Final Observations		S9999			02/13/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.						
	Section 300.1210b) General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is NOT met as evidenced by: 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 11/15/25 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		S9999				

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S9999	Continued from page 2 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 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	S9999					

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S9999	Continued from page 3 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. (B)		S9999				